Duluth Building Trades Health Fund

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Wilson-McShane Corporation
Fund Administrators

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SUMMARY OF MATERIAL MODIFICATION No. 5

December 2021

Dear Participants:

Effective January 1, 2022, the Trustees of the Duluth Building Trades Health Fund announce the following changes to the Summary Plan Description (SPD) dated October 1, 2018:

1. **No Surprises Act and Balance Billing:** The Trustees have amended the Plan in accordance with the No Surprises Act. The No Surprises Act protects you from balance billing (*i.e.*, when an out-of-network provider bills you for the difference between the provider's charge and the allowed amount that the Plan will pay) in the following circumstances: Emergency Services, out-of-network providers at in-network facilities, Continuing Care patients, and air ambulance services.

2. **External Review:** The Plan's Claim Appeal Procedure has been amended to provide for External Review of claims involving consideration of whether the Plan is complying with the No Surprises Act's protections against surprise balance billing and cost-sharing protections related to Emergency Services, out-of-network providers at in-network facilities, Continuing Care patients, and air ambulance services.

These changes are effective January 1, 2022, and amend the Summary Plan Description dated October 1, 2018, and are reflected in the enclosed pages. Please insert the enclosed pages according to their page number in your SPD and discard the pages they replace.

If you have any questions about these amendments, please contact the Fund Office at the address or telephone number shown above.

Board of Trustees
Duluth Building Trades Health Fund

The Plan's Trustees believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for external claims review. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at 218-728-4231. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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 in-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 receive 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 provider 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 bluecrossmnonline.com.

Once your coinsurance amounts for covered expenses (including the deductible) reach the out-of-pocket maximum during the calendar year, the Plan pays 100% of remaining maximum 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.**

Annual Exam Benefit

The Annual Exam Benefit is provided to encourage active Employees and their dependents to have routine physical examinations to maintain good health. Routine physical examinations can help identify potential medical problems during their early stages. Benefits are paid up to the amount shown in the *Schedule Of Benefits* for you and your dependents.

One physical exam per year, provided through the Health Dynamics program, will be covered at 100% (no deductible or coinsurance) for you and your spouse. Participants that fail to appear for their scheduled Health Dynamics physical appointment will be assessed a $150 penalty. If a Participant schedules a Health Dynamics physical and fails to appear for his or her appointment without providing the Health Dynamics provider at least 24 hours of notice of cancelation, the Participant and/or his dependents will have $150 withheld from payment of future medical claims by the Fund. A routine physical exam includes office visit, examination, and all indicated tests based on age, physical condition, and health history. In addition, medically necessary immunizations, PSA test for men, flexible sigmoidoscopy or colonoscopy for adults, based on family health history and other risk factors, even though no colon cancer symptoms are present are also covered. If there is a family history of colon cancer, flexible sigmoidoscopy or colonoscopy will be covered at age 40; without a family history these tests will be covered at age 50. If recommended vaccines (as defined under Medical Benefits, page 29) are administered during an annual exam and the cost of the vaccine or its administration is billed separately, the Fund will pay 100% of the cost.

The following are covered annually:

- Gynecological exam and pap test;
- Mammogram; and
- PSA test for men.

Exclusions

Payment will **not** be made for:

- Expenses payable under any Workers' Compensation law;
- Services which are not performed by a Physician or under a Physician's direct supervision;
- Services received while confined in a Hospital, convalescent or extended care facility, nursing home, night-care center or similar institution;
- Medicines, drugs, appliances, equipment, materials, or supplies;
- An Accidental Injury or a Sickness;

Lifetime And Specific Benefit Maximums

You and each eligible dependent can receive medical benefits up to the lifetime and 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 actually incurred for the services and supplies listed below upon the recommendation of the attending Physician and required for treatment.

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 balance billed if you receive ground ambulance services from an out-of-network provider. However, if you receive air ambulance services from 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 or Nervous Disorder Treatment covered on the same basis as for any other Sickness.

    Outpatient treatment must be provided by:
    a. Hospital's outpatient department;
    b. Community Mental Health Center or Mental Health Clinic;
    c. Physician;
    d. Psychologist; or

e. Licensed Social Workers.

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

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 (*i.e.*, 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 Annual Exam Benefit.
9. Charges for services and supplies, which are:
    a. Not provided in accordance with generally accepted professional medical standards;
    b. For Experimental treatment; or
    c. 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 Vision Expense Benefit.
14. Charges for outpatient nutritional consultation, instruction, or treatment except as provided for under the Diabetes Education Benefit on page 34.
15. Any expense for failure to appear for a scheduled appointment or for completion of claim forms.
16. Any expense for weight loss programs, surgery or drugs.
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. Elective abortions, except therapeutic abortions when continuation of the pregnancy seriously endangers the life or health of the prospective mother.
20. 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.
21. Construction or modification to a home, residence, or vehicle required as a result of Accidental Injury or Sickness of an Employee or Dependent.
22. 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.
23. 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.
24. Any expense for vitamins, food supplements, special formula, and food substitutes, except for special dietary treatment for phenylketonuria when recommended by a physician.
25. Charges for alveolar ridge augmentation or implant procedures, whether of natural or artificial materials to stabilize or otherwise alter natural or artificial teeth.
26. Any expense resulting from a war or international armed conflict.
27. Any expense or charge for chelation therapy except for the treatment of acute arsenic, gold, mercury, or lead poisoning.
28. Any expense or charge for treatment or counseling for behavior associated with compulsive gambling or gaming.
29. Any expense or charge for cosmetic surgery and/or treatment not related to an accident, injury or birth defect.

