DISTRICT NO. 9, INTERNATIONAL ASSOCIATION OF MACHINISTS AND AEROSPACE WORKERS

WELFARE PLAN

PLAN DOCUMENT AND

SUMMARY PLAN DESCRIPTION

C3GW PLAN

Note: Your Schedule of Benefits is in the Back of this Booklet

EFFECTIVE JANUARY 1, 2021

DISTRICT NO. 9, I.A.M.A.W.
WELFARE TRUST

Dear Participant:

The Trustees of the District No. 9, I.A.M.A.W. Welfare Trust are pleased to present you with this new Booklet describing the comprehensive major medical, life insurance, and weekly disability benefits provided by the Welfare Trust. This Booklet supersedes all previous booklets or summary plan descriptions.

This Booklet, together with the group insurance certificate provided by the insurer of the life and accidental death and dismemberment benefits, constitutes the Summary Plan Description (SPD) for the plan of benefits provided by the District No. 9, I.A.M.A.W. Welfare Plan.

This Booklet describes the eligibility rules for you and your eligible dependents. These rules apply to determine when you and your family members are eligible for the medical, life insurance, accidental death and dismemberment (AD&D) and weekly disability benefits.

In addition, this Booklet describes the medical and weekly disability benefits that are paid directly out of the assets of the Fund. The certificate provided by The Guardian Life Insurance Company governs the benefits provided under the life and AD&D policy.

After you and your covered family members review this Booklet and the insurance certificate, keep them with your important papers to refer to when you or any of your family members need to use your benefits.

It is the function of the Trustees to administer and interpret the Welfare Plan. No representative of the Employer or the Union is authorized in such capacity to interpret the Welfare Plan, nor can any such person bind or obligate the Trustees or the Plan by representations concerning the Plan. Any inquiries you may have concerning your rights under the Welfare Plan should be directed to the Welfare Plan Office at the following address:

District No. 9, I.A.M.A.W. Welfare Plan
12365 St. Charles Rock Road
Bridgeton, Missouri 63044
Phone: (314) 739-6442
Toll Free: (888-739-6442)
Website: www.d9trusts.org

With our best wishes

Sincerely

The Joint Board of Trustees

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SECTION 1. PLAN'S COST CONTAINMENT FEATURES

The Trustees of the District No. 9, I.A.M.A.W. Welfare Trust continue to strive to provide you and your family with the highest quality benefits and at the same time to hold down the costs to protect the future of those benefits. In pursuit of those dual goals, the Trustees have adopted a number of features that require your participation and cooperation:

- Medical pre-certification, utilization review and case management program
- Medical network
- Mental Health, Substance Use Disorder Pre-Certification
- Reimbursement and Subrogation when the Plan provides benefits for an injury or illness for which a third party is responsible.

A. Medical Pre-Certification, Utilization Review and Case Management

1. Pre-Certification

As is discussed further below, the Plan participates in a medical network which has made arrangements with a large number of doctors, hospitals and other providers (collectively called Network Providers) to provide health care to you and your family, often at reduced costs. Under the terms of the Utilization Management Program applicable to Network Providers, the Network Providers must obtain pre-certification for elective hospital admissions, outpatient surgeries, ambulatory services, home health care and physical therapy. While you will not be penalized solely because of the failure of a provider to obtain pre-certification, it is in your interest that pre-certification be obtained in that the Plan does NOT pay for any care or treatment which is not medically necessary. Pre-certification is designed to greatly reduce the possibility that you will receive care or treatment which is not medically necessary and thus not covered by the Plan.

The pre-certification procedures are explained in detail at Section 8A2 of this Booklet. Generally, you obtain pre-certification by calling the number shown on your Plan identification card and on the Schedule of Benefits which is in the back of this Booklet.

2. Medical Utilization Review and Case Management Services.

The Trustees have made arrangements for a Case Management Program. This program is coordinated by medical Network Providers in conjunction with your health plan and offered at no additional cost to you.

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

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

The medical Network Provider shares information with health care providers who are involved in your treatment and the health benefit plan administrator so that your health plan administrator can determine the benefits that may be available under the health plan for medical care you receive.

You can always refuse any treatment or services that are recommended; however, you may not maximize your health plan benefits. You will be notified when case management services are changed or terminated and the reason(s) for such action will be explained to you.

B. Network Providers

The Plan participates in a medical network which has made arrangements with a large number of doctors, hospitals and other providers of health care services to provide health care to you and your family, often at reduced costs. A current list of doctors, hospitals and other providers who are members of the network can be obtained online (see Section 14H for website address).

Under the medical network program, there are two levels of doctors, hospitals and other providers:

- Level 1 – Network Providers; and
- Level 2 – Non-Network Providers.

Network Providers generally charge the Plan less for your care than Non-Network Providers. The level of your benefits is determined by which level of provider you choose. If you choose a Network Provider, the Plan will pay 85% of the covered charges after the deductible and you will pay 15%. If you use a Non-Network Provider, the Plan will pay 55% of the covered charges, (Non-Network Provider charges are limited to the Allowable Charges as defined in Section 2B of this Summary Plan Description), after the deductible, and you will pay 45% and any non-covered charges.

By using the Network Providers, you benefit in two ways. First, you benefit directly and immediately when you use a Network Provider, because the Welfare Plan pays 85% of the covered charges, rather than the 55% it pays when you use a Non-Network Provider. Thus, you only have to pay 15% of the covered charges when you use a Network Provider. Further, the fees charged by the Network Providers are often lower than those charged by Non-Network Providers. In such cases, you save by paying the lower percentage of a lower fee. Second, you benefit indirectly, because as indicated, the Network Providers have agreed in many cases to charge less for treating you and your family, so your Welfare Plan is required to pay less than it would have to pay if you used a Non-Network Provider. Therefore, you help to maintain the financial stability of your Welfare Plan and to ensure the availability of monies for your future health benefits.

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

The Network Provider normally will automatically contact the Plan for pre-certification, so you will not be penalized for failing to get pre-certification or pre-approval for hospitalization. **However, even if you are using a Network Provider, you may confirm, and are encouraged to confirm, that pre-certification has been done by calling the pre-certification number shown on your identification card prior to your treatment.**

The Plan follows an internal procedure called the PEARL rule, which provides network-level coverage for certain Non-Network Providers who deliver ancillary services in a network facility where the patient has no choice in the selection of those ancillary providers. Ancillary providers covered under the PEARL rule are Pathologists, Emergency Room providers, Anesthesiologists, Radiologists and Laboratory providers. This rule provides for reimbursement of those ancillary providers at the network level; however, charges must be medically necessary and are limited to Allowable Charges not to exceed usual, reasonable and customary amounts.

If you have any questions about the pre-certification requirements, about whether a provider of health care is a member of the Network, or about how to receive the benefits of using a Network Provider, please contact the Welfare Plan Office at (314) 739-6442 or (888) 739-6442.

C. Mental Health and Substance Use Disorder Network

You are encouraged to obtain pre-certification for treatment for mental health issues or for Substance Use Disorder. The telephone number for pre-certification is in the back of this Booklet. The Plan will pay 85% of covered charges of Network Providers and 55% of covered charges of providers who are not in the Network. See Section 8A4 of this Booklet for more information about the Mental Health Pre-certification requirements.

D. Reimbursement and Subrogation

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

against the responsible parties. The Plan can bring its own lawsuit against the responsible parties or intervene in any lawsuit you bring.

You must tell the Plan Office when you suffer an illness or injury for which a third person may be responsible. The Plan Office will require, before paying out any benefits with respect to such an illness or injury, that you provide information and documentation sufficient to permit the Plan to protect its rights and will require you to execute an agreement confirming the Plan's rights. See Section 11 of this Booklet for more information about subrogation and reimbursement.

E. Coordination of Benefits Rules

The coordination of benefits (COB) rules are used when a person is covered by more than one medical benefits plan to determine which plan must pay its benefits first.

In applying the COB rules, the Plan will take into account any individually purchased health insurance policy or medical benefits plan or HRA (Health Reimbursement Account), FSA (Flexible Spending Account), HSA (Health Savings Account) by which a person is covered and will also take into account any vehicle or property insurance medical-pay benefits by which the person is covered. See Section 8H of this Booklet for more information about coordination of benefits.

F. Emergency Room Co-Payment

Each time you or a family member visits the emergency room, you will be required to pay a $100.00 co-pay. This $100.00 will not count toward the annual deductible. To the extent an illness of accident can be addressed in a doctor's office, it obviously is less expensive for you to visit the doctor rather than the emergency room.

G. Urgent Care Co-Payment

Each time you or a family member visits an urgent care center, you will be required to pay a $50.00 co-pay. This $50.00 will not count toward the annual deductible . To the extent an illness or accident can be addressed in a doctor's office, it obviously is less expensive for you to visit the doctor rather than an urgent care center.

H. Office Visit Co-Payment

Each time you or a family member visits a physician and incur an office visit charge, other than for Preventive Services as described in Section 8G3, you will be required to pay a $15 or $25 office visit co-pay. This $15 or $25 will not count toward the annual deductible. A $15 co-payment applies to a Primary Care Provider (PCP) one that is credentialed in Family Practice, General Practice, Internal Medicine, Pediatrics, or OB/GYN; all other disciplines are considered Specialists and are subject to a $25 co-payment.

