# Duluth Building Trades Health Fund

Summary Plan Description
September 1, 2023

# DULUTH BUILDING TRADES HEALTH FUND

# SUMMARY PLAN DESCRIPTION – SEPTEMBER 1, 2023

**DULUTH BUILDING TRADES HEALTH FUND**

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This Summary Plan Description/Plan Document has been prepared for participants of the Duluth Building Trades Health Fund and is the official Plan rules and regulations. Benefits under this Plan will only be paid if the Board of Trustees decides, in its sole discretion, that the applicant is entitled to them. The Plan will be interpreted and applied in the sole discretion of the Board of Trustees (or its delegate, including a subcommittee of the Board of Trustees). Such decisions will be final and binding on all persons covered by the Plan who are claiming any benefits under the Plan. The Trustees also reserve the right to amend or terminate the Plan at any time.

# Introduction

The Board of Trustees of the Duluth Building Trades Health Fund is pleased to provide you with this updated Summary Plan Description/Plan Document ("SPD" or "the Plan"), which contains current health benefits information. The benefits described in this booklet are effective September 1, 2023. This SPD replaces and supersedes prior SPDs.

It is the Trustees' goal to maintain a financially stable Fund while providing quality health care coverage to you and your family. The Fund has implemented some cost-saving methods such as medical deductibles and out-of-pocket maximums to ensure that we can meet your current and future health care needs. You can do your part in helping the Fund manage health care costs by:

- **Visiting network providers** – Network providers and participating providers, including Hospitals, Physicians, and other health care providers, charge negotiated, reduced rates. If you need to find a network provider, call the phone number on the back of your medical ID card or at bluecrossmn.com.
- **Examining emergency treatment alternatives** – In the event of an emergency, the most important consideration is to seek medical care, especially in a life-threatening situation. However, in some cases, you can obtain the same level of care at a Physician's office or an urgent care facility as in an emergency room. Keep your Physician's telephone number easily accessible and locate the nearest facility so you will be prepared in case of an emergency.
- **Requesting generic medications** – Often medications come in two forms: generic and brand name. Generic medications have to meet the same quality standards for pureness and effectiveness, but can cost much less than their brand name equivalent. Check with your doctor to see if a generic medication is appropriate for you.

**It is important to keep the Plan informed if you change your address. To protect your family's rights, you must notify the Fund Office if you or any family member has a change of address. You should also keep a copy, for your records, of any notices that you send to the Fund Office.**

Also, be sure to notify the Fund Office if you:

- Want to change your beneficiary;
- Are receiving workers' compensation benefits;
- Are injured in an accident and you make a claim against an insurer or other responsible party;
- Become disabled or return to work after such disability ends;
- Enter the uniformed services of the United States;
- Acquire a new dependent;
- Have a change in marital status;
- Have a dependent who no longer meets the Plan's definition of a dependent to ensure that you receive a proper COBRA notice; or
- Become eligible for Medicare. Medicare eligible retirees may self-pay for medical and prescription drug coverage through a fully insured plan. See page 13 for retiree eligibility requirements.

**If you have questions about how the Plan works, please call 218-728-4231 or 800-570-1012 or write to the Fund Office at Wilson-McShane Corporation, 2002 London Road, Suite 300, Duluth, MN 55812.**

We urge you to read this information and, if you are married, share it with your spouse. Please keep this SPD with your important papers so you can refer to it when needed.

Sincerely,
Board of Trustees

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# SCHEDULE OF BENEFITS

| Schedule Of Benefits For Active Employees And Dependents | |
|---|---|
| **Comprehensive Major Medical Expense Benefit** | **Coverage** |
| Calendar Year Deductible | $200 per individual/$400 per family |
| Plan Coinsurance For Most Covered Expenses | 85% |
| Out-Of-Pocket Maximum for Medical Benefits (Including Deductibles) | $1,200 per individual/$2,400 per family |
| Diagnostic tests for suspected COVID-19 infection, when performed at an office visit | 100%<br>(over-the-counter COVID-19 tests for at home use are not covered) |
| Chiropractic Expense Benefit<br>(Diagnostic x-ray and lab expenses in connection with chiropractic services are payable under the Comprehensive Major Medical Expense Benefit.) | Up to 15 visits per calendar year |
| Online or Telehealth Visit through Doctor on Demand<br>Online or Telehealth Visit through any other provider | 100%<br>Covered as any other office visit |
| Preventive Care, including annual exam and recommended vaccines and their administration | 100% |
| Emergency Room Deductible (Waived, if the patient is admitted to the hospital within 24 hours of the Emergency Room visit or if Plan is secondary.) | $50 per visit |
| Home Health Care Expense Benefit<br>Maximum Lifetime Benefit | <br>30 months |
| Wigs | $300 per lifetime |
| Rehabilitation Services (Occupational, Physical, and Speech Therapy, and Development Delay Therapy; excludes Maintenance Rehabilitation and Coma Stimulation Services)<br>Calendar Year Limit | <br>24 visits |
| Acupuncture Treatment<br>Calendar Year Limit | <br>15 visits |
| **Prescription Drugs** | **Coverage** |
| Out-of-Pocket Maximum for Prescription Drug Benefits | $7,900 per individual/$15,800 per family |
| Plan Coinsurance (In-Network Only) | 85%, except Specialty Drugs included in the Flex Access program will have co-payments between $0 - $30 |
| Out-Of-Network | Not covered |

| Schedule Of Benefits For Active Employees And Dependents | |
|---|---|
| **Dental Care Expense Benefit (For Dependent Children Up to Age 19)** | |
| Class A Services | 100% of Reasonable Charges |
| Class B Services | 80% of Reasonable Charges |
| Class C Services | 80% of Reasonable Charges |
| Class D Services | 80% of Reasonable Charges |
| Class D Lifetime Maximum Benefit | $1,000 |
| TMJ Treatment | 80% of Reasonable Charges |
| **Dental Care Expense Benefit (For Employees, Spouses, and Dependent Children Age 19 and Older)** | |
| Calendar Year Maximum Benefit | $1,000 |
| Class A Services | 100% of Reasonable Charges |
| Class B Services | 80% of Reasonable Charges |
| Class C Services | 80% of Reasonable Charges |
| TMJ Treatment | 80% of Reasonable Charges |
| Lifetime Maximum Benefit (Included in the Calendar Year Maximum Benefit For Classes A, B, And C Combined) | $1,000 |
| **Vision Care Expense Benefit (For Dependent Children Up to Age 19)** | **Coverage** |
| Exams and Refractions | 100% |
| Frames | $250 Every Two-Year Period (beginning with even years) |
| Lenses for Glasses and Contact Lenses | 100% (limited to one pair of lenses for glasses or one order of contact lenses every calendar year) |
| **Vision Care Expense Benefit for Adults** | **Coverage** |
| Maximum Benefit Every Two Calendar Years (Beginning with even years) | $250 |
| **Hearing Expense Benefit** | **Coverage** |
| Maximum Benefit Once Every Five Years* | $1,000 per person |
| **Weekly Income Benefit (For Bargaining Unit Employees Only)** | **Coverage** |
| Weekly Benefit | $325 |
| Maximum Benefit Period | 13 weeks |
| Waiting Period | |
| For Accident | None |
| For Sickness | 7 days |
| **Death And Dismemberment Benefit (For Employees Only)** | |
| Amount | $5,000 |

*Contact the Fund Office regarding information on the Hearing Aid Discount Program or call EPIC Hearing at 1-866-956-5400 for assistance in locating hearing aid professionals.

| Reduced Schedule Of Benefits For Self-Pay Active Employees And Dependents | |
|---|---|
| **Comprehensive Major Medical Expense Benefit** | **Coverage** |
| Calendar Year Deductible | $500 per individual/$1,000 per family |
| Plan Coinsurance For Most Covered Expenses | 70% In-network<br>65% Out-of-network |
| Out-Of-Pocket Maximum for Medical Benefits (Including Deductibles) | $5,000 per individual/$10,000 per family |
| Diagnostic tests for suspected COVID-19 infection, when performed at an office visit | 100%<br>(over-the-counter COVID-19 tests for at home use are not covered) |
| Chiropractic Services | Not covered |
| Acupuncture Treatment | Not covered |
| Online or Telehealth Visit through Doctor on Demand<br>Online or Telehealth Visit through any other provider | 100%<br>Covered as any other office visit |
| Preventive Care, including annual exam and recommended vaccines and their administration | 100% |
| Emergency Room Deductible (Waived if the patient is admitted to the hospital within 24 hours of the Emergency Room visit or if Plan is secondary) | $100 per visit |
| Home Health Care Expense Benefit<br>Maximum Lifetime Benefit | <br>30 months |
| Wigs | Not covered |
| Rehabilitation Services (Occupational, Physical, Speech Therapy, and Development Delay Therapy; excludes Maintenance Rehabilitation and Coma Stimulation services) Calendar Year Limit | <br><br>24 visits |
| Organ Transplant | 50% In-network only |
| **Prescription Drugs** | **Coverage** |
| Out-of-Pocket Maximum for Prescription Drug Benefits | $4,100 per individual/$8,200 per family |
| Plan Coinsurance (In-Network Only) | 50%, except Specialty Drugs included in the Flex Access program will have co-payments between $0 - $30 |
| Out-Of-Network | Not covered |
| **Dental** | Not covered |
| **Vision** | Not covered |
| **Hearing Expense Benefit** | Not covered |
| **Death And Dismemberment Benefit (For Employees Only)** | Not covered |

| Option 1: Schedule Of Benefits For Non-Medicare Eligible Retirees, Dependents, And Surviving Spouses | |
|---|---|
| **Comprehensive Major Medical Expense Benefit** | **Coverage** |
| Calendar Year Deductible | $200 per individual/ $400 per family |
| Plan Coinsurance For Most Covered Expenses | 85% |
| Out-Of-Pocket Maximum for Medical Benefits (Including Deductibles) | $1,200 per individual/$2,400 per family |
| Diagnostic tests for suspected COVID-19 infection, when performed at an office visit | 100%<br>(over-the-counter COVID-19 tests for at home use are not covered) |
| Chiropractic Expense Benefit Limit<br>(Diagnostic x-ray and lab expenses in connection with chiropractic services are payable under the Comprehensive Major Medical Expense Benefit.) | Up to 15 visits per calendar year |
| Online or Telehealth Visit through Doctor on Demand<br>Online or Telehealth Visit through any other provider | 100%<br>Covered as any other office visit |
| Preventive Care, including annual exam and recommended vaccines and their administration | 100% |
| Emergency Room Deductible (Waived if the patient is admitted to the hospital within 24 hours of the Emergency Room visit or if Plan is secondary) | $50 per visit |
| Home Health Care Expense Benefit<br>Maximum Lifetime Benefit | <br>30 months |
| Wigs | $300 per lifetime |
| Rehabilitation Services (Occupational, Physical, And Speech Therapy; and Development Delay Therapy; Excludes Maintenance Rehabilitation And Coma Stimulation Services)<br>Calendar Year Limit | <br>24 visits |
| Acupuncture Treatment<br>Calendar Year Limit | <br>15 visits |
| **Prescription Drugs** | **Coverage** |
| Out-of-Pocket Maximum for Prescription Drug Benefits | $7,900 per individual/$15,800 per family |
| Plan Coinsurance (In-Network Only) | 85%, except Specialty Drugs included in the Flex Access program will have co-payments between $0 - $30 |
| Out-Of-Network | Not covered |
| **Dental Benefit** | Not covered |
| **Vision Benefit** | Not covered |
| **Hearing Expense Benefit** | Not covered |
| Death Benefit (For Retirees Only) | $5,000 |

| Option 2: Schedule Of Benefits For Non-Medicare Eligible Retirees, Dependents, And Surviving Spouses | |
|---|---|
| **Comprehensive Major Medical Expense Benefit** | **Coverage** |
| Calendar Year Deductible | $200 per individual/$400 per family |
| Plan Coinsurance For Most Covered Expenses | 85% |
| Out-Of-Pocket Maximum for Medical Benefits (Including Deductibles) | $1,200 per individual/$2,400 per family |
| Diagnostic tests for suspected COVID-19 infection, when performed at an office visit | 100% (over-the-counter COVID-19 tests for at home use are not covered) |
| Chiropractic Expense Benefit Limit<br>(Diagnostic x-ray and lab expenses in connection with chiropractic services are payable under the Comprehensive Major Medical Expense Benefit.) | 15 visits per calendar year |
| Online or Telehealth Visit through Doctor on Demand<br>Online or Telehealth Visit through any other provider | 100%<br>Covered as any other office visit |
| Preventive Care, including annual exam and recommended vaccines and their administration | 100% |
| Emergency Room Deductible (Waived if the patient is admitted to the hospital within 24 hours of the emergency room visit or if Plan is secondary) | $50 per visit |
| Home Health Care Expense Benefit<br>Maximum Lifetime Benefit | <br>30 months |
| Wigs | $300 per lifetime |
| Rehabilitation Services (Occupational, Physical, And Speech Therapy, and Development Delay Therapy; Excludes Maintenance Rehabilitation And Coma Stimulation Services)<br>Calendar Year Limit | <br>24 visits |
| Acupuncture Treatment<br>Calendar Year Limit | <br>15 visits |
| **Prescription Drugs** | **Coverage** |
| Out-of-Pocket Maximum for Prescription Drug Benefits | $7,900 per individual/$15,800 per family |
| Plan Coinsurance (In-Network Only) | 85%, except Specialty Drugs included in the Flex Access program will have co-payments between $0 - $30 |
| Out-Of-Network | Not covered |

| Option 2: Schedule Of Benefits For Non-Medicare Eligible Retirees, Dependents, And Surviving Spouses | |
|---|---|
| **Dental Care Expense Benefit (For Dependent Children Up to Age 19)** | |
| Class A Services | 100% of Reasonable Charges |
| Class B Services | 80% of Reasonable Charges |
| Class C Services | 80% of Reasonable Charges |
| Class D Services | 80% of Reasonable Charges |
| Class D Lifetime Maximum Benefit | $1,000 |
| TMJ Treatment | 80% of Reasonable Charges |
| **Dental Care Expense Benefit (For Retirees, Spouses, and Dependent Children Age 19 and Older)** | |
| Calendar Year Maximum Benefit | $1,000 |
| Class A Services | 100% of Reasonable Charges |
| Class B Services | 80% of Reasonable Charges |
| Class C Services | 80% of Reasonable Charges |
| TMJ Treatment | 80% of Reasonable Charges |
| Lifetime Maximum Benefit (Included in the Calendar Year Maximum Benefit For Classes A, B, And C Combined) | $1,000 |
| **Vision Care Expense Benefit (For Dependent Children Up to Age 19)** | **Coverage** |
| Exams and Refractions | 100% |
| Frames | $250 Every Two-Year Period (beginning with even years) |
| Lenses for Glasses and Contact Lenses | 100% (limited to one pair of lenses for glasses or one order of contact lenses every calendar year) |
| **Vision Care Expense Benefit for Adults** | **Coverage** |
| Maximum Benefit Every Two Calendar Years (Beginning with even years) | $250 |
| **Hearing Expense Benefit** | **Coverage** |
| Maximum Benefit Once Every Five Years * | $1,000 per person |
| **Death Benefit (For Retirees Only)** | **Coverage** |
| Amount | $5,000 |

*Contact the Fund Office regarding information on the Hearing Aid Discount Program or call EPIC Hearing at 1-866-956-5400 for assistance in locating hearing aid professionals.

| Option 1: Schedule Of Benefits For Medicare Eligible Retirees, Dependents, And Surviving Spouses | |
|---|---|
| **Comprehensive Major Medical Expense Benefit** | **Coverage** |
| Medicare Supplement Plan (*only benefit offered under Option 1*) | Contact Fund Office for details on Medicare Supplement Plan |

| Option 2: Schedule Of Benefits For Medicare Eligible Retirees, Dependents, And Surviving Spouses | |
|---|---|
| **Comprehensive Major Medical Expense Benefit** | **Coverage** |
| Medicare Supplement Plan | Contact Fund Office for details on Medicare Supplement Plan |
| **Dental Care Expense Benefit (For Dependent Children Up to Age 19)** | |
| Class A Services | 100% of Reasonable Charges |
| Class B Services | 80% of Reasonable Charges |
| Class C Services | 80% of Reasonable Charges |
| Class D Services | 80% of Reasonable Charges |
| Class D Lifetime Maximum Benefit | $1,000 |
| TMJ Treatment | 80% of Reasonable Charges |
| **Dental Care Expense Benefit (For Retirees, Spouses, and Dependent Children Age 19 and Older)** | |
| Calendar Year Maximum Benefit | $1,000 |
| Class A Services | 100% of Reasonable Charges |
| Class B Services | 80% of Reasonable Charges |
| Class C Services | 80% of Reasonable Charges |
| TMJ Treatment | 80% of Reasonable Charges |
| Lifetime Maximum Benefit (Included in the Calendar Year Maximum Benefit For Classes A, B, And C Combined) | $1,000 |
| **Vision Care Expense Benefit (For Dependent Children Up to Age 19)** | **Coverage** |
| Exams and Refractions | 100% |
| Frames | $250 Every Two-Year Period (beginning with even years) |
| Lenses for Glasses and Contact Lenses | 100% (limited to one pair of lenses for glasses or one order of contact lenses every calendar year) |
| **Vision Care Expense Benefit for Adults** | **Coverage** |
| Maximum Benefit Every Two Calendar Years (Beginning with even years) | $250 |
| **Hearing Expense Benefit** | **Coverage** |
| Maximum Benefit Once Every Five Years * | $1,000 per person |

*Contact the Fund Office regarding information on the Hearing Aid Discount Program or call EPIC Hearing at 1-866-956-5400 for assistance in locating hearing aid professionals.

# ELIGIBILITY

## Initial Eligibility

**Bargaining Unit Employees**

The Fund receives contributions for a month of work in the following month (*e.g.*, March contributions are received in April). The first day of the month following the month the Fund receives contributions (*e.g.*, the first of the month following April is May 1) is your coverage effective date, if:

- The Fund has received at least 405 hours of contributions on your behalf, and
- Contributions for the 405 hours worked must be made within not less than two, but not more than twelve, consecutive calendar months.

*For example:*

*If you worked 150 hours in January, 150 hours in February, and 150 hours in March, the Fund would receive your March Employer contributions in April and your coverage would be effective May 1.*

This initial eligibility rule applies only once for each bargaining unit employee. After you meet the initial eligibility requirements, if you lose coverage under the Plan, you must have at least 405 hours of contributions made on your behalf within 12 consecutive calendar months to become eligible again.

*Option to Self-Pay for Coverage Prior to Initial Eligibility*

Once the Fund has received at least 270 hours of contributions on your behalf, you have the option to self-pay for coverage up to 135 hours per month until you meet the initial eligibility requirements for bargaining unit employees discussed above. Contact the Fund Office for instructions on self-paying for coverage prior to initial eligibility.

**Non-Bargaining Unit Employees**

Non-bargaining unit employees are initially eligible for coverage on the first day of the month following the month the Fund receives its first monthly contribution on their behalf from an employer signatory to a Participation Agreement.

## *Enrollment*

After you meet the eligibility requirements, you must complete an enrollment card to enroll yourself and your eligible dependents (see page 12 for a definition of dependent). To enroll dependents:

- Complete a new enrollment card;
- For your spouse – supply copy of marriage certificate;
- For your child/step-child – supply copy of state issued birth certificate and/or divorce decree (if applicable);
- For children born outside of marriage – state issued birth certificate, paternity papers and documentation showing responsibility for insurance coverage; and,
- For all dependents, provide documentation of other insurance coverage (if applicable) for coordination of benefits purposes.

### *Dependent Special Enrollment for Active Employees*

Active employees may add new dependents following initial eligibility by submitting to the Plan a written request for enrollment along with any enrollment information the Plan may require (for example, copy of marriage certificate, proof of loss of other coverage, etc.). If you are adding a new dependent because of:

- marriage, birth, adoption, or placement for adoption;
- termination of other health coverage due to loss of eligibility, or exhaustion of COBRA coverage under another health plan; or
- loss of eligibility for Medicaid or the Children's Health Insurance Program (CHIP), or eligibility to participate in a financial assistance program through Medicaid or CHIP;

you must submit a written request for enrollment along with any required enrollment information so that it is received by the Plan within 90 days of the event (for example, marriage, birth, loss of coverage, etc.) for coverage to be effective on the date of the qualifying event. If the written request for enrollment and required enrollment information is not received by the Plan within 90 days of the qualifying event, or if you are enrolling a new dependent for a reason other than those listed above, new dependent coverage will be effective on the first day of the month following the date the Plan receives the request for enrollment and the required enrollment information.

## Continuing Eligibility

After you meet the initial eligibility requirements, you can continue your eligibility if you work for a Contributing Employer and the employer makes contributions for at least 135 hours per month on your behalf.

Because the contributions for hours worked in a month are not made to the Plan until the following month, your current work earns future eligibility as follows:

| If Contributions For The Month Of… | Are Received By The Due Date In… | You Earn Eligibility For The Month Of… |
|---|---|---|
| January | February | March |
| February | March | April |
| March | April | May |
| April | May | June |
| May | June | July |
| June | July | August |
| July | August | September |
| August | September | October |
| September | October | November |
| October | November | December |
| November | December | January |
| December | January | February |

If you have not worked the minimum hours required (or the contributions for those hours have not been made), you can continue eligibility by using hours that were credited to your Hours Bank.