If the Plan fails to make timely decisions or otherwise fails to comply with the applicable federal regulations, the claimant may go to court to enforce his or her rights. A claimant may not file suit against the Plan until the claimant has exhausted all of the procedures described in this section.

The claimant will be informed of the Trustees' decision, normally within five calendar days of the determination. The decision will be in writing.

When the claimant receives the written decision, it will contain:

- The reasons for the decision and specific references to the particular Plan provisions upon which the decision was based;
- A statement explaining that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;
- A statement of the claimant's right to bring an action under Section 502(a) of ERISA, including the Plan's contractual limitations period to bring such an action and the calendar date on which the contractual limitations period expires;
- The internal rules, guidelines, protocols or similar criteria relied on to make the decision, or a statement that such rules, guidelines, protocols or similar criteria do not exist;
- If the decision was based on a medical judgment, the claimant will be informed of his or her right to receive, upon request, an explanation of that determination, free of charge; and
- For disability claims, the written decision will also include an explanation of the basis for disagreeing with or not following:
    - The views presented by the claimant's health or vocational professionals;
    - The views of medical or vocational experts obtained by the Plan in connection with the claimant's disability claim, without regard to whether the advice was relied upon;
    - A disability determination made by the Social Security Administration, if provided by the claimant.

External Review

Certain claims are eligible for External Review by an Independent Review Organization following your receipt of the Board of Trustees' written decision on your appeal.

You may file a request for an External Review with the Fund Office within four months after the date you received a written decision on your appeal from the Board of Trustees. If the last date falls on a Saturday, Sunday or Federal holiday, the filing deadline is extended to the next business day.

Within five (5) business days following receipt of your request for External Review, the Fund Office will 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:

- You were covered under the Plan at the time the health care item, service or other benefit was provided;
- The claim involves consideration of whether the Plan is complying with the protections against surprise balance billing and cost-sharing protections related to Emergency Services, air

- ambulance services, Continuing Care Patients and/or out-of-network care at an in-network facility;

- You have exhausted the Plan's internal appeal process (*i.e.*, the Board of Trustees issued a decision on your claim appeal); and,

- You have provided all of the information required to process an External Review.

You will receive written notice of the results of the Fund Office's preliminary review within one (1) business day after its completion. If you are not eligible for External Review, the notice will contain reasons for the ineligibility. If the request is not complete, the notice will describe what information is needed to perfect the request, which must be done within the later of the four-month filing period or within 48 hours following your receipt of notice following the preliminary review.

If you are eligible for External Review, it will be assigned to an accredited Independent Review Organization (IRO) in a manner that ensures independence and protection against a bias toward the Plan. The IRO will timely notify you in writing of the acceptance for External Review and such notice will include a statement that you may submit in writing within ten (10) business days any additional information the IRO must consider in the External Review. If you provide new information to the IRO, the IRO must submit it to the Fund Office and the Board of Trustees may reconsider their decision on your appeal. If the Board of Trustees reverses its previous decision you will be notified of that reversal within one (1) business day.

Within five (5) business days of the assignment to an IRO, the Fund Office will provide the IRO with any documents or information that were considered in the internal appeal process. The IRO is not bound by any decision or conclusions reached in the internal appeal process. The IRO will provide written notice of its External Review decision to you and the Fund Office within forty-five (45) days after the IRO is assigned the matter. The IRO's External Review decision will contain:

- A general description of the reason for the request for External Review, including sufficient information to identify the claim at issue;

- The date the IRO receive the assignment to conduct the External Review;

- The date of the IRO's decision on the External Review;

- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching the decision;

- An explanation of the principal reason(s) for the IRO's decision, including the rationale for the decision and any evidence-based standard 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;

- A statement that judicial review may be available to you; and,

- Current contact information for any health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

In the event that the IRO reverses the decision of the Board of Trustees, the Plan will provide coverage or payment for the claim in accordance with applicable law and regulations, but the Plan reserves the right to pursue judicial review or other remedies available to the Plan.

Legal Action

No legal action can be brought against the Plan before 60 days after proof of loss has been filed according to the Plan's claims filing procedure. Legal action under Section 502(a) of ERISA must be brought within two years from the date of the Trustees' written decision on the claimant's appeal. This contractual limitations period shall begin to toll from the date of the Board of Trustees' written decision on the claimant's appeal, regardless of whether you seek an External Review 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;

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

As of October 1, 2018, the Trustees of this Health Plan are:

Union Trustees

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

Craig Olson
Painters Local #106
2002 London Road, Suite 106
Duluth, MN 55812

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

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

Employer Trustees

Mitchell T. Diers
Northern Mechanical Plumbing Contractors Assn., Inc.
802 Garfield Avenue
Duluth, MN 55802-2636

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

Rick Impola
Regional Contracting & Painting
PO Box 16661
Duluth, MN 55816

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 56 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.

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.

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

1. Has been licensed in accordance with state or local law or approved by the state or local agency as meeting the licensing standards; or
2. Meets all the following requirements:
    a. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located;
    b. It is an organization with its own governing body, its own administration and its own medical staff; and
    c. The medical responsibility for patients rests with a psychiatrist or other Physician.

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 health conditions 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.

Mental Health Clinic: Community Mental Health Center as defined above.

Mental Or Nervous Disorder: Neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease of any kind.

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.