I. Prescription Drug Network

The Plan uses a pharmacy benefit manager (PBM) to provide prescription drugs through its Network of pharmacy providers. All prescription drugs should be obtained from a Network pharmacy,, but if obtained from another source, the allowable cost as established by the PBM for the prescription drug will be the maximum amount covered by the Plan. See Section 8G1b of this Booklet for more information about the Prescription Drug Benefit.

J. Other Cost Saving Features of the Plan

You may also be able to reduce the cost of your medical care by taking advantage of other cost saving features of the Plan. If you need long-term maintenance prescription drugs, you should use the mail-in drug program described in Section 8G1 of this Booklet. Also, please see Section 8D3 of this Booklet with reference to pre-admission testing and outpatient surgeries.

SECTION 2. DEFINITIONS

A. Introduction

This Section 2 contains important definitions that you should review carefully. There are additional definitions set out in other parts of this Booklet.

B. Definitions

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

"Actively at work," "active work" and "actively working" mean the active expenditure of time and energy in the service of the employer. However, a covered individual will be considered actively at work on each day of a regular paid vacation or on a regular non-working day on which he or she is not disabled, provided he or she was actively at work on the last preceding regular working day.

Allowable Charge – With respect to a Network Provider, the negotiated fee/rate set forth in the agreement with the participating Network Provider, facility, or organization and the Plan. With respect to a Non-Network Provider, the amount as determined by the Board of Trustees for a particular service or supply. The Plan will not pay any allowable charge for Non-Network services or supplies that is determined by any provider, facility, or organization other than the Board of Trustees.

Ambulatory Services – Services that are performed at a place other than:

1. A doctor's office; or
2. At a hospital while the person is an inpatient.

See the list of such services for which your doctor or provider is required to obtain pre-certification in Section 8A2 of this Booklet.

Audiologist – A specialist in the evaluation and treatment or rehabilitation of disorders of the hearing function who is licensed or certified as required by law in the state in which he or she practices.

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

Calendar Month – Any one of the twelve months of the calendar.

COBRA – Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as COBRA, requires the opportunity for a temporary continuation of health coverage in certain instances called "qualifying events."

Co-Insurance – A percentage amount of covered charges which must be paid by the covered individual.

Concurrent Care Decisions – A Concurrent Care Decision is a decision by the Plan with respect to an ongoing course of treatment previously approved by the Plan to be provided over a period of time or number of treatments and which involves either:

1. A decision upon a request to extend the course of treatment; or
2. A decision to terminate or reduce the treatment before its scheduled expiration; and
3. Any determination on an appeal from a decision to terminate or reduce the treatment.

Contributing Employer is:

1. Any employer (including an employer association) who now or hereafter has a collective bargaining agreement with the Union (or another labor union which may, from time to time, bargain jointly with the Union), which collective bargaining agreement requires periodic contributions to the Welfare Trust, and who makes the contributions to the Welfare Trust as required by that agreement; or

2. Such other employer (related contributing employer) who has been accepted for participation by the Trustees, and who has agreed to contribute and does contribute on substantially the same basis as other contributing employers.

Co-Payment or Co-Pay – A set amount of covered charges which must be paid by the covered individual.

Cosmetic – Surgery or other treatment to enhance or improve a person's appearance.

Covered Charges – Charges covered under this Plan as set forth in Sections 8E and 8G of this Booklet.

Covered Employee is:

1. Any person who is covered by and currently works under a collective bargaining agreement between a contributing employer and District No. 9, I.A.M.A.W., or a related trade union, and for whom the employer is obligated to make contributions to the Welfare Trust, excluding any supervisory or managerial employees possessing the power to hire or fire other employees.
2. Any person who was formerly employed by a contributing employer and who was covered by and performed work under a collective bargaining agreement between a contributing employer and District No. 9, I.A.M.A.W., or a related trade union, and for whom the former employer is obligated pursuant to a collective bargaining agreement to continue to make contributions to the Welfare Trust even after the cessation of the employee's employment, excluding any supervisory or managerial employees possessing the power to hire or fire other employees.
3. Any employee of an employer which has signed a Special Participation Agreement for Non-Bargaining Unit Employees. (In this instance "employee" does not include the sole proprietor of the business or a partner in the business that constitutes the employer or any other person who is prohibited by law from participating in the Plan). Such employees may be covered only while the employer makes contributions on behalf of the bargaining unit employees.
4. Any employee of a related contributing employer where said employer has been accepted by the Trustees for participation in the Welfare Trust.

Covered Employment – Employment with a contributing employer in a position for which the employer is required to make contributions to the Welfare Trust.

Covered Individual – An individual who is eligible for benefits under this Plan.

Custodial Care – Health services or other related services (such as assistance in activities of daily living) which:

1. Are not intended to cure;
2. Are provided during periods when acute care is not required or when the medical condition of an insured individual is not changing; or
3. Do not require continued administration by licensed medical personnel.

Deductible – A set amount of covered charges which must be paid each calendar year by the covered individual before the Plan will pay any comprehensive major medical benefits. (See Section 8D1 of this Booklet and the Schedule of Benefits in the back of this Booklet).

Direct Care – Treatment in the presence of a physician.

Durable Medical Equipment – Equipment which can withstand repeated use, is not disposable, is prescribed only when medically necessary, is appropriate for use in the home and is not useful in the absence of an illness or injury.

Emergency – An emergency involves:

1. An acute or sudden illness or injury that without immediate medical care could result in death or cause serious impairment to bodily function; or
2. A medical situation which if not promptly addressed could seriously jeopardize the life or health of the individual or the ability of the individual to regain maximum function; or

3. A medical situation which in the opinion of a physician with knowledge of the individual's medical condition would, if not promptly addressed, subject the individual to severe pain that cannot be adequately managed without prompt care or treatment.

Emergency Room Co-Payment or Emergency Room Co-Pay – The amount the covered person must pay each time he or she visits the emergency room. (See Section 8D1d of this Booklet and Schedule of Benefits in the back of this Booklet).

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

1. If, with respect to the illness being treated, the drug, device, treatment or procedure cannot be lawfully marketed in the U.S. or has not been approved by the U.S. Food and Drug Administration (FDA) at the time the drug or device is furnished; or
2. If, with respect to the illness being treated, the drug, device, treatment or procedure, or the patient informed consent document used with the drug, device, treatment or procedure, requires review and approval by the treating facility's Institutional Review Board or other body serving a similar function, or if U.S. federal law requires such review and approval; or
3. If, with respect to the illness being treated, reliable evidence shows the drug, device, treatment or procedure is the subject of an on-going phase I, phase II or phase III clinical trials, is the research, experimental, study or investigational arm of an on-going phase II or phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
4. In the case of a drug or device, if it is prescribed or used "off label," i.e., dispensed for a use for which it is not approved by the U.S. Food and Drug Administration; or
5. If the drug, device, medical or dental treatment or procedure is considered by the U.S. Department of Health and Human Services Health Care Financing Administration to be investigational, not reasonable and necessary, not primarily medical in nature, or not verified as effective by scientific controlled studies.

The Plan Administrator may, from time to time, retain a medical consultant, who may, in the exercise of judgment, waive the exclusion of a drug, device, medical treatment or procedure described in subparagraph (b) or (d) above, or in subparagraph (c) above (but may not waive the exclusion of a drug, device, medical treatment or procedure that is the subject of an ongoing Phase I clinical trial).

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

This Experimental or Investigative definition and its application by the Plan does not include participation in or the "Routine Patient Costs" for "Approved Clinical Trials," as defined above, for which coverage is required by the PPACA.

Flexible Spending Account or FSA - An employee-funded account which can be used to pay for qualified expenses under a cafeteria plan such as medical and dependent care expenses.

Health Reimbursement Account or HRA – An employer-funded plan that provides employees with reimbursement for the employee's (and often dependent's) medical expenses that are not otherwise paid by an insurance policy or health plan.

Health Savings Account or HSA – An account that can be funded by an employee or an employee and his employer if the employee is covered by a high deductible health plan, which can be used to pay for qualified medical expenses.

Hospital – A facility which:

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

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

Illness – means:

1. A disorder or disease of the body or mind; or
2. An accidental bodily injury; or
3. Pregnancy of the covered employee or the covered dependent spouse of a covered employee. Pregnancy of a dependent child is not a covered illness under this Plan.

All illnesses due to the same cause, or to a related cause, will be deemed to be one illness.

The donation of an organ or tissue by a covered individual for transplanting into another person is considered to be an illness of the covered individual making the donation, but only if the recipient's health insurance or other medical plan does not cover the donor's expenses.

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

1. Drugs and medicines that require a written prescription of a physician and which must be dispensed by a licensed pharmacist or physician; and
2. Blood and other fluids to be injected into the circulatory system; and
3. Prosthetic or artificial limbs, breasts and eyes and their replacement, regardless of when the original loss of the limb, breast or eye occurred, and certain supplies necessary for the use of an artificial limb, breast or eye; and
4. Casts, splints, trusses, braces, surgical dressings; and
5. Crutches, wheelchairs, hospital beds, iron lungs, equipment for the administration of oxygen and other durable medical equipment. (See definition of Durable Medical Equipment above).

Medicare – Medical benefits provided under the Federal Social Security Act.