### *Hours Bank*

When you work more than the minimum number of hours required to meet the initial or continuing eligibility requirements, and contributions are made for those hours, the excess hours are credited to your

Hours Bank. Your Hours Bank reflects a bookkeeping entry for hours that are added or applied, and does not reflect that any actual money has been set aside for you. The hours in your Hours Bank can be used to continue eligibility, subject to important exceptions contained in this Summary Plan Description. At no time will you, or any participant, have a claim or right to any portion of the assets of the Trust that sponsors this Plan. Your Hours Bank hours are not vested, and will not be considered vested benefits under any circumstances. The Hours Bank arrangement can be changed or terminated by the Board of Trustees at any time if they deem it appropriate to do so.

There is a maximum number of hours that can be contributed to your Hours Bank. Currently, up to 2,400 hours can be contributed to your Hours Bank account, although that number can change in the sole discretion of the Board of Trustees. When the employer contribution increases, the Fund Office will reduce the number of hours in your Hours Bank in proportion to the percent of increase in your contribution rate, subject to some exceptions. Your Hours Bank account will be reduced to zero upon the occurrence of either of the following events:

- You accept any employment in the building trades from an employer who is not a party to a collective bargaining agreement with a participating union; unless your employment is sanctioned by your local union as part of a campaign to organize that employer; or
- Your home local union takes an action that will terminate the provisions of the collective bargaining agreement that requires contributions for your work. You will still be eligible for coverage based on your hours worked before the effective date of the termination, even though your Hours Bank was reduced to zero. For example, if your union withdraws from the Fund on May 1 (with the last reported hours being April's hours), and you have the required work hours for June eligibility, then your coverage will cease June 30. If you did not have the required hours in April, but did in March, your coverage would end May 31. If you did not work the required hours in April, you will not be allowed to self-pay the difference.

The Fund will not credit hours reported by an employer to your Hours Bank account until the contributions for those hours are received by the Fund Office.

If the hours in your Hours Bank account plus the number of hours contributed to the Fund on your behalf are not enough to continue eligibility and you do not elect to self-pay the difference, these hours will remain in your Hours Bank account for twelve consecutive months. To maintain your account, you must remain available for work in the building trades in the jurisdiction of a participating Union or work for a non-union employer in employment that is sanctioned by your local union as part of a campaign to organize that employer. If you retire and work limited hours that allow you to still receive a monthly pension benefit you will be considered unavailable for work and your hours bank (but not your dollar bank) will be reduced to zero. The hours in your account may be used to continue eligibility within twelve consecutive months. If you do not reestablish eligibility within twelve consecutive months, the hours in your Hours Bank account will be reduced to zero.

### *Non-Portability of Hours*

If a participating Union or a group covered by a collective bargaining agreement ends participation in the Fund, all banked hours recorded for those members of the Union or group on the date of withdrawal will be reduced to zero. All contributions received by the Fund attributable to hours worked through the date of termination remain assets of this Fund. If your Union or group withdraws participation, under no circumstances will you, or the Union or group, be entitled to transfer any hours or any assets related to those hours to another Fund or entity.

## *Reciprocity*

The Board of Trustees has entered into reciprocity agreements with other health funds that provide for the transfer of employer contributions to the fund of the Employee's home local union when he or she works in the jurisdiction of another local union.

If you are eligible for reciprocity and request in writing that employer contributions be transferred from one fund to another, the administrators will first determine which fund is the home fund of the Employee. Your home fund is the fund located in the city or area where you reside and principally work. The administrator of the non-home fund will transfer the contributions received on your behalf to your home fund. The hours credited will be determined by dividing the amount of money received from the non-home fund by the home fund contribution rate. This Fund will go back no more than 6-months from the date transfer authorization was received, provided no claims have been paid by the Fund during that 6-month period.

If you meet the eligibility requirements, you will receive benefits from your home fund. Contributions from self-employed participants are not accepted.

## *Self-Pay Coverage*

If you have completed at least 300 hours of employment for a Contributing Employer in the preceding 12 months, you may continue all benefits by making the required contributions for Self-Pay Coverage. You can choose between the full active plan of benefits (see *Schedule Of Benefits For Active Employees And Dependents)* or a reduced plan of benefits (see *Reduced Schedule Of Benefits For Self-Pay Active Employees And Dependents*) at a lower self-payment rate. Your ability to self-pay 135 hours per month is limited to nine consecutive months following the last month the Fund receives an employer contribution on your behalf. However, if you are Totally Disabled and have applied for Social Security Disability, you can continue to self-pay for coverage as long as you have a pending Social Security Disability claim.

Self-pay coverage is continued as follows:

| To Self-Pay For The Month Of… | You Must Have Worked 300 Hours During The Previous 12-Month Period Of… |
|---|---|
| January | December through November |
| February | January through December |
| March | February through January |
| April | March through February |
| May | April through March |
| June | May through April |
| July | June through May |
| August | July through June |
| September | August through July |
| October | September through August |
| November | October through September |
| December | November through October |

*For example, to self-pay for January 2024, you must have worked at least 300 hours between December 2022 and November 2023. To self-pay for July 2024, you must have worked at least 300 hours between June 2023 and May 2024.*

If you receive a self-payment notice from the Fund, your payment must be received by the 25th of the month. **Payments received after the 25th of the month will not be accepted and your coverage will**

**end as of the last day of the previous month.** If you self-pay for coverage, you cannot elect COBRA Continuation Coverage.

Owner Operators are not eligible for self-pay. You are not eligible for self-pay coverage if you are retired as defined by your Union and you will no longer be eligible for the Active benefits under this Plan.

## Owner Operator & Non-Bargaining Employees

An Owner Operator is defined as a member of a participating union and an owner of a Contributing Employer.

Owner Operators may participate in the Plan by paying the hourly contribution rate pursuant to a Collective Bargaining Agreement that requires a minimum of 160 hours per month be paid on behalf of the Owner Operator. Alternatively, Owner Operators may participate in the Plan by signing an Owner Operator Participation Agreement that will be for the shorter of a one-year term or the expiration of the Collective Bargaining Agreement. The Participation Agreement will require the Owner Operator to make contributions on a minimum of 160 hours per month in order to become and remain eligible for coverage. If an Owner Operator also works as a Bargaining Unit Employee for another Contributing Employer, then the contributions made on behalf of the Owner Operator by the other employer will be deducted from the required contribution of the Owner Operator. If an Owner Operator pays for more than 160 hours in a month, the excess contributions will go into his or her Hours Bank account. If a Bargaining Unit Employee becomes an Owner Operator, he or she may run out his or her Hours Bank account, at 160 hours per month of eligibility, before contributing.

An Employer signatory to a Non-Bargaining Unit Participation Agreement with the Fund may elect to cover non-bargaining unit employees (subject to the approval of the Board of Trustees) through the payment of monthly premiums. A bargaining unit employee who becomes a non-bargaining unit employee will have their Hours Bank account suspended. Upon leaving non-bargaining unit employment the Participant may utilize his or her Hours Bank account subject to the Continuing Eligibility rules of the Plan.

## *Eligible Dependents*

Your dependents will be eligible for benefits on the date you become eligible or on the date you first acquired the dependent, whichever is later.

Dependents include:

- Your spouse; and,
- Your child until the end of the last day of the month in which he or she attains age 26.

"Child" is limited to your:

- Natural child;
- Stepchild; or
- Legally-adopted child or one for whom legal adoption proceedings have been initiated as evidenced by certified copies of pleadings from a court of competent jurisdiction being provided to the Fund Office. A child for whom coverage must be provided because of a Qualified Medical Child Support Order (QMCSO) is also an eligible dependent.

A spouse or child will not be eligible as a Dependent during any period that he or she is in the military, naval or air force of any country, except as required by the Uniformed Services Employment and Reemployment Rights Act (USERRA), as amended.

### *Qualified Medical Child Support Order (QMCSO)*

Health plans are required to recognize a judgment, decree or order which provides child support or health benefit coverage to the child of a Plan participant. The judgment, decree, or order must be issued by a court of competent jurisdiction. The Fund has adopted procedural rules for determining if a judgment, decree, or order is a qualified medical child support order. You or your attorney may request a copy of the rules, which have been adopted by this Fund from the Fund Office free of charge. If you have dependent children and are involved in a divorce or separation, advise your attorney of the requirements of this Plan regarding qualified medical child support orders.

## *Retirees*

You must notify the Fund Office at least 30 days before your Retirement Date. **Your Retirement Date is the date of your first pension benefit.** If you are over age 65, you must notify the Fund Office at least 90 days before your Retirement Date. On your Retirement Date, your Hours Bank account is converted to a dollar bank, regardless of when notification of your retirement was received in the Fund Office. If this results in a lapse of coverage, you will have the option to make the necessary retiree self-payments to bring your coverage current. If you elect not to make the payments and claims have been paid, the Fund will require reimbursement on the expenses paid. You may offset your self-payments with amounts from the dollar bank. Dollar bank amounts are used before self-payments. Employer contributions for hours worked after retirement will go into the Fund's reserves and will not increase your dollar bank, unless you earn enough hours to re-qualify for initial eligibility. While you are working to earn your initial eligibility, you remain eligible for retiree coverage. When you eventually re-retire you will be eligible for retiree benefits regardless of how many months in the previous 60 that you were eligible for active benefits and any hours in your hours bank will not be converted to a dollar bank. Your "re-retirement" occurs the month you begin receiving a monthly pension benefit or will be deemed to occur no later than the month following the month you worked zero hours. Your dollar bank is forfeitable, non-vested, and can be eliminated at the Trustees' discretion. If your Union discontinues contributions to the Fund, Retiree coverage will terminate as of the last day of the month for which Active contributions were received by this Fund.

If the Fund Office receives timely notification of your retirement and you do not complete the required paperwork to choose a retirement option, you will automatically be placed in the highest option.

If you are an Active Participant, you become eligible for Retiree benefits if you:

- Have made written notification of your retirement to the Board of Trustees at least 30 days prior to your Retirement Date (90 days if you are age 65 or older);
- Have sufficient eligibility for active benefits from the Health Plan immediately prior to retirement. This requirement can be met if either: (1) you were eligible for active benefits from the Health Plan for at least 54 of the previous 60 months; or (2) you were eligible for active benefits from the Health Plan for at least 48 of the previous 60 months and you had 15 years of continuous participation in each Plan year immediately prior to retirement. For purposes of this provision, "participation in each Plan year" means a calendar year in which you were eligible for benefits for at least three consecutive months; and
- Receive a pension benefit from either a local or a national AFL-CIO Building Trades Pension Plan, or from an ERISA and tax qualified pension plan sponsored by a contributing employer for which contributions were made at the same time as contributions were made to this Plan.

You will remain eligible for coverage if the required self-payment is made by the due date. If the required self-payment is not received by the due date, coverage will end. Self-payments must be received by the 15th of the month prior to the coverage month.

You will be considered eligible for active benefits from the Health Plan for any month that you receive wage loss benefits from workers' compensation related to a work injury for up to 12 of the 54 months you would have otherwise been covered for active benefits.

When requested by the Fund Office, if you are an Owner Operator, partner, sole proprietor, etc., you must provide a notarized affidavit verifying your retirement in a form approved by Fund Counsel. Non-Bargaining Participants must be at least age 62 and have 5 years of participation in total in the Plan at retirement to qualify for Retiree Benefits. COBRA participants are NOT eligible for retiree coverage.

### *Dependent Special Enrollment for Retirees*

After your initial eligibility for Retiree coverage, you may only add dependents if there is a change in status that meets one of the following criteria:

a) You get married. Election of coverage for your spouse must be made within 30 days from the date of marriage. Enrollment is effective on the date of marriage, except that for Medicare-eligible dependents, enrollment is effective on the first day of the first calendar month beginning after the date the completed request for enrollment is received by the Plan.

b) You become legally responsible for a dependent child or children through birth, adoption, or placement for adoption. Election for coverage of your child or children must be made within 30 days of the date of birth, adoption, or placement of adoption. Enrollment is effective on the date of birth, date of adoption, or date of placement for adoption.

c) Your dependent(s) lose coverage under another health plan under COBRA which was exhausted, or coverage was not under COBRA and was terminated due to loss of eligibility, including legal separation, divorce, death, termination of employment, or reduction in hours of employment, or termination of employer contributions. (However, lost eligibility does not include a loss due to failure of the individual or the Participant to pay premiums on a timely basis or termination of coverage for cause.) Election for coverage of your dependent(s) must be made within 30 days of the exhaustion or termination of the other health coverage. Enrollment is effective on the date of the loss of coverage, except that for Medicare-eligible dependents, enrollment is effective on the first day of the first calendar month beginning after the date the completed request for enrollment is received by the Plan.

d) You have dependents who are eligible for coverage under the Fund, that are not enrolled, and either of the following occurs:

- The dependent loses eligibility under Medicaid or the Children's Health Insurance Program (CHIP), and you or the dependent request coverage within 60 days after termination of Medicaid or CHIP, or

- The dependent becomes eligible to participate in a financial assistance program through Medicaid or CHIP and you or the dependent request coverage under the Fund within 60 days after becoming eligible for the assistance.

Enrollment is effective on the date of loss of eligibility for Medicaid or CHIP or the date the dependent becomes eligible to participate in a financial assistance program through Medicaid or CHIP, except that for Medicare-eligible dependents, enrollment is effective on the first day of the first calendar month beginning after the date the completed request for enrollment is received by the Plan.

**NOTE: In order to request special enrollment, you or your dependent must submit to the Plan a written request for enrollment specifying the change in status, along with a copy of the official document demonstrating such change in status, and any additional information the Plan may require. An additional monthly self-pay contribution is required for a retiree to add coverage for a dependent spouse (this is not required for a dependent child). The additional self-pay contribution must be paid to the Fund at the time you submit your written request for coverage for your spouse.**

### *Benefits For Non-Medicare Eligible Retirees*

If you meet the retiree eligibility requirements above, you may be eligible for retiree benefits under the Plan if you are not eligible for Medicare (*e.g*., you are under age 65). The Plan offers two options:

- Option 1: Medical, prescription drug, and death benefits. If Option 1 is chosen, you **cannot change to** Option 2 in the future.
- Option 2: Medical, prescription drug, dental, hearing, vision, and death benefits. If Option 2 is chosen, you can change to Option 1 in the future.

### *Benefits For Medicare Eligible Retirees*

If you meet the retiree eligibility requirements above, you may be eligible for retiree benefits under the Plan if you are eligible for Medicare (*e.g.,* you are over age 65). The Plan offers two options:

- Option 1: Medicare Supplement Only. If Option 1 is chosen, you **cannot change to** Option 2 in the future.
- Option 2: Medicare Supplement, dental, vision, and hearing benefits. If Option 2 is chosen, you can change to Option 1 in the future.

Please contact the Fund Office for information about the Medicare Supplement Plan for Medicare eligible retirees.

## *One Time Opt-Out Provision Available to Retirees*

Retired Participants, and all current active Participants who at the time of retirement are otherwise eligible for retiree benefits from the Plan, may exercise a one-time Opt-Out of the Fund as described below. *Note, if a retired Participant or an active Participant at the time of retirement exercises the one-time opt-out election, the election will be applicable to the Participant, the Participant's dependent spouse and all dependent children, if any.*

**Required Documentation:** In order to exercise this opt-out provision, the Participant needs to provide the following to the Fund:

(a) Documentation of other group or individual health insurance coverage, the effective dates of that coverage and who is eligible for coverage; and
(b) Completed and executed opt-out application form (available from the Fund Office).

All documents need to be received by the Fund Office 15 days prior to the one-time opt-out period commencing and will only be effective on the first day of the applicable month.

**Re-Enrollment in The Fund:** If a Retired Participant and his or her dependents exercise the one-time opt-out option, they will have a one-time opportunity to re-enroll in the Fund provided the following conditions are met:

(a) The "other" health coverage is lost through retirement, termination of employment (voluntary or involuntary), reduction in work hours, or by becoming Medicare eligible, or because of dissatisfaction with the "other" health coverage currently enrolled; or

(b) The Retired Participant is no longer eligible as a dependent under his or her spouse's health plan due to divorce or legal separation. This change in eligibility would only allow the Retired Participant to re-enroll in the Fund (a spouse or ex-spouse would not qualify to opt-in or re-enroll in the Fund).

In order to re-enroll in the Fund, the Retired Participant and his or her dependent(s) must provide documentation to the Fund regarding the events defined above. As set forth below, coverage will begin the first of the month after the Fund's receipt of the Retired Participant's notice of intent to re-enroll in the Fund along with the required documentation.

If the Retired Participant and all dependents do not re-enroll in the Fund within 30 days of loss of coverage, the Retired Participant and all dependents will lose the ability to re-enroll in the Fund permanently.

**Dollar Bank:** When a Retiree opts out of the Fund, their dollar bank will be suspended until they re-enroll in the Fund. However, at the time a Retiree opts out they have the ability to waive and thereafter forfeit their remaining dollar bank balance. A Retiree may choose to forfeit their dollar bank balance to become eligible for premium assistance tax credits for other health care coverage.

**Rates and Effective Date of Coverage After Re-enrollment:** Retired Participants will pay the same monthly self-pay according to the Fund rules in effect at the time of re-entry as if the Retiree had never left the Fund through the one time opt-out provision and as set by the Board of Trustees each year. Coverage will begin the first of the month after the Fund's receipt of the Retired Participant's notice of intent to re-enroll in the Fund along with the required documentation. *For example, if the Fund receives the notice of intent to re-enroll in the Fund on March 10, coverage will begin on April 1.*

## *If You Become Disabled*

If you are Totally Disabled and have worked a minimum of 300 hours in the previous 12 months, you can continue self-payments if you have applied for Social Security Disability benefits. You must make the same self-payment as an Active Employee. You may not perform or be able to perform work that would be covered under the bargaining agreements related to this Fund, nor have any other earned income (including unemployment compensation benefits). When you become entitled (the date on the Social Security award letter) to Social Security Disability benefits, you will no longer be eligible for Active Plan benefits and will become eligible for the Retiree Plan at the self-payment rate required for that coverage.

After 13 continuous weeks of disability, the Fund will provide coverage for the subsequent three-month period without self-payment provided you have a pending Social Security Disability claim. You can resume self-paying for coverage following this three-month period and you can continue to self-pay for coverage as long as you have a pending Social Security Disability claim. If you choose to self-pay for coverage for a period longer than nine months due to a pending Social Security Disability claim, you may be asked to sign a release that allows the Fund to receive information from the Social Security Administration regarding your pending Social Security Disability claim. **Fund coverage will end if Social Security does not approve the disability.**

## When Eligibility Ends

When your coverage ends, you will be provided with written notification of the date your coverage was terminated.

### *For Active Employees*

Your coverage under this Plan will end on the earliest of the following dates:

- At the end of the month in which your employer has not reported and contributed payments for enough hours to earn eligibility for the next month;
- The date your Hours Bank account does not have sufficient hours to maintain eligibility;
- The last day of the month following the 12-month period when you did not complete 300 hours of employment for a Contributing Employer;
- The date you do not make the required self-payment to the Fund;
- The date you begin working for a non-union or non-contributing contractor in the building and construction industry, including maintenance and service work typically done by the building trades, unless your employment is sanctioned by your local union as part of a campaign to organize that employer;
- The date the Plan is discontinued; or
- The last day of the month following the month in which contributions were last reported due to changes to the Collective Bargaining Agreement.

### *For Dependents*

Dependent coverage ends on the earliest of the following:

- The date he or she becomes eligible as an Employee;
- The date he or she no longer is an eligible dependent;
- The date of your divorce for your spouse and stepchildren;
- If dependent children are covered through a surviving spouse following your death, when the surviving spouse becomes eligible for Medicare; or,
- The date your coverage terminates.

### *For Retired Employees*

Your eligibility for retiree coverage will end on the earliest of the following:

- The date you die;
- The day the Plan is terminated;
- The last day of the month in which your self-payment is not received;
- The date you no longer meet the eligibility requirements for retiree coverage;
- The date you elect to opt-out of retiree coverage; or
- The last day of the month in which contributions were last reported due to changes to the Collective Bargaining Agreement.

In the event of your death, your surviving dependents may be eligible to self-pay to continue coverage.

## Family And Medical Leave Act (FMLA)

The Family and Medical Leave Act (FMLA) of 1993 allows you to take up to 12 weeks of unpaid leave for your serious health condition or that of your parent, child or spouse, to care for a child after the birth, adoption, or placement for adoption of a child, or for a qualifying exigency arising out of the fact that your spouse, child or parent is a military member on active duty. The Act also entitles covered employees to up to 26 weeks of unpaid leave to care for a servicemember with a serious illness or injury if that person is your spouse, child, parent or next of kin. The Family and Medical Leave Act requires employers to maintain health coverage under any health plan for the length of a leave as if you were still employed. In addition, the Act states that if you take a family or medical leave, you may not lose any benefits that you had accrued before the leave. You must meet certain eligibility requirements to qualify for FMLA as listed below.