Mental Health Illness – Any illness or disorder which impairs the behavior, emotional reaction or thought process of a person, regardless of medical origin. In determining benefits payable, charges made for the treatment of any physiological symptoms related to a mental or nervous disorder will not be considered to be charges made for treatment of a mental or nervous disorder.

Month – A period starting at 12:01 a.m. on any day in a Calendar Month and ending at 12:01 a.m. on that same-numbered day in the next Calendar Month. If that next Calendar Month does not have a same-numbered day, the month will end at 12:00 midnight of the last day of that next Calendar Month. (Examples: 12:01 a.m. of May 14 up to 12:01 a.m. of June 14; 12:01 a.m. of May 31 through 12:00 midnight of June 30.)

Necessary to the Care or Treatment of Illness or Medically Necessary – Recommended by a doctor and required to treat the symptoms of a certain diagnosis. The care or treatment must be:

1. Consistent with the diagnosis and prescribed course of treatment for the covered individual's illness; and
2. Required for reasons other than the convenience of the covered individual or his or her doctor; and
3. Generally accepted as an appropriate form of care for the illness being treated and not considered experimental or investigative treatment with respect to that illness; and
4. Likely to result in physical improvement of the patient's illness which is unlikely to ever occur if the care or treatment is not administered.

Non-Network Provider – A doctor or other provider of medical care or supplies who is not part of the network of providers who provide services to individuals covered under this Plan at negotiated rates.

Occupational Therapist – Someone who is licensed to perform occupational therapy by the state in which he or she performs his or her services, if that state requires licensing.

Occupational Therapy – Treatment which consists primarily of instructing a covered individual to perform the normal activities of daily living.

Office Visit Co-Payment or Office Visit Co-Pay – The amount the covered person must pay each time he or she incurs a physician office visit charge. (See Section 8D1f of this Booklet and Schedule of Benefits in the back of this Booklet).

Outpatient Surgery – Surgery performed during a hospital stay that is 23 hours or less. Any hospital stay that exceeds 23 hours will be considered a hospital admission.

Participant – Covered employee.

Physical Therapist – Someone who is licensed to perform physical therapy by the state in which he or she performs his or her services, if that state requires licensing.

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

Plan – The plan of benefits provided by the District No. 9, I.A.M.A.W. Welfare Trust.

Primary Care Provider – A provider that is credentialed in Family Practice, General Practice, Internal Medicine Pediatrics, or OB/GYN.

Qualified Medical Child Support Order (QMCSO) – An order issued by a court or issued through an administrative process established by state law which orders the District No. 9, I.A.M.A.W. Welfare Plan to provide medical benefits to the child of a participant in the Plan. In order to be qualified, the Order must meet certain requirements. If you would like a copy of the Plan's procedures for reviewing medical child support orders, contact the Fund Office. Once the Plan receives a medical child support order and determines if it is qualified, the child is covered and, for purposes of notices, is treated as a participant. Any reimbursements due from the Plan to the child will be paid in accordance with the QMCSO.

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

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

Related Contributing Employer – Any employer, other than an employer which has a collective bargaining agreement with the Union, which has been accepted for participation in the Plan by the Trustees and which has agreed to contribute and does contribute on substantially the same basis as other contributing employers.

Related Trade Union – A labor union other than District No. 9, I.A.M.A.W. which, from time to time, bargains jointly with District No. 9, I.A.M.A.W. or enters into a collective bargaining agreement requiring contributions to the Welfare Trust.

Restorative Speech Therapy – Services rendered by a physician or licensed speech therapist to restore or rehabilitate speech lost or impaired by illness (other than a functional nervous disorder) or by surgery due to an illness.

Room and Board Charges – Charges made by a hospital or skilled nursing facility for the room, meals and routine nursing services for covered individuals confined as bed patients.

Skilled Nursing Facility – A facility considered as such under Medicare or licensed by the State of Missouri or the state in which it is located.

Specialist Care Provider – A provider that is credentialed in anything other than Family Practice, General Practice, Internal Medicine, Pediatrics, or OB/GYN.

Speech Therapist – Someone who is licensed to perform speech therapy by the state in which he or she performs his or her services, if that state requires licensing.

Speech Therapy – Treatment administered by a speech therapist to improve or restore a covered individual's speech capabilities after a decrease in those capabilities following an illness.

Spouse – The term "spouse" means an individual to whom you are married regardless of gender. The term "Spouse" shall not mean domestic partners or individuals in civil unions.

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

Totally Disabled – Unless otherwise defined in specific sections of this Plan, a covered individual shall be deemed to be totally disabled under the following circumstances:

1. If a covered employee is claiming benefits under any coverage provided in this Plan, then such employee is totally disabled if he is unable, because of an illness, to perform the material and substantial duties of his or her normal job;

2. If a covered dependent is claiming benefits under any coverage provided in this Plan, then such dependent is totally disabled if, because of an illness, the dependent is unable to do the substantial and material duties of a person of the same age and sex in similar circumstances who is in good health.

One Continuous Period of Disability – Means a period of time during which an individual is disabled. When an employee has successive periods of disability which are due to the same or related causes and which are not separated by:

1. Three or more months of continuous active work with the employer on a full-time basis for Weekly Income Benefits; and

2. Two or more continuous weeks of active work with the employer on a full-time basis for all other benefits.

such successive periods will be considered one continuous period of disability.

Trustees – Trustees of the District No. 9, I.A.M.A.W. Welfare Trust.

The Union or This Union – District No. 9, I.A.M.A.W. and its affiliated local unions.

Urgent Care Co-Payment or Urgent Care Co-Pay – The amount the covered person must pay each time he or she visits urgent care. (See Section 8D1e of this Booklet and Schedule of Benefits in the back of this Booklet).

Vocational Rehabilitation – Teaching and training which allows a covered individual to resume his or her previous job or to train for a new job.

Working Day – Any day on which you are normally scheduled to work in covered employment for a contributing employer or any day on which you actually work in covered employment for a contributing employer.

You – Covered employee.

SECTION 3. ELIGIBILITY

A. Eligibility of Employees

1. Generally

The covered employees of contributing employer who satisfy the eligibility requirements set forth below are eligible to participate in the District No. 9, I.A.M.A.W. Welfare Plan.

2. Commencement of Eligibility

a. Present and New Employees

Present full-time covered employees and new full-time covered employees will become eligible for life insurance and accidental death, dismemberment and loss of sight on the first working day of the calendar month coincident with or immediately following their commencement of covered employment. Present full-time covered employees and new full-time covered employees will become eligible for weekly income, and comprehensive major medical, benefits on the first day of the first calendar month that commences coincident with or immediately following the commencement of covered employment.

To the extent the collective bargaining agreement or other agreement pursuant to which you work requires a waiting period before your employer is required to contribute to this Plan on your behalf, your eligibility will not begin until the first (working day for life and accidental death and dismemberment insurance and calendar day for other benefits) of the calendar month for which contributions are first due on your behalf.

In no event will coverage commence later than the first day of the month coincident with or immediately following the 60th calendar day after commencement of covered employment.

b. Returning Employees

(1) Generally. If your employment is terminated after you have satisfied the above eligibility requirements and you are subsequently re-employed, you will be eligible for all benefit coverages on the date that you resume covered employment, provided:

(a) that your employer makes a contribution on your behalf in the month in which you resume covered employment or for the month immediately following the month in which you resume covered employment, and

(b) you resume covered employment within 12 months of your termination of coverage under the Plan.

B. Eligibility of Dependents

1. Generally

Dependents who are eligible to participate include only your spouse and your children through the end of the month in which they attain age 26. Your dependents eligibility commences on the later of the date your eligibility commences or the date on which they first become dependents within the meaning of this Plan.

Benefits, however, will not be provided for any expenses incurred or losses suffered prior to the date that you provide the Plan Office with proof that your dependent is eligible unless you provide such proof within 30 days after your dependent first becomes eligible.

2. Children

For the purposes of eligibility for coverage under the Plan, "Children" includes:

b. Your natural children;

c. Your adopted children or children placed with you for adoption;

d. Your step-children; and

e. Children of whom you have been granted physical custody by a court of competent jurisdiction and of whom you have been ordered to assume legal or financial responsibility by a court (referred to hereafter as "custodial children").

You will be asked to certify that your children meet this definition.

3. Limiting Age for Dependent Children

a. Generally. The general limiting age for children is 26. This means that, assuming you remain eligible, your eligible child will remain eligible through the end of the month in which occurs the child's twenty-sixth birthday, unless the child's eligibility terminates for another reason before that date. However, life insurance coverage for your dependent child will end at 12:01 a.m. on the date the child attains the limiting age.

b. Incapacitated Children. If your unmarried child is incapable of self-sustaining employment because of a medically determinable physical or mental handicap and is dependent on you for support, the child's benefits will be continued beyond the limiting age, provided his or her incapacity existed before the attainment of the applicable limiting age and while he or she was an eligible dependent under this Plan, and provided proof of the child's incapacity is furnished to the Welfare Plan Office not later than 31 days after the child's coverage would otherwise terminate.

Coverage will not be reinstated for a child who becomes incapacitated after the applicable limiting age. Proof of Status as an Eligible Dependent

a. Generally

The Trustees or their representatives may require proof, satisfactory to the Trustees, that an individual is, in fact, your eligible dependent. The following documents may be required:

(1) Certified Marriage Certificate from the Recorder of Deeds or other government agency

(2) Children's Certified Birth Certificate from the Bureau of Vital Statistics or other government agency

(3) Copy of Social Security Cards

(4) Adoption Papers

(5) Divorce Decree

(6) Any legal document that would apply to you, your spouse or your dependents.

You may also be required to submit periodic proof that your child who is age 26 or older continues to be incapacitated.

b. Natural Children of Unmarried Male Employees

The natural child of a male employee who was not married to the child's mother at the time of the child's birth will be eligible only if the Welfare Plan Office receives a birth certificate naming the employee as the child's father and a satisfactory statement establishing the employee's financial responsibility for the child or a Qualified Medical Child Support Order.

c. Adopted Children

Your adopted children or children placed with you for adoption will be considered eligible upon the Welfare Plan Office's receipt of preliminary or final adoption papers naming the eligible employee as the adoptive parent.

d. Custodian Children

Custodian children will be considered eligible only upon the Welfare Plan Office's receipt of an order from a court of competent jurisdiction granting the employee physical custody of the child and imposing on the employee legal and financial responsibility for the child.

e. No Benefits for Period Prior to Furnishing Proof of Dependent Status

No benefits will be paid for any loss that occurs or service that is rendered prior to the date you provide the Welfare Plan Office with necessary proof of your dependent's eligibility, unless you provide such proof within 30 days after your dependent first becomes eligible. Therefore, you should provide the Welfare Plan Office with such proof immediately when your dependent becomes eligible or you acquire a new dependent.

C. Effect of Employer's Failure to Make Required Contributions

IF YOU ARE A COVERED EMPLOYEE OF A CONTRIBUTING EMPLOYER WHO FAILS TO MAKE THE REQUIRED CONTRIBUTIONS ON BEHALF OF HIS EMPLOYEES, YOU AND YOUR DEPENDENTS, AS WELL AS THE OTHER EMPLOYEES OF THAT CONTRIBUTING EMPLOYER AND THEIR DEPENDENTS, WILL BE INELIGIBLE FOR BENEFIT COVERAGE FOR CLAIMS INCURRED DURING THOSE MONTHS FOR WHICH YOUR EMPLOYER FAILED TO MAKE THE REQUIRED CONTRIBUTIONS. CONTRIBUTIONS RECEIVED FROM A DELINQUENT EMPLOYER WILL BE CREDITED BACK TO THE FIRST MONTH OF DELINQUENCY. WHEN THE REQUIRED CONTRIBUTIONS ARE FINALLY RECEIVED FOR A MONTH, ALL CLAIMS INCURRED DURING THAT MONTH WILL BE CONSIDERED FOR PAYMENT.

D. Special CHIPRA Enrollment Rights

CHIPRA (Children's Health Insurance Program Reauthorization Act of 2009) created two new special enrollment events if you are an eligible participant in the Plan but not enrolled in the Plan. First, if you or your dependents were covered under Medicaid or a state CHIP plan and lose that coverage, you or your dependents are entitled to a special enrollment period in this Plan. Second, if you or your dependents become eligible for the state's premium assistance, you are entitled to a special enrollment period. You have 60 days to notify the Plan of the event, and 31 days to provide proof of eligibility and enroll. To request Special CHIPRA Enrollment or obtain more information, contact the Fund Office at (314) 739-6442 or toll free at (888) 739-6442.

E. Annual Eligibility Information Update

Each year you will be required to update the enrollment information you have on file with the Plan for you and your dependents by submitting a Member Information Update Form. Your failure to promptly complete and submit a required form could cause the Welfare Fund Office to delay processing and pend all claims for benefits by a Participant until the required form containing the Participant's updated information is received by the Welfare Fund Office. If the required form is not received within the time limit for filing a particular claim, that claim will not be covered, as more fully discussed in Section 12A of this Booklet.

SECTION 4. TERMINATION OF ELIGIBILITY

A. Employees

1. Generally

Your eligibility and the eligibility of your dependents automatically terminates on the earliest of the following dates:

a. The last day of the calendar month during which you cease to be employed in covered employment, or if later, the last day of the last calendar month in which your employer is required by a collective bargaining agreement or other agreement to make contributions to the Welfare Trust on your behalf;

b. The last day of the last calendar month for which contributions are received on your behalf; or

c. The date on which the Plan no longer provides benefits.

2. Active Employees and Medicare

If you are actively employed in covered employment and are eligible for Medicare, this Plan will in almost all instances be the primary payor of your benefits, unless you reject this Plan. If you reject this Plan, Medicare will become the primary payor and you will no longer be eligible for benefits from this Plan. (See Section 8H of this Booklet for more information about this Plan and Medicare.)

B. Dependents

1. Generally for All Dependents

The eligibility of all of your dependents automatically terminates on the earliest of the following date:

a. The date the Plan no longer provides coverage to dependents;

b. The date your eligibility terminates;

c. The date your dependent child becomes eligible as an employee under the Plan; or

d. The date of your death (See Section 5D of this Booklet).

2. Spouse

In addition to the reasons set forth in Section B1 above, the eligibility of your spouse will end on the date on which you and your spouse are divorced or legally separated. The date of divorce or legal separation is the date on which a court of competent jurisdiction first enters a decree of divorce or legal separation.

3. Children

In addition to the reasons set forth in Section B1 above, the eligibility of your children will end for the reasons and on the dates set forth here.

a. At the end of the month in which your child attains the limiting age (however, life insurance coverage for your dependent child will end at 12:01 a.m. on the date the child attains the limiting age).

b. If your child is incapacitated and covered beyond the normal limiting ages (as described at Section 3B3 of this Booklet), his or her eligibility will terminate on the earlier of the date on which the child is no longer incapable of self-sustaining employment or the date on which the child gets married.

C. Coverage During Family and Medical Leave

1. Continuation of Coverage

If you are granted leave by your employer under the Family and Medical Leave Act, please notify the Welfare Plan Office. Provided that you and/or your employer continues to make the required contributions, you may continue coverage for yourself and your dependents during a period of FMLA leave as if you had not taken FMLA leave but had instead continued your employment and your participation in the Plan.

You will not have the right to continue coverage during a period of FMLA leave if you inform your employer before beginning your leave that you do not intend to return to work for your employer at the conclusion of your leave. In that event, you may have a right to continue coverage in accordance with the provisions of Section 5.

2. Termination of Coverage

If you elect to continue coverage during a period of FMLA leave, and you and/or your employer continue to make the required contributions, your coverage (and that of your dependents) will continue until the earliest of:

a. the expiration of your 12-weeks of FMLA entitlement;

b. the date you notify your employer that you do not intend to return to work for your employer after the conclusion of the FMLA leave.

c. the date your employment is terminated because you fail to return to work for your employer after the period of FMLA leave; or

d. the date your employer's participation in the Plan terminates.

3. Restoration of Coverage

Any coverage you do not continue while on FMLA leave will be reinstated upon your return from FMLA leave. You and your dependents will receive the same coverage you had prior to the commencement of FMLA leave.

4. Construction

The rules in this section will be interpreted and applied in a manner consistent with the provisions of the Family and Medical Leave Act of 1993 and any amendments.

D. Continuation of Coverage

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

E. Your Duty to Inform Plan of Termination of Dependent's Eligibility

If any of the following occur, it is your responsibility to inform the Welfare Plan Office:

- You get divorced or legally separated;
- Your child reaches the limiting age; or
- Your incapacitated child recovers or gets married.

If you fail to inform the Welfare Plan Office when one of these events occurs, your dependent may lose his or her right to COBRA continuation coverage. Further, if because you have failed to inform the Welfare Plan Office, the Plan pays out benefits for an ineligible dependent, the Plan will have the right to recover such benefits from you, your dependent or any provider to whom such benefits were paid. The Plan may at its option withhold future benefits due to you and your other covered dependents in order to recoup amounts it paid on behalf of an ineligible dependent. If the Trustees bring a legal action to collect such benefits, the Trustees, upon prevailing, will be entitled to receive and you will be required to pay not only the overpayments, but also pre-judgment interest and the reasonable attorney's fees and costs the Trustees incur in such action.

F. Rescission of Coverage

The Plan will not retroactively terminate coverage under the Plan for any Covered Individual unless the Covered Individual (or an individual seeking coverage on behalf of that Covered Individual) performs an act or practice that constitutes fraud with respect to the Plan, makes an intentional misrepresentation of a material fact, or fails to pay any required contributions or premiums required for coverage. In the event the Plan retroactively terminates a Covered Individual's coverage due to fraud or intentional misrepresentation of

material fact, the Plan will provide at least thirty (30) days advance written notice to each Covered Individual who would be affected before coverage will be rescinded. Such notice will include at least:

1. The name of the affected Covered Individual(s);
2. The name of the Plan;
3. The date that coverage will be rescinded (30 days after the notice date);
4. The date that coverage will be retroactively terminated;
5. The reason(s) for the rescission; and
6. An explanation of the Plan's appeal procedures.

In the event the Plan retroactively terminates a Covered Individual's coverage due to the failure to pay any required contributions or premiums required for coverage, no advance written notice is required.