### *Eligibility*

To be eligible for FMLA benefits, you must:

- Work for a Contributing Employer;
- Have worked for the employer for at least 12 months;
- Have worked at least 1,250 hours over the previous 12 months; and
- Work at a location where at least 50 employees are employed by the employer within 75 miles.

### *Leave Entitlement*

An employer covered under FMLA may grant you up to a total of 12 weeks of unpaid leave during any 12-month period for one or more of the following reasons:

- For the birth or placement of a child for adoption or foster care;
- To care for an immediate family member (spouse, child, or parent) with a serious health condition;
- To take medical leave when you are unable to work because of a serious health condition; or,
- For any qualifying exigency arising out of the fact that a spouse, child, or parent is a military member on covered active duty.

Spouses employed by the same employer are entitled to a *combined* total of 12 weeks of family leave for the birth, placement of a child for adoption, foster care, or to care for a child or parent (but not parent-in-law) who has a serious health condition.

Under some circumstances, you may take FMLA leave intermittently – which means taking leave in blocks of time, or by reducing your normal weekly or daily work schedule. Intermittent FMLA leave for birth or adoption, or foster care placement requires your employer's approval. FMLA leave may be taken intermittently whenever it is medically necessary to care for a family member's serious health condition, or because you have a serious health condition and are unable to work.

An eligible employee may also take up to 26 workweeks of "military caregiver leave" during a single 12-month period to care for a covered servicemember with a serious illness or injury when the employee is the spouse, child, parent or next of kin of the covered servicemember.

### *Returning To Work*

Upon return from FMLA leave, you must be restored to your original job, or to an equivalent job with equivalent pay, benefits, and other employment terms and conditions. In addition, your use of FMLA leave cannot result in the loss of benefits that you earned or were entitled to before using FMLA leave.

### *Termination Of FMLA Health Care Coverage*

Health care coverage during FMLA leave ends on the earliest of the following dates:

- When you return to work; or
- When 12 weeks of leave ends (or 26 workweeks of military caregiver leave).

## Service In The Armed Forces

The Uniformed Services Employment and Reemployment Act provides certain benefit protections to employees on military leave in the uniformed services.

If you enter into the uniformed services (active duty or inactive duty training), you may elect to continue your health coverage, as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Service in the uniformed services means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes:

- Active duty;
- Active duty for training;
- Initial active duty for training;
- Inactive duty training;
- Full-time National Guard duty; and
- A period for which you are absent from a position of employment for an examination to determine your fitness for duty.

When you enter military service, your Hours Bank account is frozen as of the last day of the month prior to military activation. Your Hours Bank will be reactivated the first of the month following discharge. You will be required to show proof of your activation and discharge. If you wish to use your Hours Bank to continue coverage, contact the Fund Office.

If you enter active military service for up to 31 days, you can continue your medical, dental, and vision coverage during that leave period if you continue to either pay the required contributions or use your Hours Bank. If you enter active military service for more than 31 days and after your Hours Bank has been exhausted, you may be able to continue your medical, dental and vision coverage at your own expense for up to 24 months under COBRA. To continue coverage, you or your dependent must pay the required self-payment.

Your coverage will continue until the earlier of:

- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or,

- 24 consecutive months after your coverage would have otherwise ended.

However, your coverage will end the earliest day:

- Your coverage would otherwise end as described above;
- Your former employer ceases to provide any health plan coverage to any employee;
- Your self-payment is due and unpaid; or,
- You again become covered under the Plan as an active Employee.

Your coverage ends on the first day of the month following the date you enter uniformed services and elect not to continue coverage. Your eligible dependents may continue coverage under the Plan by electing and making self-payments for COBRA Continuation Coverage (see page 21).

You need to notify the Fund Office when you enter the military and when you return to covered employment. For more information about continuing coverage under USERRA, contact the Fund Office.

### *Reinstating Your Coverage*

Following discharge from military service, you may apply for reemployment with your former employer in accordance with USERRA. Reemployment includes the right to elect reinstatement in the existing health coverage provided by your employer. According to USERRA guidelines, reemployment and reinstatement deadlines are based on your length of military service.

When you are discharged or released from military service that was:

- Less than 31 days, you have one day after discharge (allowing eight hours for travel) to return to work for a Contributing Employer;
- More than 30 days but less than 181 days, you have up to 14 days after discharge to return to work for a Contributing Employer; or
- More than 180 days, you have up to 90 days after discharge to return to work for Contributing Employer.

When you are discharged, if you are Hospitalized or recovering from an illness or injury that was incurred during your military service, you have until the end of the period that is necessary for you to recover to return to or make yourself available for work for a Contributing Employer. The Fund will maintain your prior eligibility status until the end of the leave, provided your employer properly grants the leave under the federal law and makes the required notification and payment to the Fund. If you do not return to work within the required timeframes, you must again meet the initial eligibility requirements to be eligible for coverage.

## In The Event Of Your Death

### *For Active Employees*

Your surviving spouse and any eligible dependent children may continue coverage in the event of your death by choosing Option 1 or Option 2 coverage as described beginning on page 4. Coverage may continue until your spouse remarries or becomes eligible for Medicare. Once your surviving spouse becomes eligible for Medicare, they may enroll in one of the Medicare Eligible Retiree options. Once your surviving spouse becomes eligible for Medicare, coverage for your dependent children will terminate under this Plan (they may continue coverage under COBRA continuation as described below).

Upon your death, any amounts credited to your Hours Bank account will be available for use by your surviving spouse if your spouse elects to continue coverage under this Plan.

If you have no surviving spouse, but have surviving eligible dependent children, your surviving dependent children may continue coverage under COBRA Continuation as described below. A separate premium will be charged for each dependent.

If the required self-payment is not received by the due date, coverage will end.

### *For Retired Employees*

Your surviving spouse and any eligible dependent children may continue with the same Retiree Option they currently have by making the self-payment. Coverage may continue until remarriage.

If you have no surviving spouse, but have surviving eligible dependent children, your surviving dependent children may continue coverage under COBRA Continuation as described below. A separate premium will be charged for each dependent.

## COBRA Continuation Coverage

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Continuation Coverage can become available to you when you would otherwise lose your group health coverage. It can become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This section gives only a summary of your COBRA Continuation Coverage rights. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Fund Office.

If you have a newborn child, adopt a child, or have a child placed with you for adoption or legal guardianship (for whom you have financial responsibility) while COBRA Continuation Coverage is in effect, you may add the child to your coverage. You must notify the Fund Office in writing of the birth or placement and provide a completed enrollment form and other necessary documentation (i.e., state issued birth certificates, legal documents) to have this child added to your coverage. Children born, adopted, or placed for adoption or legal guardianship as described above have the same COBRA rights as a spouse or dependents who were covered by the Plan before the event that triggered COBRA Continuation Coverage. Like all qualified beneficiaries with COBRA Continuation Coverage, their continued coverage depends on timely and uninterrupted payments on their behalf.

#### *COBRA Continuation Coverage In General*

COBRA Continuation Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a qualifying event. Specific qualifying events are listed later in this section. COBRA Continuation Coverage must be offered to each person who is a qualified beneficiary. You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event.

***Type of coverage.*** If you choose COBRA Continuation Coverage, you will be entitled to the same type of coverage that you had before the event that triggered COBRA. You will be allowed to choose medical, prescription drug, dental, and vision coverage. However, COBRA Continuation Coverage does not include Weekly Income, Death, or Dismemberment Benefits.

***Cost of coverage.*** Under the Plan, qualified beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. The Fund is permitted to charge the full cost of coverage for similarly situated participants and dependents (including both the Fund's share and the participant's share, if any) plus an additional 2%. If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Fund is permitted to charge the full cost of coverage for similarly situated participants and dependents (including both the Fund's share and the participant's share, if any) plus an additional 50% for COBRA family members that include the disabled person for the 11-month disability extension period.

### *Qualifying Events*

If you are an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events occurs:

- Your hours of employment are reduced; or
- Your employment ends for any reason, other than your gross misconduct.

Your spouse will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason, other than gross misconduct;
- You become entitled to Medicare benefits (under Part A, Part B, or both) (Becoming entitled to Medicare means that you were eligible for Medicare benefits *and* enrolled in Medicare, under Part A, Part B, or both. The entitlement date is the date of enrollment.); or
- You become divorced.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of any of the following qualifying events occurs:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason, other than the parent-employee's gross misconduct;
- The parent-employee becomes enrolled in Medicare benefits (Your parent-employee becoming entitled to Medicare means that your parent-employee was eligible for Medicare benefits *and* enrolled in Medicare under Part A, Part B, or both. The entitlement date is the date of enrollment.);
- The parents become divorced; or
- The child no longer meets the Plan's definition of a dependent child.

If an Employee's dependent child is covered by a Qualified Medical Child Support Order (QMCSO), the dependent child will be offered the same COBRA rights as other dependents if coverage ends for any of the above reasons. Notices will be sent to such a dependent in care of the custodial parent.

If you or a covered dependent enters service in the uniformed services as defined by the Uniformed Services Employment and Reemployment Rights Act (USERRA) for at least 30 days, that service is considered a qualifying event under COBRA because it is a reduction in hours or end of employment. You or the dependent is entitled to elect to make self-payments for COBRA Continuation Coverage,

regardless of any coverage provided by the military or government. This Plan will pay primary benefits before the military/government pays, except for service-related disabilities. Under USERRA, you are eligible to continue coverage for up to 24 months for leaves that begin after December 10, 2004.

### *When COBRA Continuation Coverage Is Available*

The Plan will offer COBRA Continuation Coverage to qualified beneficiaries only after the Fund Office has been notified that a qualifying event has occurred.

### *Electing COBRA Continuation Coverage*

To elect COBRA Continuation Coverage, you must complete an Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect COBRA Continuation Coverage. For example, both you and your spouse may elect COBRA Continuation Coverage, or only one of you. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the Election Form. Failure to do so will result in loss of the right to elect COBRA Continuation Coverage under the Plan. A qualified beneficiary may change a prior rejection of COBRA Continuation Coverage any time until that date.

In determining whether to elect COBRA Continuation Coverage, you should consider the following consequences if you fail to continue your group health coverage through COBRA:

- First, you may have pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of COBRA Continuation Coverage may help eliminate such a gap.
- Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not elect COBRA Continuation Coverage for the maximum time available to you.
- Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of COBRA Continuation Coverage if you elect COBRA Continuation Coverage for the maximum time available to you.

### *Employer Must Give Notice Of Some Qualifying Events*

When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, or the Employee becoming entitled to Medicare benefits (qualified for *and* enrolled in coverage under Part A, Part B, or both), the employer must notify the Fund Office of the qualifying event within 30 days of any of the events.

### *You Must Give Notice Of Some Qualifying Events*

For the other qualifying events (divorce or legal separation or a dependent child losing eligibility for coverage as a dependent child), you must notify the Fund Office. You are required to notify the Fund Office within 60 days of the later of the date the qualifying event occurs or the date coverage is lost. You must send this notice to:

**Board of Trustees**
**Duluth Building Trades Health Fund**
**c/o: Wilson-McShane Corporation**
**2002 London Rd., Suite 300**
**Duluth, MN 55812**

### *How COBRA Continuation Coverage Is Provided*

Once the Fund Office receives notice that a qualifying event has occurred, COBRA Continuation Coverage will be offered to each qualified beneficiary. For each qualified beneficiary who elects COBRA Continuation Coverage, COBRA Continuation Coverage will begin ***on*** the date that Plan coverage would otherwise have been lost, provided the required self-payment for such coverage is made.

### *Length Of COBRA Continuation Coverage*

COBRA Continuation Coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the Employee's entitlement to Medicare benefits (qualified for *and* enrolled in coverage under Part A, Part B, or both), divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA Continuation Coverage lasts for up to a maximum of 36 months, depending on the reason for the coverage.

When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to (qualified for *and* enrolled in) Medicare benefits less than 18 months before the qualifying event, COBRA Continuation Coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. However, the covered Employee's maximum coverage period will be 18 months. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA Continuation Coverage lasts for up to a total of 18 months. This 18-month period of COBRA Continuation Coverage can be extended in two ways, as explained below. If you are continuing coverage under USERRA and your leave that begins after December 10, 2004, your coverage lasts for a total of 24 months.

### *Disability Extension Of 18-Month Period Of COBRA Continuation Coverage*

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Fund Office in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60$^{th}$ day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of coverage.

You must make sure that the Fund Office is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA Continuation Coverage. You must also notify the Fund Office within 30 days of the date that

the Social Security Administration determines that you or your dependent is no longer disabled. You must send this notice to the Fund Office at the address listed on page 24.

### *Second Qualifying Event Extension Of 18-Month Period Of COBRA Continuation Coverage*

If your family experiences another qualifying event while receiving 18 months of COBRA Continuation Coverage, the spouse and dependent children in your family can get up to an additional 18 months of COBRA Continuation Coverage, up to a maximum of 36 months, if you give notice of the second qualifying event to the Plan within 60 days of the event. This extension is available to the spouse and dependent children if:

- The Employee or the former Employee dies;
- The Employee or the former Employee becomes entitled to Medicare benefits (qualified for *and* enrolled in coverage under Part A, Part B, or both);
- The Employee or the former Employee gets divorced or legally separated; or
- The dependent child stops being eligible under the Plan as a dependent child.

The extension is available only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

In all of these cases, you must make sure that the Fund Office is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Fund Office at the address listed on page 24.

### *Making Your Payments For COBRA Continuation Coverage*

If you elect COBRA Continuation Coverage, you do not have to send any payment for COBRA Continuation Coverage with the Election Form. However, you must make your first payment for COBRA Continuation Coverage within 45 days after the date your election form is returned to the Fund Office. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for COBRA Continuation Coverage within those 45 days, you will lose all COBRA Continuation Coverage rights under the Plan.

Your first payment must cover the cost of COBRA Continuation Coverage from the time your coverage under the Plan would have otherwise ended up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the Fund Office to confirm the correct amount of your first payment.

After you make your first payment for COBRA Continuation Coverage, you will be required to pay for COBRA Continuation Coverage for each subsequent month of coverage. Under the Plan, these periodic payments for COBRA Continuation Coverage are due on the first day of the month for which payment is made. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods. A COBRA self-payment will be considered on time if it is received within 30 days of the due date. A COBRA self-payment is considered made when it is mailed (postmarked) or personally delivered.

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days to make each periodic payment. You should note that the grace period does not apply to the first COBRA payment, which is due within 45 days of election of COBRA Continuation Coverage, as

described in the previous information. Your COBRA Continuation Coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage and you submit a claim within that period, you may receive an explanation of benefits that a benefit determination cannot be made due to a pending COBRA payment.

Self-payments for COBRA Continuation Coverage should be sent to:

**Board of Trustees**
**Duluth Building Trades Health Fund**
**c/o: Wilson-McShane Corporation**
**2002 London Rd., Suite 300**
**Duluth, MN 55812**

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA Continuation Coverage under the Plan.

### *If You Have Questions*

Questions concerning your Plan or your COBRA Continuation Coverage rights should be addressed to the Fund Office. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of regional and district EBSA offices are available through the EBSA website.)

# MEDICAL BENEFITS

The Plan offers comprehensive health care coverage to help you and your eligible dependents stay healthy and helps provide financial protection against catastrophic health care expenses.

## How The Plan Works

### *Preferred Provider Organization (PPO)*

For active Employees, non-Medicare eligible retirees, and dependents, the Plan utilizes a Preferred Provider Organization (PPO) network as a cost management feature to help manage certain health care expenses. A PPO is a network of Physicians and Hospitals that have agreed to charge negotiated rates. When you use a network provider (or preferred provider), you save money for yourself and the Plan because the network provider has agreed to charge a discounted dollar amount. The PPO's agreements with network providers may include financial incentives to promote the delivery of health care in a cost-efficient and effective manner; however, your coinsurance and deductible amounts will not be changed by any subsequent adjustments to the negotiated rate.

Inpatient expenses incurred at out-of-network facilities are not covered by the Fund, unless an emergency exception applies as detailed in paragraph 1 under General Exclusions and Limitations. If you use an out-of-network provider for outpatient care at an out-of-network facility, his or her charges can exceed the Reasonable and Customary Charges. Any amount above the Plan's Reasonable and Customary Charge is not covered under the Plan and you will have to pay the extra amount (called balance billing).

*For example:*

*Suppose the Reasonable and Customary Charge for a procedure is $1,000 and your out-of-network provider at an out-of-network facility charges $1,200. You are an active employee and you've already met your annual deductible. The Plan would pay 85% of the $1,000 or $850 and you would have to pay the rest ($1,200 minus $850 equals $350). Keep in mind that any charge over the Reasonable and Customary Charge (the extra $200) does not count toward the Out-of-Pocket Maximum. If you used a network provider, you would have only had to pay $150 because network providers can't charge more than the Reasonable and Customary Charge.*

However, you are protected from balance billing and will only pay the in-network cost-sharing amount in the following circumstances:

1. **Emergency Services**

   **If you have an Emergency Medical Condition and received Emergency Services from an out-of-network provider or facility, you are protected from balance billing and you will not pay more than the in-network cost-sharing amount.** This protection may apply to services you receive after you are in stable condition, however, you can waive your protections against balance billing for post-stabilization services if you give written consent to the provider.

2. **Out-of-Network Providers at In-Network Facilities**

   If you receive services from an in-network hospital or ambulatory surgical center and providers within that facility are out-of-network, you are protected from balance billing and you will not pay more than the in-network cost-sharing amount. You can waive your protections against balance billing if you give written consent to the provider, however, you cannot waive your protections against balance billing for the following out-of-network services at an in-network facility:

anesthesiology, pathology, radiology, neonatology, and diagnostic services, including radiology and laboratory services.

**3. Continuity of Care following Termination of Provider's In-Network Status**

If the treating provider for a Continuing Care Patient loses their status as an in-network provider, the Plan will provide notice to the Continuing Care Patient and they will have the opportunity to elect to continue to receive services from that provider for up to 90 days under the terms that were applicable to that provider prior to termination of its in-network status, to allow for a transition of care to an in-network provider.

It's your decision whether or not to use a network provider. You always have the final say about the Physicians and Hospitals you and your family use. You may be responsible for higher out-of-pocket costs if you do not use a network provider. If you have questions, or need a listing of Physicians and Hospitals that participate in the PPO network (provided free of charge), contact the PPO network at the phone number listed on the back of your ID card. You can also access an updated list of in-network providers at bluecrossmn.com.

Once your coinsurance amounts for covered expenses (including the deductibles) reach the out-of-pocket maximum during the calendar year, the Plan pays 100% of remaining allowable amounts for covered services for the rest of that year up to any specific benefit maximums. **You must show your ID card each time you receive medical services.** Note that some expenses may be covered differently or subject to different benefit maximums. See the *Schedule Of Benefits* for more information.

## Chiropractic Expense Benefit

The Chiropractic Expense Benefit is payable when you or your dependent require the services of a chiropractor as the result of a non-occupational Accidental Injury or Sickness. The Plan reimburses Reasonable Charges, up to the maximum amounts specified in the *Schedule Of Benefits*. Charges in excess of the Chiropractic Expense Benefit are **not** payable under the Comprehensive Major Medical Expense Benefit. **There is no chiropractic expense benefit for the Reduced Self-Pay Plan.**

## Preventive Care

### *In General*

Pursuant to the Patient Protection and Affordable Care Act (the "Affordable Care Act"), the Fund will pay the in-network preventive items or services listed below at 100% and without any cost-sharing. The preventive services will be covered in accordance with the recommendations issued by the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), the Health Resources and Services Administration's (HRSA's) Bright Futures Project, and the HRSA-sponsored Women's Preventive Services Initiative (WPSI).