SECTION 5. EXTENSIONS OF COVERAGE

A. Introduction

There are a number of circumstances in which your coverage and the coverage of your dependents can be continued beyond the date it would normally terminate. The Plan provides some short-term extensions free of charge and others you or your dependents must pay for. Please note that most extensions of coverage are counted toward the maximum COBRA continuation periods described below in Part E of this Section 5. Some of the extensions do not include coverage for weekly income benefits and some do not include life insurance. Moreover, under COBRA, there is no coverage for life insurance, accidental death and dismemberment, or weekly income benefits.

B. Branch O Coverage (Self-Pay)

In the event your covered employment terminates for any reason, you may continue your medical, life and accidental death and dismemberment coverage on a self-pay basis, for a period not to exceed 12 months. This extended coverage is called Branch O coverage. In order to elect Branch O coverage you must notify the Welfare Office of your intention to purchase Branch O coverage no later than the 30th day of the month following the month in which your covered employment terminates and must pay the required monthly amount by the 1st day of each month commencing with the first month following the month in which your covered employment terminates.

After your Branch O coverage has ended, you have the right to COBRA coverage for the balance of the maximum COBRA continuation period described in Section 5E5 below. (The benefits provided under Branch O are the same as those provided under COBRA, except that under COBRA, you cannot continue the life insurance, accidental death and dismemberment insurance, or weekly income benefits).

C. Continued Coverages When You Cannot Work Due to Illness or Injury

Many collective bargaining agreements and other agreements that provide for contributions to the Plan require employers to continue to make contributions for an extended period for individuals who cannot work due to illness or injury. If the agreement pursuant to which you are employed includes this requirement, you and your family will continue to be covered, free of charge, for as long as your employer is required to and does make such contributions. You will need to consult your collective bargaining agreement or other agreement to determine how long your employer will continue to make contributions during your absence from work due to illness or injury.

After your employer's obligation to make contributions has terminated, you may continue your coverage by electing and paying for COBRA coverage as described below in Section 5E. The extended coverage provided by your employer's contributions will count toward the maximum COBRA continuation period.

D. Dependents of Deceased Employee

If you die while eligible for benefits as an active employee, your eligible dependents will continue to be covered, at no charge, for three months following the month in which your employer last made a contribution to the Plan on your behalf, or, if sooner, until the dependent's coverage would otherwise end under the terms of the Plan.

This extension of coverage will be counted toward the maximum COBRA continuation period described in Section 5E.

E. COBRA Continuation Coverage

1. Generally

a. What COBRA Coverage is

The District No. 9, I.A.M.A.W. Welfare Plan provides continued health and welfare coverage on a self-pay basis pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as COBRA. Eligible employees and their dependents are offered the opportunity for a temporary extension of health coverage called "continuation coverage" after certain life events called "qualifying events," which would normally otherwise cause coverage to end. When you

become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

You do not have to show that you are insurable to qualify for continuation coverage. However, you must pay the cost of the continuation coverage.

b. Things to Consider When Deciding Whether to Take COBRA Coverage

If you become eligible for COBRA continuation coverage, your will receive a Notice from the Plan explaining your election options. It is important that you read this Notice in order to make an informed decision regarding your health care coverage options.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if the Plan generally does not accept late enrollments. Other options may be available to you through Medicare, Medicaid, or the Children's Health Insurance Program (CHIP). You can learn more about many of these options at www.healthcare.gov.

c. Contact for COBRA Questions

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

District No. 9, I.A.M.A.W. Welfare Plan
Attn: COBRA Coordinator
12365 St. Charles Rock Road
Bridgeton, Missouri 63044
Phone: (314) 739-6442
1-888-739-6442

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

2. Qualifying Events That Give Rise to Right to Elect COBRA Continuation Coverage

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

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

a. For Employees

As an eligible employee of a contributing employer for whom the contributing employer is making contributions to the Welfare Trust, you will have the right to choose COBRA continuation coverage, if you lose coverage under the Plan due to:

(1) A reduction in hours of employment, or

(2) Termination of employment for reasons other than gross misconduct on your part.

b. For Spouses

The spouse of an eligible employee covered by the Plan has the right to choose continuation coverage if the spouse loses coverage under the Plan for any of the following reasons:

(1) Death of the employee;

(2) The termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment;

(3) Divorce of legal separation from the employee; or

(4) The employee becoming entitled to Medicare.

c. For Dependent Children

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

(1) Death of the employee-parent;

(2) The reduction of hours of employment or the termination of the employee-parent's employment (for reasons other than gross misconduct);

(3) Employee-parent's divorce or legal separation;

(4) Employee-parent becoming entitled to Medicare;

(5) Child ceases to be an eligible "dependent child" under this Plan.

d. For Certain Retired Employees and Their Dependents

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

3. Benefits Available Under COBRA Continuation Coverage

The only benefits available under COBRA continuation coverage are comprehensive major medical benefits

Life insurance, accidental death and dismemberment coverage, and weekly income benefits may not be continued under COBRA.

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

4. Required Notices, Election and Payments

(a) Notice to the Plan

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

In addition, if a person who has COBRA continuation coverage has a second qualifying event, he or she (or someone on his or her behalf) must provide written notice to the Plan of that second qualifying event within 60 days after the occurrence of that second event in order to qualify. If the Plan Office does not receive written notice of the second qualifying event, rights to additional COBRA coverage, if any, will be lost.

To give any of the above notices, you or your dependent should write to the Plan Office at the address listed below and include the following information:

(1) Name and Participant ID of Employee

(2) Names and addresses of dependents who will lose coverage

(3) Date of Qualifying Event

(4) Nature of Qualifying Event

District No. 9, I.A.M.A.W. Welfare Plan
Attn: COBRA Coordinator
12365 St. Charles Rock Road
Bridgeton, Missouri 63044
Phone: (314) 739-6442
1-888-739-6442

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

(b) Plan's Notice to Employee and Dependents

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

(c) Election

(1) Time Limit for Election

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

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

(2) Who May Elect COBRA Coverage

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

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

(d) Payment

COBRA continuation coverage is not free. You must pay for it. The initial payment is due within 45 days after the date you make your election. The first payment must include payment for all months between the termination of regular coverage and the date of payment. Subsequent payments are due on the first day of each month, but will be accepted for up to 30 days after the due date.

(e) Coverage During Election and Payment Period

During the period between the termination of your regular coverage and your election and payment for COBRA continuation coverage, the Welfare Plan cannot pay for any expenses incurred after the termination and will notify providers of health care that you have not yet elected or paid for COBRA continuation coverage. If you do ultimately elect and pay for COBRA continuation coverage, the Welfare Plan will then adjudicate claims you may have incurred in the interim.

5. Duration of COBRA Continuation Coverage

a. Termination or Reduction of Hours of Employment

(1) Generally

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

(2) Extensions

(a) Disability

If prior to the end of that 18-month period, any of the qualified beneficiaries who elected COBRA is determined by Social Security to have been disabled during the first 60 days of COBRA continuation coverage, the maximum COBRA continuation period is extended for an additional 11 months. The disabled person and all other qualified beneficiaries who have COBRA coverage by virtue of the same qualifying event, may purchase coverage for up to a total of 29 months from the date of the original qualifying event. If the disabled person is covered during this 11-month extension, the premium will be 50% higher.

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

(b) Medicare Entitlement

If the former employee was entitled to Medicare at the time of the qualifying event, the COBRA continuation coverage period of the employee's dependents will not end until 36 months after the date the employee became entitled to Medicare. For example, if you became entitled to Medicare in May of 2020, and then terminated employment in June of 2020, <u>your</u> COBRA period ends December of 2021, but your eligible dependents can continue their COBRA coverage until May of 2023, which is 36 months after your Medicare entitlement.

(c) Second Qualifying Event

If a second qualifying event occurs during the 18-month (or 29-month) period, the maximum continuation period will be extended to 36 months from the date of the original qualifying event for the qualified beneficiaries affected by the second qualifying event. For example, if your employment is terminated on December 31, 2020, you and your eligible dependents are entitled to COBRA continuation coverage until June 20, 2022. However, if in May of 2021, your son turns 26, he has had a second qualifying event, and his COBRA continuation period can continue until December 31, 2023 (36 months from the date of the original qualifying event).

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

b. Other Qualifying Events

For all qualifying events other than the termination of employment or the reduction in hours of employment, the maximum COBRA continuation coverage is 36 months from the date of the qualifying event.

6. Termination of COBRA Continuation Coverage

All rights to COBRA continuation coverage permanently end on the <u>earliest</u> of the following occurrences:

a. The expiration of the applicable maximum COBRA continuation coverage;

b. The failure to make a payment before the end of the applicable grace period;

c. After the date that COBRA is elected, the covered individual becomes covered under Medicare or under another group plan;

d. The District No. 9, I.A.M.A.W. Welfare Plan or the contributing employer for whom the employee worked or works stops providing group health benefits; or

e. For COBRA coverage that is extended due to disability, the first day of the first month that begins more than 30 days after the date that a disabled Qualified Beneficiary is finally determined by the Social Security Administration to be no longer disabled.

7. Coordination of COBRA Continuation Coverage With Other Periods of Continued Coverage

The maximum period of COBRA continuation coverage for employees and dependents will be reduced by the number of months during which the employee was covered by virtue of his or her making self-payments for Branch O coverage and by virtue of his or her employer's making continued contributions after his or her employment ended. The maximum period of COBRA continuation coverage for a dependent child or spouse will also be reduced by the number of months during which the Plan extends coverage after the death of the employee spouse or parent.