**1. Covered Preventive Services For All Adults**

- Abdominal aortic aneurysm one-time screening for men between 65-75 who have ever smoked
- Diabetes (Type 2) screening for adults aged 35-70 who are overweight or obese
- Low-dose aspirin use to prevent cardiovascular disease and colorectal cancer for adults aged 50-59 with a high cardiovascular risk
- Colorectal cancer screening for adults aged 45-75 (may include fecal occult blood testing, sigmoidoscopy, colonoscopy or virtual colonoscopy)
- Depression screening
- Falls prevention exercise interventions for community-dwelling adults aged 65 years and over
- Healthy diet behavioral counseling interventions for adults with hypertension or elevated blood pressure, dyslipidemia, or those who have mixed or multiple risk factors (*e.g.*, metabolic syndrome or an estimated 10-year cardiovascular disease risk of 7.5% or greater).
- Hepatitis B virus screening in persons at high risk for infection
- Hepatitis C virus screening in adults aged 18-79
- HIV screening for everyone ages 15 to 65, and other ages at increased risk
- High blood pressure screening for adults age 18 or older
- Latent tuberculosis screening in populations at increased risk
- Lung cancer annual screening for adults 50-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years
- Obesity screening (BMI of 30 or higher) and for those determined obese, intensive multicomponent behavioral interventions
- Preexposure prophylaxis (PrEP) medication for the prevention of HIV infection for persons at high risk, including required testing and screening before and during use of PrEP medication, and adherence counseling.
- Sexually transmitted infection (STI) prevention counseling for adults at higher risk
- Skin cancer prevention behavioral counseling for young adults and parents of young children about minimizing exposure to UV radiation to reduce risk for skin cancer for persons aged 6 months to 24 years with fair skin types

- Low to moderate dose statin medication for the prevention of cardiovascular disease for adults ages 40 – 75 with certain risk factors
- Syphilis screening for adults at higher risk
- Tobacco use screening, behavioral interventions, and Food and Drug Administration-approved pharmacotherapy for cessation (up to two cessation attempts per year)

**2. Covered Preventive Services For Pregnant Women Or Women Who May Become Pregnant**

- Asymptomatic bacteriuria screening using urine culture
- Breastfeeding: Comprehensive lactation support services from a trained provider, including counseling, education, and breastfeeding equipment, during pregnancy and the postpartum period (breastfeeding equipment requires prior authorization and is subject to specific restrictions, contact the Fund office for information)
- Folic acid supplements for women who may become pregnant
- Gestational diabetes screening for women at 24 weeks of gestation or after
- Healthy weight and weight gain – behavioral counseling interventions for pregnant women
- Hepatitis B screening for pregnant women at their first prenatal visit
- Human Immunodeficiency Virus (HIV) screening
- Preeclampsia screening throughout pregnancy and low-dose aspirin as preventive medication after 12 weeks gestation in women at high risk for preeclampsia
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Syphilis screening for all pregnant women
- Tobacco use screening and behavioral interventions for cessation

**3. Other Covered Preventive Services For Women**

- BRCA-related cancer: One office visit risk assessment for women with a personal or family history associated with certain cancers or ancestry associated with breast cancer susceptibility (BRCA1/2 gene mutations), and up to two sessions of genetic counseling and evaluation for BRCA testing
- Breast cancer medication: Risk reducing medications, such as Tamoxifen and Raloxifene, to women who are at increased risk for breast cancer and low risk for adverse medication effects
- Breast cancer biennial screening (mammography) for women over 40
- Cervical cancer screening
    - Pap test (also called a Pap smear) every 3 years for women 21 to 65
    - Human Papillomavirus (HPV) DNA test with the combination of a Pap smear every 5 years for women 30 to 65 who don't want a Pap smear every 3 years
- Chlamydia and gonorrhea screening for sexually active women aged 24 and younger and for older women at increased risk

- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs)
- Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before
- Interpersonal and domestic violence screening
- Obesity prevention counseling for women aged 40 to 60 years with normal or overweight body mass index
- Osteoporosis screening for postmenopausal women younger than 65 who are at increased risk, and all women 65 years and older
- Urinary incontinence screening for women yearly
- Well-woman visits to get recommended services for women

**4. Covered Preventive Services For Children**

- Alcohol, tobacco, and drug use assessments for adolescents
- Anemia risk assessment or screening, as appropriate
- Autism screening for children at 18 and 24 months
- Behavioral/social/emotional assessments throughout childhood
- Bilirubin concentration screening for newborns
- Blood pressure screening throughout childhood
- Blood screening for newborns
- Cervical dysplasia screening for sexually active females
- Depression and suicide risk screening for adolescents beginning routinely at age 12
- Developmental screening throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders
- Fluoride varnish for all infants and children as soon as teeth are present and thereafter every 3 to 6 months based on risk
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing and vision screening for all children
- Height, weight and body mass index (BMI) measurements throughout childhood
- Hematocrit or hemoglobin screening for all children
- Hemoglobinopathies or sickle cell screening for newborns

- Hepatitis B screening for children at high risk
- HIV screening for adolescents at higher risk
- Hypothyroidism screening for newborns
- Lead screening for children at risk of exposure
- Maternal depression screening for mothers of infants at 1, 2, 4, and 6-month visits
- Obesity screening in children age 6 and older and up to three office visits a year for counseling and behavioral interventions
- Oral fluoride supplements for children without fluoride in their water source
- Phenylketonuria (PKU) screening for newborns
- Sexually transmitted infection (STI) prevention counseling for sexually active adolescents
- Skin cancer prevention behavioral counseling for adolescents
- Sudden cardiac arrest risk assessment for children aged 11 and older
- Tobacco use interventions, including education and brief counseling, to prevent initiation of tobacco use (including e-cigarette products, *i.e*., vaping)
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening for children age 5 and under to detect amblyopia or its risk factors, and periodic vision acuity screenings throughout childhood and adolescence

**5. Covered Preventive Immunizations**

| Immunization vaccines, according to the recommended schedule: | Adults | Children |
|---|---|---|
| • Diphtheria, Tetanus, Pertussis (Whopping cough) | X | X |
| • Haemophiles Influenza Type B (Hib) | | X |
| • Hepatitis A | X | X |
| • Hepatitis B | X | X |
| • Herpes Zoster (Shingles) | X | |
| • Human Papillomavirus (HPV) | X | X |
| • Inactivated Poliovirus | | X |
| • Influenza (Flu shot) | X | X |
| • Measles, Mumps, Rubella | X | X |
| • Meningococcal | X | X |
| • Pneumococcal | X | X |
| • Rotavirus | | X |
| • Varicella (Chickenpox) | X | X |
| • COVID-19 | X | X |

## Comprehensive Major Medical Expense Benefit

### *Deductible*

The calendar year deductible is the amount of covered expenses that you pay each calendar year before the Plan begins to pay benefits under the Comprehensive Major Medical benefit.

The deductible applies to each covered person each calendar year. The family deductible is met once two or more covered members of a family meet the amount as shown on the *Schedule Of Benefits* for the family maximum. Once an individual and/or family deductible is met, no further deductibles are required for that year for the individual and/or family.

Normally, the individual deductible is applied to each member of the family. However, if two or more covered members of a family are injured in the same accident, the medical expenses that result from the accident will be combined and only one deductible will apply to all expenses incurred because of that accident.

### *Coinsurance And Copayment*

Once you or your family has met the deductible, the Plan pays a percentage of covered expenses, called coinsurance. The amount the Plan pays depends on the type of covered expense as listed on the *Schedule Of Benefits*. Your payment is the remaining percentage of covered expenses. For certain services, you pay a flat dollar amount called a copayment.

**Note: The Plan pays benefits up to Reasonable and Customary Charges and in cases of medical necessity. For a definition of Reasonable and Customary and Medically Necessary, see *Definitions* beginning on page 82.**

### *Out-Of-Pocket Maximum*

The out-of-pocket maximum limits the amount you pay out-of-pocket in a calendar year for covered expenses. If your copayments and coinsurance toward covered expenses reach the out-of-pocket maximum (including the deductible), the Plan pays 100% for most additional covered expenses for the rest of the calendar year.

The following expenses do not apply toward the out-of-pocket limit:

- Charges not considered covered medical expenses;
- Charges made after the maximum benefit has been received or paid;
- Amounts above the Reasonable and Customary charges; and
- Out-of-pocket prescription drug charges, which have a separate out-of-pocket maximum.

*Lifetime And Specific Benefit Maximums*

You and each eligible dependent can receive medical benefits up to the specific benefit maximums specified on the *Schedule Of Benefits*. Certain services have separate lifetime or annual benefit maximums.

## Covered Medical Expenses

Covered medical expenses are Reasonable Charges that are Medically Necessary and actually incurred for the services and supplies listed below upon the recommendation of the attending Physician.

1. Hospital charges for:
   a. Room and Board;
   b. Other Hospital services and supplies; and
   c. Charges for radiology and pathology.

   This Fund complies with federal law that prohibits restricting benefits for a mother or newborn child for a Hospital stay in connection with childbirth to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section.
2. Charges for Midwives.
3. Hospital Miscellaneous Charges for outpatient treatment provided within 24 hours of and in connection with an accident or a surgical procedure.
4. Physician's or Surgeon's services for a surgical procedure and other medical care and treatment.
5. When multiple surgical procedures are performed during the same operative session, the Fund will consider the full Reasonable Charge for the major procedure and 50% of the Reasonable Charge for all subsequent procedures.
6. Nursing care by a trained nurse performed in a Hospital, Ambulatory Surgical Center or Urgent Care Facility.
7. Emergency transportation service by professional ambulance to and from the Hospital (limited to the first trip) for any one injury or Sickness. You may be balanced billed if you receive ground ambulance services from an out-of-network provider. However, if you receive air ambulance services for an out-of-network provider, you will not pay more than the in-network cost-sharing amount. The term "air ambulance" means medical transport by a rotary-wing or fixed-wing air ambulance.
8. X-ray and laboratory examinations made for diagnostic or treatment purposes.
9. Radiation therapy by X-ray, radium, and radioactive isotopes.
10. Anesthetics and their administration.
11. Mental Disorder Treatment covered on the same basis as for any other Sickness.

    Mental Disorder treatment must be provided by:
    a. A Hospital or Hospital's outpatient department;
    b. Mental Health Residential Treatment Center, up to a maximum of 28 days;
    c. Physician;
    d. Psychologist; or

e. Licensed Social Worker.

Group or family therapy: Covered charges are those which are applicable for the specific eligible person and not for the group or family.

12. Alcohol and Drug Addiction Treatment

Residential Treatment Programs: Reasonable Charges for confinement in a residential treatment facility licensed or approved by the regulatory authority having such responsibility, up to a maximum of 28 days.

Nonresidential Treatment Programs: Reasonable Charges for outpatient treatment under a nonresidential treatment program licensed or approved by the regulatory authority having such responsibility.

Payment will **not** be made for:

a. Any confinement not recommended by a Physician (MD);

b. An admitting fee or deposit; and

c. Claims submitted by the family of the Employee or dependent when they are made part of the therapy.

13. Home Health Care services when prescribed by a Physician to replace or shorten a Hospital confinement. Services for Home Health Care must be:

a. Provided for the same or related condition which required or would have required a Hospital confinement of at least five days without Home Health Care,

b. Be approved in writing and established by the attending Physician with the Home Health Care provider,

c. Provided by a registered nurse (RN), a licensed practical nurse (LPN), or Home Health Care aides, and

d. Reviewed at least every 30 days by the attending Physician.

Payment will not be made for:

a. Service of a Caregiver or a person who lives in the Employee's home or is a member of his or her family; or

b. Services unrelated to the patient's care.

14. Skilled Nursing Care Facility charges for a Skilled Nursing Care Confinement as the result of an Injury or Sickness. Benefits will be payable for the Reasonable and Customary Charges incurred for the period of confinement in a Skilled Nursing Care Facility, up to 28 days per period of disability.

15. Medical supplies and equipment such as:

a. Surgical supplies and the first appliance to replace a lost limb, eye, or other body part that is not otherwise excluded under the Organ Transplant Expense Benefit.

b. Oxygen and rental of equipment for its administration.

c. Rental of durable medical equipment such as a wheelchair, Hospital-type bed, apnea monitor or glucometer (total rental charges may not exceed purchase price).

d. Rental of respiratory paralysis equipment.

17. Rehabilitation Services (Occupational, Physical, and Speech Therapy, and Developmental Delay treatment) for short term, active, progressive services performed by a licensed or duly qualified

therapist as ordered by a Physician up to the limit stated in the *Schedule Of Benefits*. Maintenance rehabilitation and coma stimulation services **will not** be covered.

Upon reaching the maximum visits allowed for rehabilitation services you may submit a request to the Fund Office for coverage of additional therapy visits. You will be required to provide clinical information and a treatment plan to the Fund Office in order for continued visits to be approved following a medical review. The Fund will not pay for additional therapy unless the treatment is expected to make significant measurable improvement to your condition within a reasonable and predictable period of time.

18. Up to fifteen (15) visits for acupuncture treatment per year, if provided in a chiropractic or medical setting by a physician, chiropractor or other provider that is licensed to perform such treatment.
19. Inpatient nutritional consultation, instruction, or treatment.
20. Medical and surgical benefits in connection with a mastectomy for certain reconstructive surgery as required by the Women's Health and Cancer Rights Act of 1998. Under federal law, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. This covers reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance, and prostheses of all stages of mastectomy, including lymphedemas.
21. Hospice Services for an Employee or his or her dependent who has been diagnosed as Terminally Ill. Charges must be incurred during a confinement in a hospice or a facility operating under the direction of a Hospice Agency following a Hospice Plan. Covered expenses are:

    a. Counseling of an Employee and the immediate family; and

    b. Bereavement counseling of the immediate family.

    Counseling and bereavement must be rendered by a:

    a. Psychiatrist;

    b. Licensed Psychologist; or

    c. Licensed social worker.

    Benefits for bereavement counseling will be payable even if Plan coverage ends before the completion of counseling services.

    Inpatient hospice benefits are payable when:

    a. There are no suitable Caregivers available to provide hospice benefits;

    b. It is determined by the Hospice Agency that home hospice is impractical because the persons that regularly assist with home care find the patient is unmanageable; and

    c. Respite Care is needed.

    Payment will **not** be made for:

    a. Hospice Services and supplies, which are not part of a Hospice Plan;

    b. Services of a Caregiver or a person who lives in the Employee's home or is a member of his or her family;

    c. Domestic or housekeeping services that are unrelated to the patient's care;

    d. Services that provide a protective environment when no skilled service is required, including companionship or sitter services other than Respite Care;

e. Services that are not directly related to an Employee's medical condition, including (but not limited to):

   i. Estate planning, drafting of wills or other legal services;

   ii. Pastoral counseling or funeral arrangement or services;

   iii. Nutritional guidance or food services such as "meals on wheels"; or

   iv. Transportation services.

f. Any requirement that the care be part of an active plan of medical treatment, which is reasonably expected to reduce the disability.

22. Organ Transplant Surgery when medical documentation shows that conventional treatment could be unsatisfactory, unavailable, and/or more hazardous than a transplant. The PPO **must** manage the condition and their transplant network **must** be used. Contact the Fund Office for details.

    For the transplant benefit, the following terms are used:

    Transplant Surgery: Transfer of a body organ from the donor to the recipient.

    Donor: A person who undergoes a surgical operation for donating a body organ for transplant surgery.

    Body Organ: Any of the following:

    a. Kidney;

    b. Heart;

    c. Heart/lung;

    d. Liver;

    e. Pancreas (when condition not treatable by use of insulin therapy);

    f. Bone marrow; and

    g. Cornea.

    Recipient: An eligible Employee or dependent that undergoes a surgical operation to receive a body organ transplant.

    a. The following charges are covered:

       i. Expenses incurred by a Recipient for:

       ii. The use of temporary mechanical equipment, pending the acquisition of a "matched" human organ;

       iii. Multiple transplants during one operative session;

       iv. Replacement or subsequent transplant; and

       v. Follow-up expenses for covered charges (including immunosuppressant therapy).

    b. Expenses incurred by a Donor for:

       i. Testing to identify suitable Donor;

       ii. The expense for the acquisition of organ from a Donor;

       iii. The expense of life support of a Donor pending the removal of a usable organ;

       iv. Transportation for a living Donor; and

v. Transportation of Body Organ or a Donor on life-support systems.

Donor Benefits are payable only when the Recipient is a covered person under this Plan.

Payment will **not** be made for:

a. Any animal organ or mechanical equipment or device;

b. Any organ not listed in the definition of Body Organ;

c. Any financial consideration to the Donor other than for Covered Charges incurred because of the transplant surgery;

d. Organ transplant expenses that the patient may not be legally required to pay;

e. Body Organ transplant expenses, which are in excess of the Reasonable Charges for the procedure.

24. Educational programs designed to improve patient knowledge of diabetes and techniques for self-management of diabetes.

    This benefit will be paid only when ordered by a Physician and when all of the following conditions are met:

    a. The Employee submits a receipt showing the:

        i. Name of the patient;

        ii. Cost of the program;

        iii. Name, address, and telephone number of the program sponsor;

        iv. Dates and times classes were held; and

        v. Classes actually attended by the Employee or dependent.

    b. The Employee or dependent must attend 80% or more of the scheduled classes.

25. Wigs when undergoing chemotherapy up to the lifetime maximum shown in the *Schedule Of Benefits*.

26. Dental implants and bone grafts to restore teeth lost due to an accident if there is not a conventional alternative. The 90-day work completion requirement does not apply to this circumstance.

27. Office visit and lab work related to sexual dysfunction.

# PRESCRIPTION DRUG BENEFIT (FOR EMPLOYEES, RETIREES, AND DEPENDENTS)

The Plan has contracted with Prime Therapeutics, Inc.'s network of participating pharmacies.

## Retail Program

When filling a prescription, simply present your prescription drug ID card and pay the applicable coinsurance. The amount you pay depends on the pharmacy you use and whether you have your prescription filled with a generic or brand name. For the Plan's coinsurance, see the *Schedule Of Benefits*.

It's always your decision where you have prescriptions filled, but when you use participating pharmacies, you save money for yourself and the Plan because participating pharmacies have agreed to charge discounted rates for prescription drugs. If you do not show your ID card when having your prescription filled, the Plan still provides coverage, but the amount you pay may be more because you will not receive your prescription at a discounted price at the point of sale.

If you visit a non-participating pharmacy, **no coverage is available.** This includes Wal-Mart and Sam's Club pharmacies, which are non-participating pharmacies.

## Mail Order Program

The Plan also offers a mail order program for your long-term, or maintenance, prescription drug needs. Maintenance medications are often prescribed for heart disease, high blood pressure, asthma, etc. Through the mail order program, you receive up to a 90-day supply. With the mail order program, you enjoy the convenience of having the medication sent directly to your home.

To place an order, complete an order form, which is available by contacting Prime Therapeutics, Inc. or the Fund Office. You may mail the written prescription from your Physician, have your Physician fax the prescription, or your Physician may phone in the prescription. You will need to submit the applicable coinsurance amounts when you request a prescription or refill. The amount you pay depends on whether you have your prescription filled with a generic or brand name medication. For the Plan's coinsurance, see the *Schedule Of Benefits*. For more information about how to use the mail order program, call the Fund Office.

**If you enroll in Medicare Part D (prescription drug) coverage other than through the Plan's Medicare Supplement Coverage, no prescription drug benefits will be payable through the Plan.**

## Generic And Brand Name Medications

Almost all prescription drugs have two names: the generic name and the brand name. By law, both generic and brand name medications must meet the same standards for safety, purity, and effectiveness.

When you receive a brand name medication, you generally pay more because they are more expensive. When you or your dependent needs a prescription, you may want to ask your doctor whether a generic medication can be substituted for a brand name medication.

In general, using generic medications will help control the cost of health care while providing quality medications – and can be a significant source of savings for you and the Plan. Your doctor or pharmacist can assist you in substituting generic medications when appropriate.

## Prime Therapeutic's Flex Access Specialty Drug Program

The Fund participates in Prime Therapeutic's Flex Access Specialty Drug program. This program allows the Fund and participants to maximize the value of copayment assistance programs that drug manufacturers offer for certain high-cost specialty drugs. For certain specialty drugs that qualify for the Flex Access program, you won't pay coinsurance but instead you will have a copayment and your copayment amount will be between $0.00 – $30.00, as determined by Prime Therapeutics.

Prime Therapeutics will contact any participant or dependent taking a drug that is part of this program to assist them with accessing the benefits of the Flex Access Specialty Drug program. If you are unable to participate in, or do not qualify for, the Flex Access Specialty Drug program, your coinsurance for the specialty drug will be as set forth in the Schedule of Benefits. The list of specialty drugs eligible for the Flex Access Specialty Drug program, and the amount of your copayment under this program, is subject to change.

## Prescription Drug Covered Charges

Covered prescription drugs include only drugs that require, by applicable law, a written prescription by the attending Physician. The Fund covers certain medications and recommended vaccines as preventive care items, see page 29.

The following items are covered by the Plan:

1. Prescription drugs approved by the Food and Drug Administration that are:
   a. Purchased from a licensed participating pharmacy;
   b. Dispensed in accordance with the prescription of the treating Physician; and
   c. Prescribed for a Medically Necessary and covered treatment of an Illness or an Injury.
2. Diabetic supplies. The Plan provides coverage for diabetic supplies such as insulin syringes and needles, sugar test tablets, sugar test tape, diabetic test strips, and acetone test tablets. If insulin and needles/syringes are dispensed at the same time, only one copayment will be applicable, even if the insulin and needles/syringes are on separate prescriptions.
3. Up to 6 doses per month for medications related to sexual dysfunction (Viagra, Cialis, and Levitra only) if prescribed by your Physician.
4. Self-injectables when acquired at retail and Walgreens Specialty Pharmacy.

**The Plan can impose quantity limits, prior authorization, and/or step therapy requirements on any of the prescription drugs covered by the Plan. Contact the Fund Office if you have any questions regarding those requirements or limitations.**

## Prescription Drug Exclusions

For expenses not covered, see General Exclusions and Limitations on page 57. **Please refer any questions to the Fund Office.**

Benefits are not payable under Prescription Drug Benefits for:

1. Medicines or drugs obtainable without a Physician's prescription.
2. Edex, Caverject and Muse.

3. Medications used for cosmetic purposes, including Vitamin A derivatives (retinoids) for dermatological use (*e.g.*, Retin A, Renova).
4. Vitamins and nutritional and dietary supplements (may be covered as preventive care items).
5. Smoking deterrents, (may be covered as preventive care items).
6. Anabolic steroids.
7. Antiviral drugs used for influenza (flu) treatment or prevention.
8. Weight control drugs or anorexiants.
9. Serum allergy antigen solutions.
10. Existing and new drugs that are not uniformly and professionally endorsed by the general medical community for prescription in the course of standard medical care, including existing and new drugs that are experimental in nature.
11. Fluoride Preparation and OTC products.
12. PCSK9 inhibitors.