If a participant or dependent initially chooses COBRA coverage rather than any other extended coverage available to the participant or dependent, the participant will have no right at the end of the COBRA period to elect the other extended coverage.

8. Keep Plan Office Informed of Addresses

In order that the District No. 9, I.A.M.A.W. Welfare Plan can make certain that you and all of your covered dependents get all of the notices about COBRA, please keep the Plan Office informed of your current address and the addresses of any covered dependents.

9. Special Rules for Medicare-Eligible Individuals

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

10. Special COBRA Rules for Individuals Eligible for Trade Adjustment Assistance

a. Trade Act – Generally

The Trade Act of 2002 provides that certain workers whose employment is adversely affected by international trade (increased imports or a shift in production to another country) may be determined by the United States Department of Labor or other government agency to be eligible for "trade adjustment assistance" or "TAA." TAA consists primarily of career counseling, up to two years of training, income support during training, job search assistance, and relocation allowances.

b. Special Election Period

If you do not take COBRA during the normal election period and are determined to be eligible for TAA, you will be entitled to a second 60-day COBRA election period. That second 60-day election period will begin on the first day of the month in which you are determined to be eligible for TAA, but you must make your election no later than six months after your active coverage under the Plan ends.

c. Commencement of Premiums and Coverage

If you elect to take COBRA during this second special election period, your COBRA coverage will begin the first day of the special second 60-day election period. Your first payment will be due within 45 days after you make your election and must include all payments due between the first day of the second election period and the date of payment.

d. Possible Help in Paying Costs of COBRA

The Trade Act of 2002 created a tax credit for TAA-eligible individuals. You may either take a tax credit or get advance payment of a certain percentage of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information is available online at: www.doleta.gov/tradeact.

F. Extended Continuation of Coverage for Surviving Spouses

1. Generally

A surviving spouse of a deceased employee who became entitled to COBRA continuation coverage because of the death of the employee is entitled to extended continuation coverage for the surviving spouse and the eligible dependent children only if the surviving spouse is 55 years of age or older at the time the COBRA continuation coverage period expires.

2. Procedures for Electing Extended Continuation Coverage

a. Exercise of COBRA Rights Required

In order to be eligible for this extended continuation coverage, the surviving spouse must have properly exercised his or her rights to COBRA continuation coverage and must have maintained that COBRA continuation coverage for the full 36 months permitted under COBRA.

b. Extended Continuation Automatic

If the spouse has complied with paragraph 2a above, the continuation coverage for that spouse and any eligible dependent children will automatically continue if the spouse is 55 or older on the date the COBRA continuation period expires.

c. Notices Required

While the extended continuation coverage should be automatic, the spouse should contact the Plan Office toward the end of the COBRA period to confirm that he or she is eligible for the extended continuation coverage.

3. Terms and Conditions of Extended Continuation Coverage

a. Payment

The spouse is required to pay for this extended continuation coverage. The Plan may charge more for this extended continuation coverage than it charges for COBRA continuation coverage and the

Plan will notify the spouse of the cost and the payment due dates at the time the extended continuation coverage becomes effective.

b. Benefits

The benefits provided under this extended continuation coverage will be the same as those that would be provided to similarly situated persons then eligible for COBRA continuation coverage.

4. Termination of Extended Continuation Coverage for Spouse and Eligible Dependent Children

This extended continuation coverage will terminate on the earliest of the following dates:

a. The date on which the spouse fails to make a required payment when due;

b. The date the Welfare Plan no longer provides benefits;

c. The date the surviving spouse becomes insured under any other group plan;

d. The date on which the surviving spouse attains the age of 65 or otherwise becomes eligible for Medicare.

G. Coverage When You Enter Active Duty in the Uniformed Services

If you, the covered employee, leave covered employment to enter active duty in one of the uniformed services of the United States (Army, Navy, Air Force, Marines, Coast Guard, or uniformed Public Health Service) your coverage and that of your dependents will continue for one month without charge. Thereafter, you and your dependents may purchase COBRA for an additional 23 months (or, if earlier, until the date on which you return to employment with the employer or fail to apply for or return to a position of employment with the employer within the time limit that applies under the Uniformed Services Reemployment Rights Act (USERRA)). If, after your active duty ends, you return to covered employment within the time set by federal law (which varies depending on the length of your active duty), your coverage under the Plan will resume upon your return as if you had not left covered employment.

You must inform the Plan Office if you enter the uniformed services to insure your rights are protected under the USERRA.

Please Note: No benefits are provided for injuries or illnesses arising out of or in connection with your service in the uniformed service of the United States or any other country.

Summary of Continuation Coverages Available						
Type of Continuation Coverage	Pre-Requisites	Maximum Duration	Payment	Dependents Covered	Benefits	Counts Toward COBRA Period
Branch O	Employment Ends	12 months	You must pay	Yes	All but weekly income	Yes
Employer-Paid Extension	Cannot Work Due to Illness or Injury	Varies	Employer must pay	Yes	Medical, Weekly Income, Life and AD&D	Yes
Surviving Dependents	You die while Active Participant	3 months	Not required	Yes	All but weekly income	Yes
COBRA	A Qualifying Event	Depends on Event	Yes	If coverage elected for dependents	Medical	Yes
Extended COBRA	Surviving spouse is 55 at end of COBRA period	Until age 65	Yes	Yes	Same as those under COBRA	Not applicable
NOTE: Read the descriptions of each type of continuation coverage set forth in this Section 5.						

SECTION 6. LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

A. Schedule of Benefits

Life benefits and Accidental Death and Dismemberment benefits are described in the Certificate of Insurance issued by The Guardian Life Insurance Company. The insurance certificate is incorporated herein by reference.

The certificate includes the following written materials:

- Nature of coverage provided to covered individuals;
- Conditions pertaining to eligibility to receive coverage (other than general conditions pertaining to eligibility for participation in the Plan) and circumstances under which coverage may be denied;
- Procedures to be followed in filing claims;
- Procedures available for the review of claims which are denied in whole or in part; and
- Circumstances which may result in disqualification, ineligibility, or loss or suspension of benefits.

Requests for such written material may be directed to:

The Guardian Life Insurance Company
7 Hanover Square
New York, New York 10004

or to the Fund Office.

SECTION 7. WEEKLY INCOME BENEFITS FOR ILLNESS OR ACCIDENTAL INJURY

A. Eligibility

The weekly income benefit is available only to covered employees as defined in Section 2. Definitions. Weekly income benefits cease upon termination of eligibility, as defined in Subsection A. Employees of Section 4. Termination of Eligibility.

B. Generally

In the event you suffer a loss of earnings due to an illness or injury which prevents you from performing your job, weekly benefits are payable up to the maximum shown in the Schedule of Benefits.

Weekly benefits begin on the first day of accidental injury, and on the eighth day of illness, and continue for the maximum number of weeks set forth in the Schedule of Benefits during any one continuous period of disability.

There is no reduction or restriction of benefits because of age.

Weekly Income Benefits do not require you to be house confined, however, you must be under the direct care of a physician.

No weekly income benefits are provided to dependents.

C. Continuous Period – New Period

For this coverage, a continuous period of illness or injury includes all periods of illness or injury due to the same or related cause or causes, separated by less than three months of continuous, full-time, active work.

D. Limitations

Coverage for Weekly Income Benefits is limited to the maximum number of weeks shown on the Schedule of Benefits per calendar year. Accordingly, if you have more than one illness or accidental injury during a calendar year that prevents you from working, all Weekly Income Benefits added together cannot exceed the maximum number of weeks shown on the Schedule of Benefits.

E. No Weekly Income Benefit for Work-Related Illness or Injury

The Plan will not pay you weekly income benefits if your illness or injury arises out of or in the course of any employment for any employer or any self-employment or for which the individual is entitled to benefits under any workmen's compensation or occupational disease law or for which the individual receives any settlement from a worker's compensation carrier or self-insured employer.

Once you allege an injury is work-related, the Plan will not pay weekly income benefits until:

1. an Administrative Law Judge (ALJ) determines the injury is not work-related, or
2. until the worker's compensation claim is dismissed and the Plan receives medical evidence that the injury is not work-related.

F. Other Exclusions

No weekly income benefits are payable for any injury or illness that results from or is due to any war or act of war, whether declared or undeclared.

No benefits are payable for any illness or injury that occurs during or as a result of your engaging in conduct that constitutes a crime, as determined by the Plan and the Trustees.

G. Guidelines Applied

The Plan applies the guidelines in the "Official Disability Guidelines Treatment in Workers' Comp" (ODG Treatment in Workers' Comp) published by the Work Loss Data Institute in determining weekly income benefits provided under this Section 7.

SECTION 8. COMPREHENSIVE MAJOR MEDICAL BENEFITS

A. Pre-Certification, Utilization Review and Case Management

1. Generally

a. Pre-Certification

As previously mentioned, under the terms of the Utilization Management Program, a Network Provider must obtain pre-certification for elective hospital admissions, outpatient surgeries, ambulatory services, home health care and outpatient physical therapy. While you will not be penalized solely because of the failure of a Network Provider or other provider to obtain pre-certification, it is in your interest that pre-certification be obtained in that the Plan does NOT pay for any care or treatment which is not medically necessary. While pre-certification does not automatically guarantee that all expenses will be paid by the Plan, it does significantly reduce the possibility that medically unnecessary care or treatment will be provided. Accordingly, both you and your provider are encouraged to obtain pre-certification through the medical network provider.

Similarly, participants requiring treatment of mental health and substance use disorders are encouraged to obtain pre-certification before treatment begins.

b. Utilization Review and Case Management

In addition to providing pre-certification services, the medical network provider will monitor the length of any hospital stay. For a complex, lengthy or expensive course of medical treatment, the Medical Case Manager will monitor and manage your ongoing treatment and help insure you are receiving the most appropriate treatment at the most appropriate cost.

2. Medical Pre-Certification

a. Services for Which Provider is Required to Obtain Pre-Certification

Under the terms of the Utilization Management Program, Network Providers must obtain pre-approval or pre-certification for non-emergency hospital admissions, certain surgical procedures, ambulatory services or ancillary services. Refer to the following website for a current list for which pre-certification is required: www.d9trusts.org.

b. How and When to Obtain Medical Pre-Certification

(1) Generally. Generally, when you learn that you or one of your covered dependents will be receiving any of the services or supplies requiring pre-certification, you or your doctor should contact the medical Network Provider prior to commencement of the recommended treatment. You or your doctor may contact the medical Network Provider at the telephone number which is set forth on the Schedule of Benefits which is in the back of this Booklet and on your Plan identification card.

(2) Emergency Hospital Admission or Treatment. You or your covered dependent should contact the medical Network Provider within 48 hours after an emergency hospitalization or commencement of emergency treatment, including a pregnancy-related admission. For such admissions that occur on holidays or weekends, the medical Network Provider should be notified within 48 hours after the admission or on the next business day, if later.

c. Effect of Obtaining Medical Pre-Certification

When your hospitalization or other treatment is approved by the medical Network Provider, that pre-approval does not guarantee that all expenses you incur will be paid by the Plan. It means only that the hospitalization or other treatment is appropriate for the illness or injury based on the facts as described. Charges submitted for pre-approval are subject to all other limitations, exclusions and conditions set forth in this Booklet.

If you or your provider fails to obtain pre-certification for one of the listed procedures or services, there is no penalty for you. However, the benefit to you is that obtaining pre-certification makes it

less likely that you will discover after you have already received a treatment or service that such treatment or service will not be covered by the Plan.

3. Medical Case Management

a. Concurrent Review of Hospital Stay or Course of Treatment

If you or one of your dependents is hospitalized or undergoing a course of medical treatment, the Medical Case Manager will monitor the hospitalization or course of treatment. If after consulting with the treating physician, the Medical Case Manager determines further hospitalization or other treatment is inappropriate, you or your doctor will be notified. The Plan will not cover continued hospitalization or treatment that has been determined to be unauthorized. Concurrent review is automatically undertaken when the pre-certification process has been initiated. (With respect to hospitalizations for childbirth, see Section 8G10 of this Booklet.)

b. Discharge Planning and Case Management

The Plan's Medical Case Manager will also monitor any hospitalization or course of treatment and will work with you or your dependent and the treating doctors to make sure you or your dependent are receiving the most appropriate care in the most appropriate setting at a reasonable cost. In most cases, the case manager's review will not affect the care you or your dependent receives. The case manager will simply report to the Plan that the care recommended for you or your dependent is appropriate. However, where the case manager determines there is a need for complex or extended treatment, the case manager will work with you and your medical providers to help insure that you or your dependent receives the care that is the most appropriate in the setting that is most appropriate for your circumstances and that is also economical for the Plan.

This can be of significant help to you and your family and can also save your Plan money. For example, if you or a dependent is hospitalized for a serious or incapacitating illness, the case manager will help identify and arrange for the services you or your dependent will need when discharged from the hospital. The case manager's helping to arrange for such services not only makes it easier for the patient when he leaves the hospital, it may also make it possible for the patient to leave the hospital sooner. This would be better for you and for the Plan.

In some limited circumstances, the Medical Case Manager may recommend alternative services or providers which would not normally be covered under the Plan if the Medical Case Manager determines such services or providers would be effective and would not cost the Plan more than services which would normally be covered. The Medical Case Manager may also provide you and your family with training and education regarding your illness.

If it is determined you or one of your dependents requires case management services, the Medical Case Manager will contact you.

c. Second Medical Opinion and Other Information

The Plan, through the Medical Case Manager, may require you to obtain, at the Plan's expense, a second medical opinion as to a recommended course of treatment or to provide other information so that the Plan can make appropriate decisions.

d. Voluntary Pre-Treatment Medical Review

When the Plan receives claims, it will make a determination about whether the services or supplies you received were medically necessary. If it determines they were not necessary, such services or supplies will not be covered. If your doctor prescribes an extended or expensive course of treatment, or what seems to you to be an unusual treatment, you may ask the Plan Office to have the proposed course of treatment reviewed before you undertake it to determine whether it will ultimately be covered.

There are a couple of treatments that are more likely than others to be determined to be unnecessary. The Plan will always review the necessity of these treatments when they are proposed if you request such a review. While the Plan cannot review every other proposed course of treatment, if your doctor prescribes or proposes a treatment that is extended, very expensive or seems unusual, the

Plan will most likely review it upon your request. The pre-treatment review may help you avoid undergoing a treatment that is not covered.

4. Mental Health and Substance Use Disorder Pre-Certification

Anyone seeking treatment for a mental health issues or for Substance Use Disorder is encouraged to get pre-certification of the treatment sought (see Section 14H for contact information). While you cannot be penalized for failing to obtain pre-certification, doing so makes it less likely that you will obtain treatment that is not covered by the Plan.

The Plan covers medically necessary treatment for mental health issues and Substance Use Disorder like any other major medical treatment you receive. The Plan will pay 85% of covered charges, after the deductible is satisfied, for treatment administered by Network providers. However, treatment administered by providers outside the Network will be covered like any other Non-Network treatment you receive, meaning that, after the deductible is satisfied, the Plan will pay only 55% of the covered charges and you will have to pay 45%.

B. Use of Network Providers

For medical treatment, the Plan participates in a medical network program which has agreements with a number of doctors, hospitals and other providers of health care services to provide health care to you and your eligible dependents at rates that are often reduced. A current list of doctors, hospitals and other providers who are members of the network can be obtained online (see Section 14H for website address).

Under the medical network program, there are two levels of doctors, hospitals, and other providers:

Level 1 – Network Providers; and

Level 2 – Non-Network Providers.

The Network Providers generally charge the Plan less for your care than Non-Network Providers. The level of your benefits is determined by which level of provider you choose. If you choose a Network Provider, the Plan will pay 85% of the covered charges after the deductible and you will pay 15%. If you choose a Non-Network Provider, the Plan will pay 55% of the covered charges, after the deductible and you will pay 45%. (Non-Network Provider charges are limited to Allowable Charges as defined in Section 2B of this Summary Plan Description)

The rates charged by Non-Network Providers are often higher than those charged by Network Providers. So, you not only pay a higher percentage of charges, but often pay a higher percentage of higher charges when you use Non-Network Providers.

Network Providers will normally obtain the necessary pre-certification. However, you may call the medical Network Provider to confirm pre-certification even when you use a Network Provider. The telephone number for pre-certification is set forth in the Schedule of Benefits in the back of this Booklet and on your Plan identification card.

The Plan follows an internal procedure called the PEARL rule, which provides network-level coverage for certain Non-Network Providers who deliver ancillary services in a network facility where the patient has no choice in the selection of those ancillary providers. Ancillary providers covered under the PEARL rule are Pathologists, Emergency Room providers, Anesthesiologists, Radiologists and Laboratory providers. This rule provides for reimbursement of those ancillary providers at the network level; however, charges must be medically necessary and are limited to Allowable Charges not to exceed usual reasonable and customary amounts.

C. Other Cost Saving Features of the Plan

In addition to saving money by using Network Providers and by complying with the pre-certification and utilization review requirements, you may also be able to reduce the cost of your medical care by taking advantage of other cost saving features of the Plan. If you need long-term maintenance prescription drugs, you should use the mail-in drug program described at Section 8G1 of this Booklet. Also, please see Section 8D3 with reference to pre-admission/pre-surgical testing and outpatient surgeries.

D. Deductibles, Co-Payments, and Maximum Out-of-Pocket Amounts

1. Deductibles

a. Individual

The individual deductible is $250.00 per year for Network Providers and $750.00 for Non-Network Providers. The network and non-network deductibles cross apply.

b. Family

The family deductible is $750.00 per year for Network Providers and $1,500.00 for Non-Network Providers. The network and non-network deductibles cross apply.

c. Carry-Over

When any part of a year's deductible is applied against expenses incurred during the last three months of that calendar year, the deductible amount you must pay in the following calendar year will be reduced by the amount so applied.

d. Emergency Room Co-Pay

Each time you or a dependent visit an emergency room, you must pay the first $100.00 of covered charges. This $100.00 does not count toward the annual deductibles. If the covered person is admitted to the hospital from the emergency room, the $100.00 emergency room co-pay will be waived.

e. Urgent Care Co-Pay

Each time you or a dependent visit an urgent care center, you must pay the first $50.00 of covered charges. This $50.00 does not count toward the annual deductibles.

f. Office Visit Co-Pay

Each time you or a dependent visit a Physician and incur an office visit charge, you must pay the first $15.00 of covered charges from a Primary Care Provider or $25.00 from a Specialist. This $15.00 or $25.00 does not count toward the annual deductibles.