# DENTAL CARE EXPENSE BENEFIT (FOR EMPLOYEES, RETIREES (IF ELECTED) AND DEPENDENTS)

Preventive dental care is important. To help meet the cost of routine and unexpected dental care, the Fund provides dental benefits to Employees and eligible dependents. Dental benefits are not covered under the Reduced Self-Pay Plan or retiree benefits Option 1.

When you or your family needs dental care, you can select any legally qualified Dentist, dental hygienist, Physician or Surgeon. The Plan will pay covered expenses for the services of a Dentist licensed to practice Dentistry within accepted standards of dental practice, up to the calendar year maximum as shown on the *Schedule Of Benefits*.

The amount the Plan pays depends on the type of dental service you receive. Once the calendar year maximum is reached, the Plan will not pay dental expenses for the remainder of the calendar year.

## Covered Dental Expenses

Covered dental expenses are those expenses that are Reasonable and Customary for the treatment when performed by a legally qualified Dentist, dental hygienist, Physician or Surgeon. Before the Plan pays benefits, you may need to provide:

- Supporting proof of loss;
- Clinical reports;
- Charts; and
- X-rays.

Benefits will be paid at the percentage of Reasonable Charges for each class of dental services up to the maximum benefit shown in the *Schedule Of Benefits*. There is a separate lifetime maximum benefit for Orthodontia-Class D Services for dependent children. The Plan pays for the following classes of services:

1. **Class A Services**
    a. Routine oral examinations, but not more than twice in a calendar year.
    b. Routine prophylaxis (cleaning and scaling of teeth) by a Dentist or dental hygienist, but not more than twice in a calendar year.
    c. Fluoride treatment by a Dentist or dental hygienist, but not more than twice in a calendar year.
    d. Dental X-rays, but not more than:
        i. One full-mouth series or one panorex in a three consecutive calendar year period; and
        ii. Four supplemental bite-wing X-rays in a calendar year.
    e. Space maintainers.
    f. Dental sealants applied to the first and second molars but only:
        i. For a dependent who is less than age 16; and
        ii. When the teeth have not been treated with sealants for at least four years.

2. **Class B Services**

   a. Extractions.

   b. Oral surgery.

   c. Fillings, other than gold.

   d. General and local anesthesia and analgesia given in connection with Covered Services.

   e. Periodontic procedures (procedures for treatment of the area around the tooth).

   f. Endodontic procedures (procedures, such as root canal work, used for the treatment of the dental pulp).

   g. Emergency treatment for the relief of dental pain.

3. **Class C Services**

   a. The first placement of full or partial removable dentures or fixed bridgework. This will include adjustments during the six-month period following placement. The placement must be needed as a result of the extraction of one or more natural teeth. The extraction must take place after an Employee or dependent is eligible under this benefit. The denture or bridgework must include the replacement of the teeth, which were extracted. The Plan will not pay for replacement of third molars (wisdom teeth).

   b. The replacement or alteration of full or partial dentures, or fixed bridgework, which is necessary because of oral surgery:

      i. Resulting from an accident;

      ii. For the repositioning of muscle attachments; or

      iii. For the removal of a tumor, cyst, torus, or redundant tissue.

      The surgery must be performed while an Employee or dependent is eligible under this benefit. The replacement or alteration must be completed within 12 months from the day of surgery.

   c. The replacement of a full denture, which is necessary because of:

      i. Structural change within the mouth and when more than five years have gone by since the prior placement; or

      ii. The prior placement of an immediate or temporary denture when the replacement occurs within 12 months of the placement of the immediate or temporary denture.

   d. Addition of teeth to, or replacement of, an existing partial or full removable denture or fixed bridgework when:

      i. The replacement or addition is needed to replace one or more additional natural teeth which are extracted while an Employee or dependent is eligible under this benefit; or

      ii. The existing denture or bridgework was put in at least five years prior to its replacement.

   e. Inlays, gold fillings and the first placement of crowns, including precision attachments for dentures.

   f. The replacement of a crown restoration when the original crown was put in more than five years before the replacement.

   g. Repair or recementing of crowns, inlays, bridgework, or dentures. This includes the rebasing or relining of dentures.

h. Treatment of craniomandibular/temporomandibular (TMJ) disorders as approved by the American Academy of Craniomandibular Disorders, to include:

   i. Diagnostic and baseline records;

   ii. Behavior modification modalities;

   iii. Repair and regeneration; and

   iv. Orthopedic stabilization.

   No other Plan benefits will be payable for this disorder. There is a separate lifetime maximum benefit for the treatment of TMJ for Participants, spouses, and children aged 19 and older.

4. **Class D Services (Dependent Children Only)**

   Orthodontic care, treatment, services, and supplies. The Plan will not pay for orthodontia performed exclusively on primary teeth.

## Dental Expenses Not Covered

In addition to the general Plan exclusions, payment will **not** be made for:

1. Any treatment, service, or supply, which the Employee received or began to receive before the Employee's eligibility under the Fund began.
2. Treatment of the teeth or gums for cosmetic purposes, including realignment of teeth.
3. Expense incurred after eligibility ends. The Plan will pay for prosthetics (an artificial replacement of one or more natural teeth), including bridges and crowns that were fitted and ordered before the date eligibility ends if received within 30 days after eligibility ends.
4. Orthodontia, prosthetics, including bridges and crowns, started prior to the date an Employee or dependent became eligible under this benefit.
5. Rebasing or relining of a denture less than six months after the first placement, and not more than one rebasing or relining in any two-year period.
6. Replacement of lost or stolen prosthetics.
7. Replacement of prosthetics less than five years after a previous placement, except as provided under Class C services.
8. A new denture or bridgework if the existing denture or bridgework can be made serviceable.
9. Charges an Employee or a dependent are not required to pay, including charges for services furnished by any Hospital or organization which normally makes no charge if the patient has no Hospital, surgical, medical or dental coverage.
10. Orthodontic care, treatment, services, and supplies, except as specifically provided under Class D services for dependent children only.
11. Procedures, restorations, and appliances to change vertical dimension or to restore occlusion (proper contact between opposing teeth).
12. Any expense paid in whole or in part by any other benefit of this Plan provided by the Fund.
13. Sealants (except as provided under part (f) of Class A services).
14. Charges for alveolar ridge augmentation, whether of natural or artificial materials to stabilize or otherwise alter natural or artificial teeth.

15. Implant procedures, whether of natural or artificial materials to stabilize or otherwise alter natural or artificial teeth.
16. Any dental treatment or procedure covered under the medical portion of the Plan.
17. Anything excluded under the General Exclusions and Limitations beginning on page 57.
18. Charges for a Participant or dependent on the Reduced Self-Pay Plan.
19. Pre-cancer screenings (covered under Comprehensive Major Medical Expense Benefit).
20. Athletic mouth guards (occlusal guards covered if due to TMJ or Bruxism).

# VISION CARE EXPENSE BENEFIT (FOR EMPLOYEES, RETIREES (IF ELECTED), AND DEPENDENTS)

Vision coverage provides active Employees and eligible dependents with coverage for routine vision related expenses. Vision Care Expense Benefits are not covered under the Reduced Self-Pay Plan or under retiree benefits Option 1.

## Covered Vision Expenses

To receive vision services, you can visit any legally qualified ophthalmologist, optometrist, or dispensing optician. You pay the doctor in full and obtain an itemized receipt. Then you submit the itemized receipt and a claim form for reimbursement. Covered vision expenses are paid up to the maximum benefit each two calendar year period as listed in the *Schedule Of Benefits*. Covered expenses include:

1. Examination — complete examination including dilation of pupil and/or relaxing of focusing muscles by drops, refraction for vision, examination for pathology.
2. Materials — new or replacement frames and/or lenses (including contact lenses) furnished by an optician or Physician, including fitting.
3. Lasik surgery — to correct nearsightedness, farsightedness, and astigmatism.

An expense is incurred on the date the services or materials were provided.

## Vision Care Benefits Not Covered

In addition to the general Plan exclusions, payment will **not** be made for:

1. Any services or materials provided as a result of a Workers' Compensation or occupational disease law, or for which no charge is made, or furnished by or payable under any plan or law of any federal or state government or any political subdivision.
2. Non-prescription sunglasses or glasses with a tint above number 2 (considered sunglasses for this Plan).
3. Aniseikonic lenses or special supplies and services not listed as covered expenses.
4. Any eye examination required by an employer as a condition of employment.
5. Medical or surgical treatment that is covered elsewhere in the Plan.
6. Lenses and frames, which are lost or broken, replaced before the two-year interval.
7. Expenses for a Participant or Dependent on the Reduced Self-Pay Plan.
8. Warranties.
9. Side Shields.
10. Non-prescription safety glasses.

# EMPLOYEE ASSISTANCE PROGRAM (FOR EMPLOYEES, RETIREES AND DEPENDENTS)

The Employee Assistance Program offers confidential counseling for you and your eligible dependents. Counseling services include: marital conflicts, legal, financial, family and relationships, alcohol and/or drug dependency, emotional or psychological, spiritual, occupational/vocational, and Workers' Compensation/rehabilitation. The Program is administered by Total Employee Assistance Management, Inc. (T.E.A.M., Inc.).

All counseling by TEAM., Inc. has been prepaid by the Fund. However, when a referral is made to another care provider, the cost will be handled according to the rules of the Plan. All services are confidential. No information will be given to either your Employer or the Union unless you specifically request it.

# WEEKLY INCOME BENEFIT (FOR BARGAINING UNIT EMPLOYEES)

If you become totally disabled as the result of a non-occupational illness or injury, you may be eligible for Weekly Income Benefits.

## Eligibility

To be eligible for benefits, you must be Totally Disabled as defined by the Plan and be under the regular care of a Physician and have no other earned income (including unemployment benefits). To receive benefits, submit a disability form, provided by the Fund Office, completed and signed by the attending/treating Physician or Surgeon, or a nurse practitioner, a Physician assistant, or medical assistant that is supervised by a Physician.

The Weekly Income Benefit is only available to bargaining unit employees covered under the full plan of benefits for Active Employees. Retirees and non-bargaining unit employees are not eligible for this benefit. You must be actively working for a Contributing Employer or continuing eligibility by using hours that were credited to your hours bank in the month in which you become Totally Disabled to be eligible for this benefit. You will not be eligible for this benefit for any week that you receive unemployment compensation benefits.

## Benefits

The amount of Weekly Income Benefits is listed in the *Schedule Of Benefits* on page 1 up to the maximum number of weeks allowed. The benefit payable for each day of any period of Total Disability, which is less than a full week, will be 1/7 of the weekly amount. The Weekly Income Benefit will be coordinated with No-Fault Auto Insurance up to the maximum benefit, provided you remain totally disabled.

## When Benefits Begin

Weekly Income Benefits will begin on the:

- First day of disability if caused by an Accidental Injury; or
- Eighth day of disability if caused by a Sickness.

## Successive Disabilities

Successive periods of disability are considered one period unless the later disability:

- Is due to an Accidental Injury or Sickness entirely unrelated to the causes of the earlier disability; or
- Occurs at least 36 months after the earlier disability ends.

In no event will the later of the successive period of disability be paid unless you return to active full-time work for a Contributing Employer for at least one full week.

## Exclusions

No Weekly Income Benefits payment shall be made for any of the following:

1. The Accidental Injury or Sickness resulted while you were engaged in any employment for wage or profit;
2. Benefits received from No-Fault Auto Insurance, which exceed the amount of Weekly Income Benefits the Employee would receive;
3. You are totally disabled on the date you are initially covered under this Plan;
4. You are already receiving a Weekly Income Benefit except where a new disability is not considered a successive disability as defined above;
5. You are on the Reduced Self-Pay Plan;
6. You are a non-bargaining unit participant;
7. You are a Retiree;
8. Any week in which you receive unemployment compensation benefits.

# DEATH AND DISMEMBERMENT BENEFIT

## Death Benefit (For Employees And Non-Medicare Eligible Retirees)

The Death Benefit is paid to your beneficiary if you die from any natural or accidental cause while eligible. The amount of the Death Benefit shown in the *Schedule Of Benefits* will be paid to your beneficiary in a lump sum after proof of death is submitted to the Fund Office.

You may designate anyone you wish as your beneficiary. You can change your beneficiary at any time, without the consent of your previous beneficiary. To designate or change a beneficiary, request a form from and file it with the Fund Office. Be sure to list your beneficiary's full name and his or her relationship to you. The change will take effect when it is received by the Fund Office. It is very important that you designate a beneficiary so your benefits will be paid as you wish. If no beneficiary is designated, benefits will be paid to the first category of available survivors listed in the order below:

- To the surviving spouse;
- Equally to the children;
- Equally to the parents; or
- Equally to brothers and sisters; or
- Your estate.

## Dismemberment Benefit (For Employees)

The Dismemberment Benefit is paid to you if you suffer the loss of a limb or sight as the direct result of an accident. The loss must occur within 90 days of the accident. No more than the full amount of the benefit will be paid for any one accident.

You will receive the full amount of the benefit for loss of:

- Two hands, two feet, or loss of sight in both eyes; or
- One hand and one foot, one hand and loss of sight in one eye, or one foot and loss of sight in one eye.

You will receive one-half of the benefit for loss of:

- One hand;
- One foot; or
- Sight of one eye.

Loss of foot means the severance of a foot at or above the ankle joint. Loss of hand means the severance of a hand at or above the wrist joint. Loss of sight of an eye means the total and irrecoverable loss of sight.

## Exclusions

The Death and Dismemberment Benefits are not payable for:

1. Self-inflicted injury or suicide or attempted suicide while sane or insane;
2. Injury resulting from the participation in a felony or gross misdemeanor or as the aggressor of an assault;
3. Loss sustained in a riot, insurrection, military service, or war whether declared or undeclared;
4. Loss due to involuntary or voluntary ingestion of poisonous gas including carbon monoxide;
5. Loss resulting from injuries received while operating or riding in any aircraft, except as a passenger in a commercial aircraft or a regularly scheduled flight;
6. Loss occurring 90 days or more after an accident, or
7. Loss to a Participant on the Reduced Self-Pay Plan.

# HRA POST–RETIREMENT REIMBURSEMENT ACCOUNTS

## A. Establishment of HRA Post Retirement Reimbursement Accounts

This portion of the Plan is designed to permit Participants to use their Post Retirement Reimbursement Account to pay for Qualifying Premium Expenses on a nontaxable basis after retirement.

1. The HRA Post Retirement Reimbursement Account benefits described in this Section are available if your local union has negotiated a contribution for those benefits or where contributions are received on your behalf through reciprocal agreements when you work outside the jurisdiction of your local union.

2. The HRA Post Retirement Reimbursement Account is not a benefit for any Medicare-eligible or Non-Medicare-eligible retiree; however, if you funded the HRA Post Retirement Reimbursement Account as an active employee and then you retired, you may use the balance of your HRA for payment of your Qualifying Premium Expenses after retirement.

3. Legal Status: This Plan is intended to qualify as an employer-provided medical reimbursement plan under Code §105 and §106 and regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. Qualifying Premium Expenses payable under the Plan are intended to be eligible for exclusion from the participating employees' gross income under Code §105(b).

4. Definitions:

   a. **"Code"** means the Internal Revenue Code of 1986, as amended.

   b. **"Health FSA"** means a health flexible spending arrangement as defined in Prop. Treas. Reg. §1.125-2, Q/A-7(a).

   c. **"Highly Compensated Individual"** means an individual defined under Code §105(h), as amended, as a "highly compensated individual" or "highly compensated employee."

   d. **"HRA"** means a health reimbursement arrangement as defined in IRS Notice 2002-45.

   e. **"HRA Account"** means the health reimbursement arrangement account described later in this section under "Establishment of Account."

   f. **"HRA Participant"** means a person who is eligible for benefits from the Duluth Building Trades Health and Welfare Fund and for whom the required contributions have been negotiated and paid into the HRA portion of this Plan.

   g. **"Retired Employee"** an employee that is eligible for Retiree benefits under this Plan.

**B**. **Benefits Offered and Method of Funding**

1. **Account Balances**. Each Employee who has money paid into his HRA either through employer contributions (specifically identified in the Collective Bargaining Agreement as a post-retirement contribution) or reciprocal contributions shall have an individual account established in his or her name. If there is any balance remaining in the account after all reimbursements have been paid for the calendar year, such balance shall be carried over to the subsequent calendar year. The Trustees shall determine, in their sole discretion, whether and to what extent to credit earnings and/or assess administrative charges to the accounts. The Employer or any other individual may not assign, transfer or alienate any interest in the accounts except to pay Qualifying Premium Expenses after retirement.

2. **Benefits Offered**. When an Active Employee becomes a HRA Participant through the Plan's receipt of contributions, an account will be established but Qualifying Premium Expenses shall only be payable after retirement or to the Participant's beneficiary upon death. In no event shall benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Qualifying Premium Expenses.

3. **Benefits Payable Only After Retirement.** Active employees are not eligible for payments from the HRA until after they retire.

4. **Benefits Payable to Beneficiary Upon Death**. If an employee dies, the entire balance of his or her Post Retirement Reimbursement Account immediately becomes available to the Employee's spouse and/or other individuals who qualify as dependents for the reimbursement of Qualifying Premium Expenses. In no event shall amounts in the Post Retirement Reimbursement Account be paid in cash to any person for other than reimbursement of Qualifying Premium Expenses. (For example, there are no lump sum distributions of the account balance as a death or termination benefit). The balance shall be forfeited if the Employee has no spouse or other dependents.

5. P**lan and HRA Participant Contributions.**

   a. Plan Contributions. When the required contributions have been negotiated the Contributing Employer will submit the contributions in the appropriate manner.

   b. HRA Participant Contributions. There are no HRA Participant contributions for benefits allowed under this Plan.

6. **Qualifying Premium Expenses.** After retirement a participant's account balance can be used for the payment of retiree, self-pay or COBRA premiums under this Plan or any other plan so long as the premium payments are for accident or health insurance as defined in Code §213(d). Premium expenses do not include premiums for fixed indemnity, cancer or hospital indemnity insurance, for long term care insurance premiums paid by an Employer or premiums that are for or could be deducted pre-tax through a section 125 Cafeteria Plan (including a spouse's plan.) In no event shall Qualifying Premium Expenses be provided in the form of cash other than reimbursement.

7. **No Funding Under Cafeteria Plan**. Under no circumstances will the benefits be funded with salary reduction contributions, employer contributions (e.g., flex credits) or otherwise under a cafeteria plan.

## C. Health Reimbursement Benefits

1. **Benefits**. The Plan will reimburse HRA Participants for Qualifying Premium Expenses after their Retirement Date, provided a claim for such benefits is submitted in the appropriate manner, as determined by the Board of Trustees.

2. **Other Out-of-Pocket Health Care Expenses.** The Plan does not reimburse general out-of-pocket health care expenses for active or retired employees, such as deductibles, co-payments, prescription or over-the-counter drugs, dental or vision expenses or any other similar expense.

3. **Cannot be Reimbursed or Reimbursable from Another Source**. Qualifying Premium Expenses can only be reimbursed to the extent that the HRA Participant or other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through the Plan, other insurance, or any other accident or health plan (including if the other health plan is a Health FSA).

4. **Maximum Benefits**. There will not be a maximum dollar amount that may be credited to a HRA Account for an Active Employee. Amounts may be carried over to the next calendar year.

5. **Nondiscrimination**. Reimbursements to Highly Compensated Individuals may be limited or treated as taxable compensation to comply with Code §105(h), as may be determined by the Board of Trustees in its sole discretion.

6. **Establishment of Account**. The Fund Office will establish and maintain a HRA Account with respect to each HRA Participant but will not create a separate Fund or otherwise segregate assets for this purpose. The HRA Account so established will merely be a recordkeeping account with the purpose of keeping of contributions and available reimbursement amounts.

7. **Crediting of Accounts**. A HRA Participant's account will be credited at the beginning of each month with an amount equal to the contributions received. Accounts shall be denominated in dollars, and not hours.

8. **Debiting of Accounts**. A HRA Participant's account will be debited for any reimbursement of Qualifying Premium Expenses to include self-pay premium, COBRA premiums, retiree self-payments or premiums of another Plan covering the HRA Participant or his or her dependent incurred.

9. **Available Amount**. The amount available for reimbursement of Qualifying Premium Expenses is the amount credited to the Participant's HRA as described above reduced by prior reimbursements debited as described above.

## D. Reimbursement Procedure

1. **Timing.** Within thirty (30) days after receipt by the Fund Office of a reimbursement claim from a HRA Participant, the Fund Office will reimburse the HRA Participant or the Fund Office will notify the HRA Participant that his/her claim has been denied.

    a. This time period may be extended for an additional fifteen (15) days for matters beyond the control of the Fund Office, including in cases where a reimbursement claim is incomplete.

b. The Fund Office will provide written notice of any extension, including the reasons for the extension, and will allow the HRA Participant forty-five (45) days in which to complete an incomplete reimbursement claim.

2. **Claims Substantiation**. A HRA Participant who seeks benefits may apply for reimbursement by submitting an application in writing to the Fund Office in such form as the Board of Trustees may prescribe, but no later than March 31 following the close of the Plan Year in which the Qualifying Premium Expense was incurred, setting forth:

a. the person or persons on whose behalf Qualifying Premium Expenses have been incurred

b. the nature and date of the Qualifying Premium Expenses so incurred;

c. the amount of the requested reimbursement; and

d. a statement that such Qualifying Premium Expenses have not otherwise been reimbursed and are not reimbursable through any other source and that Health FSA coverage, if any, for such Qualifying Premium Expenses has been exhausted. The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Qualifying Premium Expenses have been incurred and the amounts of such Qualifying Premium Expenses, together with any additional documentation that the Fund Office may request. Except for the final reimbursement claim, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement is at least $25.

3. **Claims Denied.** For claims that are denied, see the Benefit Appeals Procedure provision in this document.

## E. Recordkeeping and Administration

1. **Inability to Locate Payee.** If the Fund Office is unable to make payment to any HRA Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such HRA Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such HRA Participant or other person shall be subject to the provisions set forth in the "Account Forfeiture" section described later in this section.

2. **Effect of Mistake**. In the event of a mistake as to the eligibility or participation of an Active Employee, or the allocations made to the account of any HRA Participant, or the amount of benefits paid or to be paid to a HRA Participant or other person, the Fund Office shall, to the extent that it deems administratively possible and otherwise permissible under Code §105, the regulations issued thereunder or other applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such HRA Participant or other person the credits to the HRA or distributions to which he/she is properly entitled under the Plan. Such action by the Fund Office may include withholding of any amounts due to the Plan from any future benefits.

3. **Account Forfeiture**. Any account that remains inactive (no money coming in or money going out) for sixty (60) consecutive months, will have a $100 per year administrative fee assessed

beginning on the first day of the year that follows sixty (60) months of inactivity until the account balance is exhausted. In the event an account balance is $25 or less, the money will be forfeited and the account will be closed.

4. **No Guarantee of Tax Consequences**. Neither the Fund Office nor the Board of Trustees makes any commitment or guarantee that any amounts paid to or for the benefit of the Participant under this portion of the Plan will be excludable from the HRA Participant's gross income for federal, state or local income tax purposes. It shall be the obligation of each HRA Participant to determine whether each payment under this portion of the Plan is excludable from the HRA Participant's gross income for federal, state and local income tax purposes, and to notify the Fund Office if the HRA Participant has any reason to believe that such payment is not so excludable.

## GENERAL EXCLUSIONS AND LIMITATIONS

Payment will **not** be made under any health benefit or Weekly Income Benefit of the Plan for the following:

1. Inpatient expenses incurred at an out-of-network facility, unless such expenses are for Emergency Services for an Emergency Medical Condition. You will not be balance billed for out-of-network Emergency Services unless you consent in writing to waive your protections against balance billing for certain services (*e.g.*, post-stabilization care).
2. Charges for confinement or medical treatment not prescribed by a Physician.
3. Charges incurred in connection with any injury or Sickness that:
    a. Entitles you or your Dependent to benefits under a Workers' Compensation or occupational disease law;
    b. Was sustained during a job- or employment-related activity; or
    c. Was sustained while you or your Dependent was engaged for wages, profit, or gain.
4. Charges incurred while an Employee or dependent is confined in a Hospital operated by the United States of America or an agency thereof, or charges, which an Employee would not be required to pay if there were no coverage.
5. Charges for a dependent, which would be paid as an Employee or former Employee.
6. Charges for education, training, and Room and Board while an Employee or dependent is confined in an institution that is primarily a school or other institution for training, a place of rest, a place for the aged or a nursing home.
7. Charges for Custodial Care (except as specifically provided).
8. Charges incurred for medical examinations or tests of any kind not incident or necessary to the treatment of a covered Accidental Injury or Sickness, except as provided for under the Preventive Care Benefit.
9. Charges for services and supplies, which are:
    a. Not Medically Necessary;
    b. Not provided in accordance with generally accepted professional medical standards;
    c. For Experimental treatment; or
    d. Investigative, and not proven safe and effective (including prescriptions not approved by the F.D.A.).
10. Charges that result from services, tests, evaluation, etc., which are ordered for custody cases or adoption.
11. Charges for dental prosthetic appliances or surgery on the teeth and gums except:
    a. when required because of an Accidental Injury to natural teeth and incurred within 90 days of the date of injury. The 90-day work completion requirement may be waived if there is no conventional alternative. When additional charges for eligible dependent children five years of age and under are medically necessary and the dental work cannot be performed in a dental office, the facility charge, including for general anesthesia, shall be covered as a medical benefit.

12. Charges for treatment of craniomandibular or temporomandibular joint (TMJ) disorders, except as provided for under the Dental Expense Benefit.
13. Charges for routine eye care including examinations, glasses and lenses except as provided for under the Preventive Care Benefit and Vision Expense Benefit.
14. Charges for outpatient nutritional consultation, instruction, or treatment except as provided for under the Diabetes Education Benefit on page 38 or as Medically Necessary to treat a Mental Disorder.
15. Any expense for failure to appear for a scheduled appointment or for completion of claim forms.
16. Expenses for medical or surgical treatment of obesity, including, but not limited to, gastric restrictive procedures, intestinal bypass and reversal procedures, weight loss programs, dietary instructions, and any complications thereof, except as specifically provided by the Plan.
17. Any expense for orthotics and other supportive devices for the feet.
18. Any expense or charge except as provided under the Vision Care Benefit for eye exercises, vision training, or surgery to correct near-sightedness, such as laser surgery or radial keratotomy.
19. Any expense for the promotion of fertility including (but not limited to):
    a. Fertility tests;
    b. Reversal of surgical sterilization; and
    c. Any attempts to cause pregnancy by hormone therapy, artificial insemination, in-vitro fertilization, and embryo transfer.
20. Construction or modification to a home, residence, or vehicle required as a result of Accidental Injury or Sickness of an Employee or Dependent.
21. Expenses incurred in an automobile accident if automobile insurance was not obtained by the Covered person as required by state law. Payment will be considered on expenses that exceed the amount of No-Fault Auto Insurance coverage.
22. Supplies or equipment for personal hygiene comfort, or convenience such as air conditioning, humidifiers, water beds, box spring and mattress, physical fitness and exercise equipment, and home traction units.
23. Any expense for vitamins, food supplements, special formula, and food substitutes, except for special dietary treatment for phenylketonuria when recommended by a physician or as provided under the Preventive Care Benefit.
24. Charges for alveolar ridge augmentation or implant procedures, whether of natural or artificial materials to stabilize or otherwise alter natural or artificial teeth.
25. Any expense resulting from a war or international armed conflict.
26. Any expense or charge for chelation therapy except for the treatment of acute arsenic, gold, mercury, or lead poisoning.
27. Any expense or charge for treatment or counseling for behavior associated with compulsive gambling or gaming.
28. Any expense or charge for cosmetic surgery and/or treatment not related to an accident, injury or birth defect.
29. Expenses incurred before eligibility starts or after eligibility terminates.
30. Expenses in excess of Reasonable and Customary Charges.
31. Loss to which a contributing cause was your being engaged in an illegal act.

32. Behavioral problems or social maladjustments that are not specifically the result of a Mental Disorder.
33. Travel time and expenses to and from a provider.
34. Expenses for non-Durable Medical Equipment or supplies, such as cotton swabs, medical tape, bandages, etc.
35. Treatment of sexual dysfunction with the exception of the office visit and lab work required to get a prescription for medication.

# HOW TO FILE CLAIMS AND APPEALS

You must file claims with the Fund Office as soon as possible **but no later than 90 days after the date of the loss or service**. Failure to notify the Fund Office within 90 days will not invalidate nor reduce any claim if it is shown that it was not reasonably possible to furnish the proof sooner. **No claim will be accepted later than 12 months after the date of the loss or service.**

After receiving notice of loss, the Fund Office will send claim forms. If the forms are not furnished within 15 days after requested, the written proof may be in any form that covers the occurrence, character and extent of the event for which claim is made.

The Fund has the right to examine you or your dependent as often as required during consideration of a claim. The Plan also has the right to perform an autopsy in case of death where it is not forbidden by law.

## How To File A Health Care Claim

Most network providers will submit claims for you electronically.

**Step 1:** Obtain a claim form from the Fund Office at:

Duluth Building Trades Health Fund
2002 London Road, Suite 300
Duluth, Minnesota 55812
218-728-4231 or 1-800-570-1012

**Step 2:** Read the instructions on the claim form. Read the claim form carefully, answer all questions, and include any information required. If you have questions, contact the Fund Office.

**Step 3**: Complete the Employee section of the form and sign it.

**Step 4:** Have your Physician fill out the Physician section claim form or attach his or her report.

**Step 5:** Attach an itemized bill to the claim form:

- From the Hospital;
- From each Physician;
- From the ambulance service;
- For prescription drugs;
- For the anesthesiologist; or
- For other medical services provided.

A bill or cash receipt for prescription drugs must indicate the name of the patient, the date of the purchase, the name of the prescription, the prescription number, and the name of the doctor who issued the prescription.

You should keep separate records of medical expenses for each individual because the deductible amounts, the maximums, and other limitations apply separately to each individual. Save all bills for any item of covered expense and a record of the date the expense was incurred.

## Payment Of Claims

All benefits for Hospital, Physician and Dental charges will be paid directly to the provider (assignment of benefits). Other charges will be paid directly to you, unless assigned to the provider except that:

- Benefits for loss of life provided under the Death and Dismemberment Benefit are payable to a surviving beneficiary.
- Benefits provided under the Weekly Income Benefits will be paid each week during any period for which the Plan is liable. Any balance remaining unpaid at the termination of the period will be paid immediately after receipt of due proof.
- Any benefits continued after a participant's death will be paid in the following order:
  - To the surviving spouse, or if none;
  - Equally to the children, or if none;
  - Equally to the parents, or if none;
  - Equally to the brothers and sisters, or if none;
  - To the estate.

If you or your dependent has already paid a Hospital or Physician directly, the Plan will reimburse you for the covered benefits upon proof (including the amounts paid) that the Hospital or Physician has been paid.

You will be notified in writing of any benefits denied in whole or in part, or if any additional information is required.

## Claim Filing Procedure

For the Plan to pay benefits, a claim must be filed with the Fund Office in accordance with the procedures described in this section. A claim can be filed by an Employee, retiree, eligible dependent, or by someone authorized to act on behalf of the Employee, retiree, or eligible dependent. Please remember:

- A claim is considered filed on the date it is received, even if the claim is incomplete.
- A claim is a request for plan benefits, normally because the claimant has incurred a covered expense. A request for confirmation of plan coverage is not a claim if the expense has not yet been incurred. A general inquiry about eligibility or coverage when no expense has been incurred is not a claim, nor is presenting a prescription to a pharmacy.
- Claims must be filed within **90 days** of the date the claim was incurred.
- A claimant may designate another person as his or her authorized representative for purposes of filing a claim. The designation must be in writing and all notices regarding the claim will be sent to the authorized representative and not to the claimant.

A routine assignment of benefits so that the Plan will pay the provider directly is not a designation of the provider as the authorized representative.

Written proof of claims must be provided to the Fund Office within 12 months following the date on which the expense was incurred. However, when your coverage terminates for any reason, written proof of your claim must be given to the Fund Office within 90 days of the date of termination of coverage, provided the Plan remains in force. However, upon termination of the Plan, final claims must be received within 90 days of termination.

## Claim Denials

If your claim for benefits is wholly or partially denied, you will receive a written notice of an adverse benefit determination which will contain the following:

- Information sufficient to identify the claim involved, including date of service, health care provider, and claim amount;
- A statement that diagnosis and treatment codes, and their corresponding meanings, are available upon request;
- The specific reason for the denial with the applicable denial code and its corresponding meaning and specific reference to pertinent Plan provisions on which the denial is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material is necessary;
- The specific rule, guideline protocol, or other similar criterion, if any, relied upon in making the determination;
- An explanation of the scientific or clinical judgment for the determination if the adverse benefit determination was based on medical necessity or other similar exclusion or limitation; and,
- A description of the available internal appeal and external review process, how to initiate an appeal, and a statement of your right to bring a civil action under ERISA Section 502(a).

If your claim for disability benefits is wholly or partially denied, you will receive a written notice of an adverse benefit determination which will contain the following:

- The specific reason(s) for the adverse determination, along with reference to specific plan provisions on which the determination is based;
- A description of additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    - The views presented by you to the health care professionals treating you and vocational professionals who evaluated you;
    - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
    - A disability determination made by the Social Security Administration if you provided one to the Plan.
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request;
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols standards or other similar criteria do not exist;

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim of benefits; and
- A description of the available internal appeal and external review process and a statement of your right to bring a civil action under ERISA Section 502(a).

1. Emergency Care Claims. In the case of an Emergency Care claim, the Fund Office shall notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the seriousness of your medical condition, but not later than 72 hours after receipt of the claim by the Plan, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Fund Office shall notify you, within 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. You shall be given a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specific information. The Fund Office shall notify you of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specific information; or (2) the end of the period given to you to provide the specified additional information.
2. Pre-Service Claims. The benefit determination, whether adverse or not, shall be given within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the claim is filed, unless special circumstances beyond the control of the Plan require an extension of time for processing the claim. If such extension is necessary due to a failure by you to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you shall be given at least 45 days from the receipt of the notice within which to provide the specified information.
3. Post-Service Claims. The notice of denial shall be given within 30 days after the claim is filed, unless special circumstances beyond the control of the Plan require an extension of time for processing the claim. If such extension is required, you will be sent written notice before the expiration of the initial 30-day period, stating the special circumstances requiring the extension and the date by which a decision on the claim can be expected. If such extension is necessary due to a failure by you to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you shall be given at least 45 days from the receipt of the notice within which to provide the specified information.
4. Concurrent Care Decision. If you are receiving an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such treatment shall be deemed an adverse benefit termination. Notice of such determination shall be sent at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
5. Disability Claims. In the case of a claim for disability benefits, you will be notified of an adverse benefit determination no later than 45 days after receipt of the claim by the Plan.

Any request by you to extend the course of treatment beyond the period of time or number of treatments involving an Emergency Care claim shall be decided as soon as possible, taking into account the seriousness of your medical condition, and the Fund Office shall notify you of the benefit determination, whether adverse or not, within 24 hours prior to the expiration of the prescribed period of time and number of treatments. The appeal procedure is stated below.

## Claim Appeal Procedure

In accordance with federal law, the Plan provides for a two-step appeal. The first step is an internal appeal to the Board of Trustees or their designee. The second step is an external appeal to an Independent Review Organization ("IRO").

The Fund has engaged IROs on behalf of the Plan and any external appeal shall be assigned to such IROs in accordance with federal law.

## First Level Appeal ("Internal Appeal")

**1. In General:**

a) You have 180 days following the receipt of a notification of an adverse benefit determination from the Fund Office to appeal such determination pursuant to the rules regarding the Internal Appeal provided in this section.

b) You shall submit the Internal Appeal in writing to the Fund Office.

c) You shall have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.

d) You shall be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.

e) A de novo review of your Internal Appeal shall be conducted by the Board of Trustees or a committee of the Full Board. Such review shall take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

f) In deciding an Internal Appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the Board of Trustees or a Committee of the Board shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Any such health care professional consulted shall not be an individual who was consulted in connection with the adverse benefit determination at issue nor the subordinate of any such individual.

g) The identification of all medical or vocational experts whose advice was obtained on behalf of the Fund in connection with your adverse determination, without regard to whether the advice was relied upon in making the benefit determination, will be provided.

h) You will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or at the Plan's direction in connection with your claim and any with new or additional rationale as soon as possible and sufficiently in advance of the date the final internal adverse benefit determination must be provided in order to provide you with an opportunity to respond prior to that date.

**2. Time for Decision and Notification of Appeal:**

a) Except as hereinafter provided, the Board of Trustees or a Committee of the Board shall make a decision on the Internal Appeal no later than the date of the next regularly scheduled Trustees' meeting that immediately follows the Fund's receipt of the appeal, unless the Internal Appeal is filed within thirty (30) days preceding the date of such meeting. In such case, the decision may be made by no later than the date of the second meeting following the Fund's receipt of the Internal Appeal. If special circumstances require further extension of time for processing, a

decision on the Internal Appeal shall be rendered not later than the third meeting of the Trustees following a receipt of the appeal. If such an extension is required, the Board of Trustees or a Committee of the Board shall provide you with written notice of the extension which describes the special circumstances and the date as of which the decision will be made, prior to the commencement of the extension. The Board of Trustees or a designated fiduciary shall notify you as soon as possible but no later than five (5) days after a decision is made.

b) Expedited Internal Appeals for Urgent Care Claims. In the case of the Internal Appeal of an Urgent Care claim, the Board of Trustees or a designated fiduciary shall notify you of the decision on the Internal Appeal as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after the receipt of your Internal Appeal.

c) In the event you receive an adverse benefit determination that involves a medical condition for which the timeframe for completion of an Expedited Internal Appeal would seriously jeopardize the life or health of you or your dependents or would jeopardize you or your dependents ability to regain maximum function and you have filed a request for an Expedited Internal Appeal, the Fund shall waive the Internal Appeal determination and proceed to an Expedited External Review.

d) Pre-service Claims. In the case of a Pre-service Claim, the Board of Trustees or Committee of the Board shall notify you of the decision on the Internal Appeal within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days after receipt of your Internal Appeal.

e) Calculation of Time Periods. The time period within which a decision on the Internal Appeal is required to be made shall begin at the time an appeal is filed in accordance with the procedures provided in the Plan, without regard to whether all the information necessary to make a decision on the appeal accompanies the filing. However, in the event a period of time is extended due to your failure to submit information necessary to decide an appeal, the period for making a decision on appeal shall be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

**3. Notification of Final Internal Adverse Benefit Determination:**

The Board of Trustees or a Committee of the Board shall provide you with written notification of the Internal Appeal decision. In the case of an adverse determination, such notice shall include, in addition to the information contained in a notice of adverse benefit determination:

- A statement that you are entitled to receive, upon request, free access to and copies of all documents relevant to the claim;
- A description of the available external review process and how to initiate an external review request; and
- A statement that you may have the right to bring a civil action under ERISA Section 502(a) and a description of the contractual limitations period that applies to your right to bring such an action, including the calendar date that period expires.

## Second Level Appeal ("External Review")

**1. Deadline for External Review:**

You may file a request for External Review with the Fund Office within four months after the date of receipt of the adverse Internal Appeal decision. If there is no corresponding date four months after the date of receipt (*e.g.*, received on October 30th and there is not a February 30th), the request must be filed

by the first day of the fifth month following the receipt of the notice. If the last date falls on a Saturday, Sunday, or a Federal Holiday, the filing deadline is extended to the next business day.

**2. Preliminary Review:**

Within five (5) business days following the date of receipt of your External Review request the Trustees, or the Fund Office as its designee, must complete a preliminary review of the request to determine whether it is eligible for External Review. In order to be eligible for External Review the following factors must be met:

a) You are or were covered under the Plan at the time the health care item, service, or other benefit was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item, service, or other benefit was provided;

b) The adverse benefit determination or the final adverse Internal Appeal determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;

c) You have exhausted the Plan's Internal Appeal process unless you are not required to exhaust the Internal Appeals process under the federal interim final regulations or because you require an Expediated External Review;

d) You have provided all of the information and forms required to process an External Review; and,

e) Your adverse benefit determination or final adverse benefit determination involves medical judgment (including, but not limited to, determinations of medical necessity, appropriateness, or experimental or investigational nature of the treatment), a rescission of coverage, or consideration of whether the Plan is complying with the protections against surprise balance billing and cost-sharing protections related to Emergency Services, a Continuing Care Patient, and/or out-of-network care and an in-network facility.

**3. Notice of Preliminary Review:**

Within one (1) business day after completion of the Preliminary Review, the Trustees, or the Fund Office as their designee, will issue a notice in writing to you. If the request for External Review is complete, but not eligible for External Review, such notice will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, such notice will describe the information or materials needed to make the request complete and the Plan shall allow you to perfect the request for External Review within the later of the four-month filing period or within 48 hours following the receipt of the Notice of Preliminary Review.

**4. External Review by an Independent Review Organization:**

In accordance with federal law, the Trustees, or the Fund Office as their designee, shall assign an accredited Independent Review Organization ("IRO") to conduct the External Review. The IRO shall be assigned in accordance with the Fund's rules, which provide an assignment or rotation method that ensures independence and protection against a bias towards the Fund.

Upon receipt of the External Review, the IRO will:

a) Timely notify you in writing of the request's eligibility and acceptance for external review.

b) This notice will include a statement that you may submit in writing to the assigned IRO within ten (10) business days following the date you received this notice any additional information that the IRO must consider when conducting the External Review. The IRO may, but is not required, to accept and consider additional information submitted after ten (10) business days.

c) Within five (5) business days after the date of assignment to the IRO, the Trustees, or the Fund Office as their designee, must provide to the IRO any documents and any information considered

in making the adverse benefit determination or the adverse Internal Appeal determination. Failure by the Fund (or the Fund Office) to provide documents must not delay the External Review. If the Fund, or the Fund Office fails to timely provide the documents and information, the IRO may terminate the External Review and make a decision to reverse the adverse benefit determination or the adverse Internal Appeal determination. Within one (1) business day after making such decision, the IRO must notify you and the Trustees.

d) Upon receipt of any information submitted by you in accordance with provision ii. above, the IRO must within one (1) business day forward such information to the Trustees. Upon receipt of any such information, the Trustees may reconsider its adverse benefit determination or adverse Internal Appeal determination that is the subject of the External Review. Any reconsideration by the Trustees must not delay the External Review. External Review may be terminated if the Trustees determine during reconsideration to reverse the previous determination and provide coverage or payment as requested by you. The Trustees will provide written notice to the IRO and you of its reversal of the previous determination within one (1) business day of such reversal. Thereafter, the IRO will terminate the External Review proceedings.

e) The IRO will review all information and documents timely received and review the claim and all evidence de novo. The IRO is not bound by any decisions or conclusions reached during the initial benefit determination or the Internal Appeal. In addition to the documents and information provided, the IRO will consider the following, as it determines appropriate, in reaching an External Review decision:

- your medical records;
- the attending health care professional's recommendation;
- reports from appropriate health care professionals and other documents submitted by the Plan, you or your treating provider;
- the terms of the Plan (unless contrary to applicable law);
- appropriate medical practice guidelines, including evidence-based standards;
- any applicable clinical review criteria developed and used by the Plan (unless contrary to the Plan or applicable law); and
- the opinion of the IRO's clinical review.

f) The IRO will provide written notice of the final External Review decision to you and the Trustees within 45 days after the IRO receives the request for External Review.

g) The IRO's final External Review decision notice will contain:

- a general description of the reason for the request for External Review, including sufficient information to identify the claim (date or dates of service, Provider, claim amount, diagnosis code and corresponding meaning, treatment code and corresponding meaning, and reason for previous denial);
- the date the IRO received the assignment to conduct the External Review;
- the date of the IRO's final External Review decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching the decision;

- an explanation of the principal reason or reasons for the IRO's decision, including the rationale for the decision and any evidence-based standards that were relied on in making the decision;
- a statement that the determination is binding except to the extent that other remedies may be available under federal law to either the Plan or you;
- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

h) The IRO must maintain records of all claims and notices associated with the External Review for six (6) years. An IRO must make such records available for examination by you, Plan, or state or federal government oversight agency upon request unless such disclosure would violate state or federal privacy laws.

**5. Expedited External Review:**

a) Expedited External Review shall be undertaken when you have a medical condition that necessitates Expedited External Review because the timeframe for completion of the standard External Review would seriously jeopardize the life or health of you or would jeopardize your ability to regain maximum function, or if the final adverse Internal Appeal determination concerns an admission, availability of care, continued stay or health care item or service for which you received emergency services but you have not been discharged from a Provider's facility.

b) The Trustees, or the Fund Office as their designee, shall immediately upon receipt of the request for the Expedited External Review, perform the Preliminary Review and shall complete such review as soon as possible without regard to the five (5) business days referred to therein. Upon its determination of the Preliminary Review, the Trustees, or the Fund Office as their designee, will immediately send the notice of preliminary review.

c) Upon a determination that the request is eligible for Expedited External Review, the Trustees, or Fund Office as their designee, shall assign an IRO in accordance with this section and transmit or provide all documents and information required electronically, by telephone, facsimile or by any other available expeditious method.

d) The IRO must provide its final External Review decision in accordance with this section and notice of such decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an Expedited External Review. If the notice of the Expedited External Review decision is provided by the IRO other than in writing, then within 48 hours of the date such notice is provided the IRO will provide written confirmation of the decision to you and the Trustees in accordance with this section.

**6. Reversal of Adverse Determination.**

In the event the adverse benefit determination or the adverse Internal Appeal determination is reversed by the Trustees or the IRO, respectively, the Plan will provide coverage or payment for the claim in accordance with applicable law and regulations, but reserves the right to pursue judicial review or other remedies available or that may become available to the Plan under applicable law and regulations.

**7. Limitations on Actions Against the Fund:**

No lawsuit shall be brought to recover benefits under this Plan unless:

a) You have exhausted the appeal procedure provided by the Plan; and

b) Such lawsuit is filed within two years from the date of the Board of Trustees' written notification of its decision on your Internal Appeal. This contractual limitation period shall begin to toll from the date of the Board of Trustees' written notification of its decision on your Internal Appeal, regardless of whether you seek an External Appeal through an IRO.

# COORDINATION OF BENEFITS, SUBROGATION, AND PRIVACY

## Coordination Of Benefits (COB)

When members of a family are covered under more than one group benefits plan, there may be instances of duplication of coverage – two plans paying benefits for the same medical expenses. The Coordination of Benefits (COB) provision coordinates the benefits payable by this Plan with similar benefits payable under other plans, excluding Weekly Income and Death and Dismemberment Benefits**.**

Allowable Expenses are any necessary, Reasonable and Customary expenses incurred which would be covered under any of the plans. Other Plan is any plan providing benefits for medical or dental treatment. Other plans include:

- Group insurance or any other arrangement of coverage for individuals in a group whether on an insured or uninsured basis;
- Automobile reparation (no fault) insurance required under any law of a government and provided through arrangements other than those described above but only to the extent of benefits required under such no-fault law; or
- Dependents' benefits payable under this Plan when a spouse is covered both as an Employee and as a dependent or when a child is covered as a dependent of more than one Employee.

### *Which Plan Is Primary*

To decide which plan is primary, consider both the coordination provisions of the other plan and which member of your family is the patient. When another plan **does not** have a COB provision, that plan must determine benefits first.

When another plan **has** a COB provision, the primary plan will be determined by the first applicable statement from the following:

1. A plan without coordination of benefits will pay benefits before a plan that contains coordination of benefits.
2. A plan that covers a person other than as a dependent will pay benefits before a plan that covers the person as a dependent.
3. For dependent children, the plan that covers the parent whose birthday (month and day) falls first in the calendar year will pay first. The plan of the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan covering the parent for the longer period of time will pay first.
4. If one plan uses the male/female rule and the other plan uses the birthday rule, the plan using the male/female rule will pay benefits first for a dependent.
5. For dependent children of separated or divorced parents:
    a. If there is a court decree that establishes financial responsibility for medical expenses, the plan covering the dependent children of the parent who has that responsibility pays first.
    b. If there is no court decree, the plan that covers the parent with custody will pay first.

c. If there is no court decree and the parent with custody has remarried, the order of benefit payment will be:

   i. The plan of the parent with custody;

   ii. The plan of the stepparent with custody; or

   iii. The plan of the parent without custody.

6. The plan to which contributions were most recently made will pay benefits first. For the purposes of this section, utilization of Hours Bank hours will not be considered contributions.

## *Coordination Of Benefits With Medicare*

Any benefits covered under both the Plan and Medicare will be paid according to Medicare Secondary Payor legislation, regulations, and Health Care Financing Administration guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Plan provisions, and federal law. Except when federal law requires the Plan to be the primary payor, the benefits under the Plan for participants age 65 and older, or participants otherwise eligible for Medicare, do not duplicate any benefit for which members are entitled under Medicare, including Part B. Where Medicare is the responsible payor, all amounts payable by Medicare for services provided to participants will be reimbursed by or on behalf of the participant to the Plan, to the extent the Plan has made payment for such services.

### *Information About Medicare*

Medicare is a multi-part program:

- Hospital Insurance Benefits for the Aged and Disabled (commonly referred to as Part A of Medicare) covers Hospital benefits, although it also provides other benefits.
- Supplementary Medical Insurance Benefits for the Aged and Disabled (commonly referred to as Part B of Medicare) primarily covers Physician's services, although it, too, covers a number of other items and services.
- Medicare Advantage (Part C of Medicare) covers Medicare managed care offerings.
- Medicare Prescription Drug Coverage (Part D of Medicare) covers prescription drug benefits.

If you are covered by a Medicare managed care plan, the Plan will presume that you have complied with the managed care program's rules so your expenses are covered by the managed care program. **If you are a Retired Employee and if you enroll in a Medicare Part D plan outside of the Medicare Supplemental coverage available through the Plan, no prescription drug benefits will be payable under the Plan.** If you do not enroll for Part B coverage within the three months after becoming age 65, and you stop working or lose eligibility for Plan benefits, you may enroll for Part B coverage within seven months of the first day of the first month in which you are no longer covered by the Plan without any penalty or waiting period. If you are such an individual and you do not enroll for Part B coverage within this seven-month period, you may enroll during the general enrollment period. The general enrollment period occurs between January 1 and March 31 of each year and coverage begins the following July 1.

The monthly premium will be assessed a 10% increase for each full 12 months (after age 65) you are not enrolled in Part B coverage. However, months during which you were covered by the Plan are not counted.

**It's your (and your dependent's) responsibility to apply for Medicare.** If you or your dependent is eligible for Medicare and want information about enrollment, contact your local Social Security

Administration Office three months before your 65th birthday or when you are otherwise eligible for Medicare. Contact your local Social Security Administration Office if you have questions concerning Medicare eligibility, enrollment, or coverage.

It's your responsibility to notify the Fund Office of your retirement at least 30 days (90 days if you are age 65 or older) prior to your Retirement Date. If you fail to notify the Fund Office within this time and you are age 65 or older, claims will be retroactively processed as if Medicare was primary. If the Fund Office processed your claims after your Retirement Date as if the Plan was primary, you will be required to reimburse the Fund for any excess payment. Failure to reimburse will result in the Fund withholding payments for future claims or other collection means deemed necessary by the Board of Trustees.

### *Effect On Benefits*

If this Plan is primary, this Plan will determine benefits without considering the other plans. If this Plan is secondary, Medicare benefits are determined or paid first, and then benefits under this Plan are paid. Benefits are coordinated using a method called Carve Out. First, the plan calculates the Plan payment as if there were no Medicare. Then the Plan subtracts what Medicare paid. The balance, if any, is paid by the Plan. The combined Medicare and Plan benefits will not exceed 100% of the expense incurred.

*For example, suppose you have a Physician charge of $150 and the Medicare allowed amount is $100. Benefits will be paid as follows:*

| | |
|---|---|
| *85% of $100 =* | *$85* |
| *Medicare payment (80% of $100) =* | *$80* |
| *Plan payment =* | *$5* |
| *You pay ($100 - $85) =* | *$15* |

### *Order of Benefit Determination*

This Plan has secondary responsibility for the claims of an eligible person who is eligible for primary Medicare Benefits because of end-stage renal disease. This Plan has primary responsibility for claims during the waiting period even if the person is also eligible for Medicare due to age.

This Plan has primary responsibility for your claims, if you:

- Are at least age 65;
- Are eligible for Medicare Part A solely because of age; and
- Are actively employed by an employer, which pays all or part of the required contributions for eligibility.

**This Plan has secondary responsibility for your claims when you are eligible for Medicare Part A because of age and you are not actively employed by a Contributing Employer who pays all or part of the required contributions for eligibility.**

This Plan has primary responsibility for your dependent spouse's claims if:

- Your spouse is at least age 65;
- Your spouse is eligible for Medicare Part A solely because of age; and
- You are actively employed by an employer, which pays all or part of the required contributions for eligibility.

## Subrogation

Whenever the Duluth Building Trades Health Fund has been or is providing Benefits under the Plan to a Plan Participant or eligible dependent as a result of an occurrence which results in the injury, sickness, or death to the Plan Participant or eligible dependent and for which a Plan Participant or eligible dependent could possibly recover damages, indemnity, or any other benefits or payments from any Responsible Third Party (including without limitation any person; any legal entity; any liability insurer, health insurer, Workers Compensation insurer, self-insurer, or any other insurer, whether first-party or third-party; any provider of no-fault, underinsurance, or uninsurance; or any indemnitor), the Fund will be subrogated to the rights of the Plan Participant and eligible dependent against such Responsible Third Party to the extent the Fund has paid benefits on behalf of the Plan Participant and eligible dependent and to the extent the Fund has incurred reasonable attorneys' fees and costs in the representation of its interests. The Fund may make a claim or commence and prosecute a legal action against any Responsible Third Party to recover benefits it has paid and to recover any fees and costs (including attorneys' fees) the Fund may have incurred in obtaining such a recovery.

If a Plan Participant or eligible dependent recovers any payments from any Responsible Third Party (whether through settlement, judgment, or otherwise, and whether or not denominated as medical damages), the Fund has a first priority subrogation and reimbursement claim against any such recovery. The proceeds from any such recovery, however denominated, from any Responsible Third Party will be allocated as follows:

First, the Fund will be paid that amount that fully reimburses the Fund for all benefits it has paid on behalf of the Plan Participant or eligible dependent and for the Fund's reasonable attorneys' fees and costs incurred by the Fund in the representation of its interests.

If there is any balance then remaining from such recovery, the Plan Participant or eligible dependent will receive such balance, but the Plan Participant or eligible dependent will be fully responsible for payment of his fees and costs of collection, including but not limited to his attorneys' fees.

The payment of proceeds will be made in the order described whether or not the Plan Participant or eligible dependent or those claiming under him have been fully compensated for damages arising from the injury, sickness, or death. Furthermore, this allocation will apply to any claim of any eligible dependent, regardless of whether the Plan Participant or eligible dependent was legally responsible for expenses of treatment. Unless it agrees in writing, the Fund will not be liable for any expenses, costs, or fees (including attorneys' fees) a Plan Participant or eligible dependent may incur in connection with his recovery.

If a Plan Participant or eligible dependent recovers from a Responsible Third Party and does not fully reimburse the Fund the amount of benefit payments the Fund has made and the reasonable attorneys' fees and costs incurred by the Fund in the representation of its interests, the Plan Participant or eligible dependent is personally liable to the Fund for the full amount of benefits paid on behalf of the Plan Participant or eligible dependent by the Fund, along with all costs and attorneys' fees incurred by the Fund to recover that amount.

A Plan Participant or eligible dependent must not settle or compromise any claims they might have against any Responsible Third Party without obtaining the prior written consent of the Fund. A Plan Participant or eligible dependent must cooperate fully with the Fund in the prosecution of any claims against any Responsible Third Party, and must provide the Fund with the names and addresses of all potential Responsible Third Parties and their insurers; all accident reports; and all authorizations and other papers and information the Fund might request from a Plan Participant or eligible dependent. A Plan

Participant or eligible dependent must notify the Fund if they pursue a claim to recover damages and/or reimbursement of expenses related to the injury, sickness, or death that necessitated their request for and receipt of benefits.

If a Plan Participant or eligible dependent does not provide the Fund with information the Fund has requested or is entitled to receive, or fails to reimburse the Fund out of any recovery, or fails to assign to the Fund their rights of recovery, or fails to promise to reimburse the Fund, or in any way prejudices the Fund's reimbursement and subrogation rights, the Fund in its discretion may withhold payment of present and future benefits to the Plan Participant or eligible dependents until they provide the requested information, reimburse the Fund, or otherwise cease prejudicing the Fund's reimbursement and subrogation rights.

The Fund will have the right to intervene in any legal action (wherever located) that a Plan Participant or eligible dependent might commence against any Responsible Third Party. The Fund will have the right to seek equitable or legal relief in order to enforce its reimbursement and subrogation rights that exist pursuant to law or equity, pursuant to the Summary Plan Description, or pursuant to any other document. A Plan Participant or eligible dependent or their attorney or agent must hold in trust the Fund's first priority interest in any recovery they might obtain from any Responsible Third Party. By virtue of applying for and accepting benefits from the Fund, a Plan Participant or eligible dependent authorizes the Fund to seek the imposition of a constructive trust or file a claim for equitable restitution against any recipient of monies recovered from any Responsible Third Parties, or to seek any other relief (whether characterized as legal or equitable) in any court or tribunal in order to protect the Fund's interest in any such recovery.

Any rights the Fund may possess pursuant to this section will be enforceable against the heirs, successors, and assigns of the Plan Participant or eligible dependent. As a condition precedent to providing benefits, the Fund may require the Plan Participant or eligible dependent to acknowledge their responsibilities and the Fund's rights under the Summary Plan Description, to assign to the Fund the Plan Participant's or eligible dependent's rights to recovery, and to promise to reimburse the Fund.

In the event a Plan Participant recovers any sums from any Responsible Third Party related to a specific event or health condition that is or would be subject to the Plan's Subrogation provision and the Participant either: (1) recovered such sum prior to becoming covered under the Plan; or (2) the Participant failed to fully comply with the rules of the Plan's Subrogation provision, as determined by the Trustees in their sole discretion; or (3) the Participant received a sum from a Responsible Third Party, including a workers' compensation insurer, as compensation for future medical expenses and/or as consideration for closing out and resolving any claim for future medical benefits, then the Plan will be:

1. responsible to make payments for benefits only in excess of the Participant's net recovery (gross amount less actual costs of collection); or

2. entitled to reimbursement from the Participant for payment of any benefit up to the amount of the Participant's net recovery.

### *Intervention Rights*

If the Fund pays benefits on behalf of an eligible Plan participant for any Accidental Injury or Sickness that is determined to be work related, the Fund has the right to intervene in the Workers' Compensation proceeding to recover benefits paid to or on behalf of the Plan participant for the Accidental Injury or Sickness. The recovery may be made from the employer, insurer of employer, or any other party determined to be responsible for payment.

It is your responsibility and the responsibility of your attorney to notify the Fund in writing of any claim filed by you or on your behalf for a work-related Accidental Injury or Sickness.

The Fund may pay benefits for an eligible participant before claims are identified as work-related claims. This provision does not obligate the Fund to pay benefits for a work-related Accidental Injury or Sickness, but is intended to prevent the payment of duplicate benefits. The Fund may recover benefits from all components of the Workers' Compensation payment.

Unless otherwise required by law, the Fund will not be responsible for any costs or attorney fees incurred by the Plan participant in prosecution of a claim for Workers' Compensation benefits.

### *Recovery of Benefits Paid in Error*

The Plan has the right to seek repayment of benefits paid in error as described in this section.

1. If, for any reason, any Plan benefit paid to, or on behalf of, a covered employee, dependent, participant, beneficiary or any person claiming a benefit under the Plan, is thereafter determined to be in error, or wholly or partially in excess of the amount to which the payee was entitled to receive under the Plan, the Trustees may collect such erroneous benefit payment or overpayment by suit, arbitration or such other remedy as the law may provide.

2. In addition to such remedies, the Trustees shall have the right to reduce and withhold from the payment of future benefits to any covered person within the family of the eligible employee, such amount of erroneous payment or overpayment that has not been repaid after written demand has been made for the erroneous amount.

3. The Trustees shall also have the right to attach all past, present and future contributions paid into the Fund on behalf of a participant who has failed or refused to make repayment of an erroneous benefit payment or overpayment once thirty (30) days have expired after written notice and demand by the Trustees for repayment was sent to the participant at such participant's last known address. Any contributions so attached may be immediately paid over and transferred into the general funds of the Plan irrespective of any loss of credit or ineligibility that may occur to the Plan participant as the result of such attachment.

4. In addition to recovery of the principal amount of any erroneous benefit payment or overpayment, the Trustees may recover interest on the unpaid principal at an interest rate equal to the prime rate of interest plus 2%, as determined by the NY Times as of the first day of the month following the date of the Plan's written request for repayment and all reasonable costs and expenses incurred in collecting such erroneous payment or overpayment, including reasonable legal fees.

## Benefit Payment To An Incompetent Person

If the Fund determines that the person filing the claim (claimant) is incompetent or incapable of managing Plan benefits and a guardian has not been appointed, the Fund may pay any amount otherwise payable to the claimant to someone else (an alternate payee). The alternate payee may be the spouse, blood relative, or any other person or institution determined by the Fund to have provided benefits or agreed to provide care to the claimant. Any payment in accordance with this provision discharges the Fund from any further obligation for such payment.

## Privacy Policy

The Plan is required to protect the confidentiality of your Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services. You may request a complete description of your rights under the Plan's privacy policies and procedures, free of charge, from the Fund Office. Your rights under HIPAA include the right to:

- Receive confidential communications of your health information, as applicable;
- Copy your health information, at a cost;
- Receive an accounting of certain disclosures of your health information;
- Amend your health information under certain circumstances; and
- File a complaint with the Plan or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

If you need a copy of the Privacy Notice, please contact the Fund Office. The Fund will use and disclose protected health information (individually identifiable health information, regardless of the form in which it is kept) in accordance with the uses and disclosures permitted or required by HIPAA and Department of Health and Human Services Regulations Regarding Privacy of Individually Identifiable Health Information.

The Fund will not disclose protected health information to the Plan Sponsor, Board of Trustees, or permit a health insurance issuer or HMO to disclose protected health information unless the disclosure complies with HIPAA and Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information.

The Fund may disclose to the Board of Trustees summary health information. Summary health information is information that summarizes:

- Claims history;
- Claims expenses; or
- Types of claims experienced by individuals for whom the Trustees provide coverage under the Fund and from which aspects permitting identification, other than a five-digit zip code, have been eliminated.

This information may be used by the Board of Trustees to obtain premium bids from health plans for providing health insurance coverage under the Fund or for the Board of Trustees to modify, amend, or terminate this Plan.

The Fund may disclose to the Board of Trustees protected health information (PHI) concerning whether a person participates in the Fund or has enrolled or disenrolled from a health insurance issuer or HMO, if the Fund were to ever have these options. The Fund may disclose PHI if written authorization is received from you or your dependents that complies with HIPAA and Department of Health and Human Services Regulations Regarding Privacy of Individually Identifiable Health Information.

Except for the disclosures described above, for the Fund to disclose PHI to the Board of Trustees or to permit the disclosure of such information to the Board of Trustees by a health insurance issuer or HMO with respect to the Fund, for any purposes including the administration of the Fund, the Fund must ensure that the Plan documents restrict uses and disclosure of protected health information consistent with the

requirements of the Department of Health and Human Services Regulations Regarding Privacy of Individually Identifiable Health Information. These restrictions are set forth in this section.

For the Fund to disclose protected health information to the Board of Trustees other than as described above, the Board of Trustees must certify that the Plan has been amended to incorporate the following provisions. The Fund will:

- Not use or further disclose protected health information other than as permitted or required by the Plan documents or as required by law.
- Ensure that any agents, including a subcontractor, to whom the Board of Trustees provides PHI received from the Fund agree to the same restrictions and conditions that apply to the Board of Trustees with respect to the protected health information;
- Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Board of Trustees;
- Report to the Fund any use or disclosure of the PHI that is inconsistent with the uses or disclosure provided for of which it becomes aware;
- Make available protected health information as required by the Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information.
- Make available protected health information for amendment and incorporate any amendments to protected health information in accordance with Department of Health and Human Services Regulations Regarding Privacy of Individually Identifiable Health Information.
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Fund available to the Secretary of Health and Human Services for purposes of determining compliance by the Fund with Subpart E of the Department of Health and Human Services Regulations Regarding Privacy of Individually Identifiable Health Information.
- If feasible, return or destroy all PHI received from the Fund that the Board of Trustees still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible and provide for the separation of the Fund and Board of Trustees.

The Board of Trustees will ensure that adequate separation exists between the Fund and the Board of Trustees. To ensure this separation:

- Access to PHI provided from the Fund to the Board of Trustees will be restricted to the members of the Board of Trustees who are involved in matters relating to payment, health care operations or other matters pertaining to the Fund in the ordinary course of business;
- Access by the Trustees to PHI provided from the Fund to the Board of Trustees will be restricted to the Plan administration functions that the Board of Trustees provide for the Fund; and
- The Board of Trustees will provide an effective mechanism for resolving any issues of noncompliance by Trustees with the provisions of this section.

The Fund may not disclose PHI to the Board of Trustees nor permit a health insurance issuer or HMO to disclose protected health information to the Board of Trustees as otherwise permitted under the Department of Health and Human Services Regulations Regarding Privacy of Individually Identifiable Health Information unless a statement is included in the Notice of Privacy Practices.

# ADMINISTRATIVE INFORMATION

## *Important Information About The Plan*

### *Plan Name And Type Of Plan*

Duluth Building Trades Health Fund. The Duluth Building Trades Health Fund ("The Fund") is a "Taft-Hartley" Fund established by a Trust Agreement effective June 15, 1953, amended and restated effective August 2, 2013.

The Plan is maintained for the purpose of providing Medical, Prescription Drug, Dental, Vision, Weekly Income, and Death and Dismemberment Benefits. The Plan benefits are shown on the *Schedule Of Benefits*.

All benefits are provided on a self-funded basis directly from the Health Fund.

### *Plan Number*

The number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501. The number assigned to the Plan or Fund by the Internal Revenue Service is 41-6025701.

### *Plan Year*

The records of the Plan are kept separately for each Plan year. The Plan Year begins on January 1 and ends on December 31.

### *Board Of Trustees/Plan Administrator*

The Board of Trustees is the Plan Sponsor and Plan Administrator. They are selected by the employers and unions. Only the Board of Trustees is authorized to interpret the rules governing the Plan. Employer and union representatives and individual Plan Trustees may not make interpretations. To contact the Trustees, call or write the Fund Office at:

Duluth Building Trades Health Fund
2002 London Road, Suite 300
Duluth, Minnesota 55812
218-728-4231 or 1-800-570-1012

The Board of Trustees has contracted with Wilson-McShane Corporation to be the Administrative Manager of the Plan.

As of September 1, 2023, the Trustees of this Health Plan are:

***Union Trustees***
Andy Campeau
Plumbers & Steamfitters Local #11
4402 Airpark Blvd.
Duluth, MN 55811

***Employer Trustees***
Mitchell Diers
Northern Mechanical Plumbing Contractors Assn.
2230 London Road, Suite 202
Duluth, MN 55812

Jason Quiggin
Plumbers & Pipefitters Local 589
107 S 15th Ave. W
Virginia, MN 55702

Mark Swanson
Jamar Company
4701 Mike Colalillo Drive
Duluth, MN 55807

David Cartwright
Heat & Frost Insulators-Asbestos Workers
Local #49
2002 London Road, #210
Duluth, MN 55812-2144

David Hebig
Shannon's Inc.
1919 Main Avenue
International Falls, MN 56649

Jeff Stark
IUPAT District Council 82
3205 Country Drive
Little Canada, MN 55117

Mark Urick
Swanson & Youngdale
3805 Prosperity Road
Duluth, MN 55811

Jack Carlson, Alternate
Painters Local #106
2002 London Road, Suite 106
Duluth, MN 55812

The Board of Trustees has the responsibility of determining the benefits to be offered and the eligibility rules of the Fund. The Trustees reserve the right to amend or terminate the Plan in whole or in part at any time. No employer or Union or any representative of any employer or Union is authorized to act as an agent of the Trustees. If you have any questions, you have the right to get answers from the Trustees who administer the Plan. Any information regarding this Plan must be accompanied in writing, signed by the Trustees or, when authorized, by the Fund Administrator or Fund Counsel.

### *Agent For Service Of Legal Process*

The Board of Trustees is the Plan's agent for service for legal process. Any legal documents should be served upon the Board of Trustees at the office of the *Wilson-McShane Corporation, 2002 London Rd, Suite 300, Duluth, MN 55812*. Legal documents may also be served on the Board of Trustees individually at their addresses shown above.

A list of participating Local Unions and Employer Organizations affiliated with the Duluth Building Trades Health Fund is available from the Fund Office.

### *Source Of Contributions*

The benefits described in this booklet are provided through employer contributions. Contributions to the Plan are made by employers in accordance with their collective bargaining agreements with the Local Unions participating in this Plan. The amount of employer contributions and the Employees on whose behalf contributions are made are determined by the provisions of the collective bargaining agreements with the Local Unions. All benefits are paid directly from assets of the Fund.

Upon written request, the Fund Office will provide information as to whether a particular employer is contributing to the Plan on behalf of participants working under the collective bargaining agreements.

All assets are held in trust by the Board of Trustees. The Plan's assets and reserves are invested in accordance with the Trust Documents and the written investment policy(ies) that may be adopted from time to time by the Board of Trustees.

### *Eligibility*

The Plan's requirements with respect to active and retiree eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are described in this booklet. The Fund Administrator has broad discretion to determine eligibility for benefits and interpret Plan language. The Fund Administrator's decisions will receive judicial deference to the extent they do not constitute an abuse of discretion. Participation in the Plan or eligibility for benefits is not a guarantee of employment.

### *Claim Procedures*

The procedures to follow for filing a claim for benefits are listed beginning on page 61 of this booklet. If all or any part of a claim is denied, you have the right to request a review by the Board of Trustees. Certain claims are also eligible for an External Review with an Independent Review Organization.

### *Plan Amendment Or Termination*

This Plan may be amended, changed, or discontinued at any time without the consent of any covered person by a majority vote of those Trustees present and voting at a meeting where a quorum is present. An amendment may be effective prospectively or retroactively and is subject to the limitation of the Trust Agreement and to applicable law and administrative regulations.

If the Plan is modified or terminated, you will be notified in writing or as required by law. The Trust may be terminated as a result of the expiration of all collective bargaining agreements requiring payment of contributions to the Fund, or for any other reason deemed necessary by the Trustees.

In the event of a termination, any and all assets remaining after the payment of all obligations and expenses will be used, in accordance with a plan for dissolution adopted by the Trustees, to continue the benefits provided by the existing Plan until such assets have been exhausted or in such manner as will best serve the purposes of the Fund. In no event will assets be paid to or be recoverable by any Contributing Employer, association, or labor organization.

# ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants be entitled to the following rights.

## *Receive Information About Your Plan And Benefits*

You have the right to:

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all documents governing the Plan. These include insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Fund Administrator, copies of documents governing the operation of the Plan. These include insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description and Plan Document. The Fund Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Fund Administrator is required by law to furnish each participant with a copy of this summary annual report.

## *Continue Group Health Plan Coverage*

You also have the right to:

- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when:
  - You lose coverage under the Plan;
  - You become entitled to elect COBRA Continuation Coverage; or
  - Your COBRA Continuation Coverage ends.

You must request the certificate of creditable coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

## *Prudent Actions By Plan Fiduciaries*

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire

you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

## *Enforce Your Rights*

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. For instance, if you request a copy of the Summary Plan Description and Plan Document 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 Fund Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Fund Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in 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.

## *Assistance With Your Questions*

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

*Nearest Regional Office*
Employee Benefits Security Administration
1100 Main Street, Suite 1200
Kansas City, MO 64105-5148
(816) 426-5131

*National Office*
Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210
(866) 444-3272

For more information on your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting their website at www.dol.gov/ebsa.

# DEFINITIONS

When the following terms are used in this booklet, these definitions apply.

**Accidental Injury**: Any unforeseen or unintended trauma caused by a sudden external violence to the body.

**Ambulatory Surgical Center:** A specialized facility that:

1. Has been licensed by the regulatory authority having responsibility for licensing under the laws of the jurisdiction in which it is located.
2. Meets all of the following requirements:
    a. It is established, equipped, and operated primarily for the purpose of performing surgical procedures in accordance with the applicable laws in the jurisdiction in which it is located.
    b. It is operated under the supervision of a licensed doctor of medicine (MD) or doctor of osteopathy (DO) who is devoting full time to such supervision and permits a surgical procedure to be performed only by a duly qualified physician who, at the time the procedure is performed, is privileged to perform such procedure in at least one hospital (as defined) in the area.
    c. It requires in all cases other than those requiring only local infiltration anesthetics that a licensed anesthesiologist administer the anesthetics and remain present throughout the surgical procedure.
    d. It provides at least two operating rooms and one post anesthesia recovery room. It must be equipped to perform diagnostic x-ray and laboratory examinations, and has available trained personnel and necessary equipment (including but not limited to a defibrillator, a tracheotomy set, and a blood supply) to handle emergencies.
    e. It provides the full-time services of one or more registered graduate nurses (RNs) for patient care in the operating rooms and in the post anesthesia recovery room.
    f. It maintains a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications or require postoperative confinement.
    g. It maintains an adequate medical record for each patient. Such record must contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or x-rays, an operative report and a discharge summary.

**Caregiver:** A person not associated with a Hospice Agency who resides in the home and provides non-medical services and companionship. This may be a family member.

**Continuing Care Patient:** A Continuing Care Patient means an individual who, with respect to a provider or facility —

a. is undergoing a course of treatment for a Serious and Complex Condition from the provider or facility;
b. is undergoing a course of institutional or inpatient care from the provider or facility;
c. is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
d. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

e. is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

**Contributing Employer:** An employer who contributes to the Fund established in accordance with the Agreement and Declaration of Trust made the 11th day of September 1953 and a participating union.

**Custodial Care**: The type of care provided primarily to assist an individual in meeting his or her activities of daily living, wherever furnished and by whatever name called.

**Dentist:** A doctor of Dental Surgery licensed and registered to practice this profession.

**Emergency Medical Condition:** The term emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition including:

a. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

b. serious impairment to bodily functions, or

c. serious dysfunction of any bodily organ or part.

This definition includes Mental Disorders and substance use disorders.

**Emergency services:** The term emergency services includes:

a. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, including ancillary services routinely available to the emergency department, to evaluate whether an Emergency Medical Condition exists; and

b. Such further medical examination and treatment as may be required to stabilize the individual (regardless of the department of the hospital in which the further medical examination and treatment is furnished) within the capabilities of the staff and facilities available at the hospital or the Independent Freestanding Emergency Department.

**Employee:**

1. An employee whose employment is covered by a collective bargaining agreement between a Contributing Employer and a participating local union.
2. An employee of a participating local union.
3. An employee of a Contributing Employer provided the Contributing Employer covers **all employees** and the required monthly premiums per employee are made to the Fund Office. **If you work for more than one Contributing Employer, you must work at least 160 hours per month with one of the Contributing Employers.**
4. Any employee whose activities contribute to the administration of the Fund.

   If a Plan participant for whom contributions have been made by an employer covered by a collective bargaining agreement becomes an owner/operator, the plan participant must immediately notify the Fund Office in writing. Owner/operators, sole proprietors, and partners are required to pay contributions for the actual number of hours worked or 160 hours per month whichever is greater.

**Experimental/Investigative**: A service or treatment on which the consensus of expert medical opinions, based on reliable evidence (*i.e*., published reports and/or articles) indicates that further trials or studies are needed to determine the safety, efficiency and outcomes of the treatment or services compared to standard treatment.

Experimental or Investigative also means those services or treatments that are:

1. Not recognized as having proven beneficial outcomes;
2. Still primarily confined to a research setting; and
3. Not appropriate based on medical circumstances and/or given the advanced stage of a person's Sickness or the likelihood that the service or treatment will measurably improve the person's Sickness or medical condition.

**Hospice Agency**: A public or private agency or organization that:

1. Administers and provides hospice care; and
2. Is either:
    a. Licensed or certified as such by the state in which it is located;
    b. Certified (or is qualified and could be certified) to participate as such under Medicare;
    c. Accredited as such by the Joint Commission on the Accreditation of Hospitals; or
    d. Meets the standards established by the National Hospice Organization.

**Hospice Plan**: A coordinated, interdisciplinary program to meet the physical, psychological, and social needs:

1. Of Terminally Ill persons and their families;
2. By providing palliative (pain controlling) and supportive medical, nursing and other health services; and
3. Through home or inpatient care during the Sickness or bereavement.

**Hospice Services:** Any services provided:

1. Under a Hospice Plan; or
2. By a Hospital or related institution, home health agency, hospice or other facility licensed by the state to operate the hospice.

**Hospital:** An institution that is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets one of the following tests:

1. It is a hospital accredited by the Joint Commission on the Accreditation of Hospitals.
2. It is a hospital, a psychiatric Hospital or a tuberculosis Hospital as those terms are defined in Medicare, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare.
3. It is an institution that:
    a. Maintains diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified Physicians on the premises;
    b. Continuously provides 24-hour-a-day nursing services by or under the supervision of registered graduate nurses on the premises; and
    c. Operates continuously with organized facilities for operative surgery on the premises.

**Hospital Miscellaneous Charges**: Services and supplies furnished to the individual and required for treatment other than:

1. Room and Board; and
2. The professional services of any Physician and any private duty, or special nursing services (including intensive nursing care by whatever name called). Such services are considered Hospital Miscellaneous Charges regardless of whether they are rendered under the direction of the Hospital or otherwise.

**Independent Freestanding Emergency Department:** An independent freestanding emergency department is a health care facility that provides emergency services, and is geographically separate and distinct from a hospital, and separately licensed as such by a state.

**Insurance Plan:** Includes but is not limited to any plan, contract, group insurance plan, policy of insurance, group health care plan, governmental plan, etc., which is obligated, contractually or legally, to provide health care benefit payments to an individual participant or health care provider.

**Medically Necessary** or **Medical Necessity:** Care, services, or supplies required to identify or treat an Illness or Injury that are, as determined by the Plan:

1. Consistent with the symptoms, diagnosis, and treatment of the covered individual's condition, Illness, or Injury;
2. In accordance with recognized standards of care for the condition, Illness, or Injury;
3. Appropriate with regard to standards of good medical practice;
4. Not solely for the convenience of the covered individual, Physician, Hospital, or other health care provider; and
5. The most appropriate level of service that can be safely provided.

When specifically applied to inpatient services, it also means that the covered individual's medical symptoms or condition requires that the treatment of service cannot be safely provided on an outpatient basis. The Plan uses Blue Cross Blue Shield of Minnesota's medical policies to review and determine whether care, services, or supplies are Medically Necessary. Those policies can be found online at https://www.bluecrossmn.com/providers/medical-management/medical-and-behavioral-health-policies. The medical policies are subject to change.

**Mental Disorder:** Any Illness that is defined within the mental, behavioral, or neurodevelopmental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

**Mental Health Residential Treatment Center:** A facility whose primary function is the diagnosis, treatment, and/or rehabilitation of persons with Mental Disorders and:

1. Has policies, which are developed with the advice of (and with provisions for review of such policies from time to time by) a group of professional personnel, including one or more Physicians and one or more registered professional nurses, to govern Mental Disorder care and treatment and related medical care or other services provided;
2. Has a Physician, a registered professional nurse or a medical staff responsible for the execution of such policies;
3. Has a requirement that the care of every patient be under the supervision of a Physician, including a psychiatrist or psychologist;
4. Maintains clinical records on all patients;
5. Provides 24-hour nursing services that is sufficient to meet patient needs in accordance with the policies developed;

6. Provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

7. In the case of an institution in any state in which state or applicable local law provides for the licensing of institutions of this nature:

    a. Is licensed pursuant to such law; or

    b. Is approved by the agency of the state or locality responsible for licensing institutions of this nature as meeting the standards established for such licensing; and

The term Mental Health Residential Treatment Center does not include:

a. Halfway houses,

b. Wilderness programs, or

c. Supervised living or group homes, boarding houses, or other facilities that primarily provide a supportive environment and address long-term social needs, even if mental health supports and/or counseling are provided at such facilities.

**Non-Bargaining Unit Employee:** An employee of a Contributing Employer whose job is not covered by a Collective Bargaining Agreement with a Union, but who is covered by a Participation Agreement. The employee must work more than half time and, to be covered under this Plan, all Non-Bargaining Unit Employees for that Employer must participate in the Plan.

**Owner Operator:** A member of a participating union and an owner of a Contributing Employer.

**Physician Or Surgeon:** Any individual, including a psychiatrist, consulting psychologist, psychologist, chiropractor, osteopath, podiatrist, optometrist, and doctor of dental surgery, who is licensed to practice by the governmental authority having jurisdiction over such licensure, and who is acting within the usual scope of the individual's practice.

**Psychologist:** A person who specializes in clinical psychology and fulfills either of the following requirements

1. A person who is licensed or certified as a psychologist by the appropriate governmental authority having jurisdiction over such licensure or certification, as the case may be, in the jurisdiction where such person renders service to the Employee or his or her dependent; or

2. A person who is a member or fellow of the American Psychological Association, if there is no licensure or certification in the jurisdiction where such person renders service to the Employee or his or her dependent.

**Reasonable Charge (Reasonable and Customary Charge):** The charge made by providers of similar training and experience for the same service within the same geographic area or community. The charge must also be appropriate in view of the circumstances of the particular case, particularly the complexity of treatment. The Board of Trustees shall determine what the usual and customary charges are.

**Respite Care:** A short-term inpatient stay that may be necessary for the patient to give temporary relief to a Caregiver who regularly assists with home care. Each Respite Care stay is limited to five days.

**Room And Board:** Room, board, general duty nursing and any other services regularly furnished by the Hospital as a condition of occupancy. Room and Board does not include professional services of Physicians or intensive nursing care by whatever name called.

**Serious and Complex Condition:** A serious and complex condition means:

a. in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

b. in the case of a chronic illness or condition, a condition that is—

i. is life-threatening, degenerative, potentially disabling, or congenital; and

ii. requires specialized medical care over a prolonged period of time.

**Sickness:** Illness, disorder or disease, including pregnancy, that is not employment related. The illness or disorder must have started after the effective date of coverage.

**Skilled Nursing Care Confinement:** Confinement in a Skilled Nursing Care Facility:

1. Upon the specific recommendation and under the general supervision of a legally qualified Physician;
2. Beginning within 14 days after discharge from a Medically Necessary Hospital confinement lasting at least three days for which Room and Board benefits are paid; and
3. For the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the previous Hospital confinement.

**Skilled Nursing Care Facility**: An institution or that part of any institution that operates to provide convalescent or nursing care and:

1. Is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require Medically Necessary care, or rehabilitation services for the rehabilitation of injured, disabled or sick persons;
2. Has policies, which are developed with the advice of (and with provisions for review of such policies from time to time by) a group of professional personnel, including one or more Physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services provided;
3. Has a Physician, a registered professional nurse or a medical staff responsible for the execution of such policies;
4. Has a requirement that the health care of every patient be under the supervision of a Physician and provides for having a Physician available to furnish necessary medical care in case of emergency;
5. Maintains clinical records on all patients;
6. Provides 24-hour nursing services that is sufficient to meet nursing needs in accordance with the policies developed and has at least one registered professional nurse employed full time;
7. Provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;
8. In the case of an institution in any state in which state or applicable local law provides for the licensing of institutions of this nature:
    a. Is licensed pursuant to such law; or
    b. Is approved by the agency of the state or locality responsible for licensing institutions of this nature as meeting the standards established for such licensing; and
9. Meets any other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities.

**Total Disability:** Total disability means an Employee's complete inability to perform any and every duty pertaining to his or her occupation or employment.

**Terminally Ill:** An Employee or dependent for whom a Physician has determined:

1. There is no reasonable prospect of cure; and
2. The life expectancy is six months or less.