2. Co-Insurance and Out-of-Pocket Maximum

Until you have satisfied the appropriate deductible and incurred additional covered expenses for covered services equal to the out-of-pocket maximum set forth in the Schedule of Benefits contained in the back of this Booklet, you must pay part of the covered expenses of covered services. The portion of expenses you must pay is the co-insurance amount.

If you use a Network Provider, the Plan pays 85% of the covered expenses of covered services, and you pay 15%. If you use a Non-Network provider, you must pay 45% of the covered expenses of covered services, and the Plan will pay only 55%. See Section 8B for description of the two levels of providers.

a. Individual. After you have or one of your eligible dependents has satisfied the deductible and has incurred additional covered expenses for covered services in an amount equal to the individual out-of-pocket maximum set forth in the Schedule of Benefits contained in the back of this Booklet, the Plan will pay 100% of the covered expenses for covered services incurred by that same individual for the remainder of the calendar year.

b. Family. After two of your covered family members have incurred, in addition to the applicable deductibles, covered expenses for covered services in an amount equal to the individual out-of-pocket maximum, the Plan will pay $100% of the covered expense for covered services for you and all of your eligible dependents for the remainder of the calendar year.

You must satisfy the out-of-pocket maximum before the Plan pays 100% of covered expenses.

3. Out-Patient Surgeries, Pre-Admission/Pre-Surgical Testing, and Treatment of Accidental Injuries.

a. Outpatient Surgery

The normal deductible and co-insurance are applied to the following charges incurred in connection with surgery which results from an illness and which is performed other than while the individual is hospitalized or has been admitted to the hospital:

(1) Eligible charges by a legally qualified physician for such surgery, and

(2) Hospital charges and hospital-type charges.

The Plan uses internal guidelines to determine the Allowable Charges from non-network surgery centers. Therefore, covered benefits for outpatient surgeries performed at non-network surgery centers are often significantly less than covered benefits for outpatient surgeries performed at network surgery centers.

b. Pre-Admission/Pre-Surgical Testing

The deductible is waived but co-insurance applies to charges for pre-admission/pre-surgical testing within seven days of an inpatient or outpatient surgery. Pre-admission/pre-surgical testing means x-ray and lab exams made in contemplation of and within seven days before a scheduled surgery which is performed in an inpatient or outpatient surgical setting.

c. Treatment of Accidental Injuries

No annual deductible or co-insurance applies to covered charges incurred for treatment of an accidental injury that is provided during the 48 hours following the accident. You will have to pay the $100.00 emergency room co-pay if you visit the emergency room or the $50.00 urgent care co-pay if you visit an urgent care provider. Any charges incurred for treatment occurring more than 48 hours after the accident will be subject to co-insurance and all deductibles.

E. Covered Charges

Benefits are provided by the Plan for charges or expenses you or your covered dependents incur only for the medical treatments, services or supplies set forth below and only if the treatment, service or supply is medically necessary for the care or treatment of an illness, (including pregnancy for you or your covered spouse), and the charges are Allowable Charges.

Important Note: Benefits for treatments, services and supplies listed here are all subject to the limitations and exclusions set forth in Sections 8F and 8H of this Booklet, and some are subject to the additional conditions and limitations set forth in Section 8G of this Booklet. Review those Sections carefully.

Charges for the Following are Covered

1. Room and board and routine nursing services for confinement in a hospital, limited to the hospital's prevailing charge for a semi-private room. (For specific rules regarding hospitalizations for childbirth, see Sections 8G9 and 8G10 of this Booklet).
2. Medical services and supplies provided by the hospital.
3. Anesthetics and their administration.
4. Professional services and medical treatment given by or in the presence of a licensed doctor of medicine or osteopathy or professional services rendered by one of the following providers of medical care if such treatment is within the scope of the doctor's or other provider's license and the treatment is otherwise covered under this Plan.

   Licensed Chiropractor

   Licensed Dentist

   Licensed Optometrist

   Licensed Podiatrist

   Licensed Psychologist

   Licensed Speech Therapist or Licensed Speech Therapy Assistant

Licensed Audiologist

Licensed Registered Nurse

Licensed Practical Nurse

Licensed Physical Therapist or Licensed Physical Therapy Assistant

Licensed Occupational Therapist or Licensed Occupational Therapy Assistant

Licensed Nurse Practitioner

Licensed Physician's Assistant

Licensed Dietician

Certified Nutritionist

Certified Lactation Consultant

International Board Certified Lactation Consultant

Registered Lactation Consultant

Licensed Social Worker

Licensed Professional Counselor

Note: No charges for professional services of other providers of medical care are covered under the Plan unless you or your covered dependent is referred to such other provider by the Medical Care Manager and such other provider is a member of the Network.

5. X-ray exams (other than dental), lab tests and other diagnostic services including mammography and pregnancy exams.
6. X-ray and radiation therapy.
7. Speech therapy by a doctor or speech therapist to restore or rehabilitate speech lost or impaired by reason of an illness (other than a functional nervous disorder) or by reason of surgery due to an illness. If the speech loss or impairment is due to a congenital anomaly, any available surgery to correct the anomaly must have been performed prior to the speech therapy or the cost of the therapy will not be covered.
8. Physical therapy to restore or rehabilitate physical capabilities lost or impaired by reason of an illness or by reason of surgery due to an illness.
9. Occupational therapy charges for treatment or services rendered by a registered occupational therapist for conditions resulting from an injury or illness which will improve a body function through short-term therapy. The therapy must be in accord with a Physician's exact order as to type, frequency and duration of treatment. Covered expenses do not include therapy provided by a chiropractor, recreational programs, work hardening, maintenance therapy or supplies used in occupational therapy.
10. Repair or replacement of natural teeth and treatment of a fractured or dislocated jaw injured, damaged, or lost by reason of an accidental injury, but only if the treatment is initiated within 24 months of the accidental injury.
11. Transportation within the United States or Canada by a professional ambulance service, railroad, or regularly scheduled airplane to, but not returning from the hospital or facility nearest to the covered individual which is equipped to furnish treatment for the covered individual's condition. If the nearest appropriate hospital or facility is not a Network facility, transportation to the nearest appropriate Network facility will be covered.
12. Room and board and routine nursing services for confinement in a skilled nursing facility, limited to one-half of the average semi-private hospital room and board rate prevailing in the area, but only if the confinement commences within 14 days following confinement in a hospital for at least three consecutive days for the same illness and only if the confinement in the skilled nursing facility is not for

routine custodial care (see definition in Section 2 of this Booklet) and the individual is visited by his or her doctor at least once each 30 days.

13. Purchase of medical supplies or the rental of durable medical equipment up to the cost of the purchase.
14. Home health care services and supplies.
15. Hospice services.
16. Surgical sterilization, but not its reversal.
17. Prescription drugs.

Important Note: Benefits for the above listed services and supplies are all subject to the exclusions and limitations set forth in Section 8F and 8H of this Booklet, and some of them are subject to the additional terms, conditions, and limitations set forth in Section 8G of this Booklet. Review those Sections carefully.

F. Exclusions and Limitations Applicable to All Comprehensive Major Medical Benefits

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

1. Charges for any care, treatment, services, supplies or materials which are not necessary to the care or treatment of an illness.
2. Charges for any care, treatment, services, supplies or materials undertaken without the recommendation of a legally qualified doctor.
3. Charges which would not have been made if the individual were not eligible for medical insurance or benefits.
4. Charges which the covered individual is not legally obligated to pay.
5. Charges which are in excess of the Allowable Charges for the services performed and the materials furnished. (See definition in Section 2 of this Booklet).
6. Charges for treatment by a doctor or other professional which is not within the scope of his or license.
7. Charges for care, treatment, services or supplies that are experimental or investigative in nature with reference to the illness being treated. (See definition in Section 2 of this Booklet).
8. Charges for care, treatment, or surgery on the teeth, gums or alveolar process, or dentures, appliances or supplies used in such care or treatment, except the Plan will pay the hospital charges if the covered individual is admitted to a hospital while receiving such treatment, will pay dental charges arising out of an accidental injury as set forth above at Section 8E10 of this Booklet, and will pay all charges associated with the removal of impacted wisdom teeth.
9. Charges for the treatment of refractive errors, including but not limited to, eye exams, radial keratotomy procedures and other forms of surgery.
10. Charges for eyeglasses and contact lenses or the fitting of them, except that the Plan will treat charges for lenses made necessary by cataract surgery as covered charges.
11. Charges for any treatment for cosmetic purposes or for cosmetic surgery, (see definition in Section 2 of this Booklet) except the Plan will pay for cosmetic treatment or surgery due solely to an accidental injury or solely to a birth defect, provided such treatment is undertaken as soon as it is medically feasible. For specific information regarding reconstructive surgery following mastectomy, see Section 8G11 of this Booklet.
12. Charges for services of a person who usually lives in the same household as the covered individual, or who is a member of the covered individual's immediate family or the family of his or her spouse.
13. Charges for services or supplies furnished by an agency of the United States Government or a foreign government agency, unless:

    (a) excluding them is prohibited by law; or

(b) the covered individual is legally required to pay in the absence of insurance or medical benefits.

14. Charges for vocational rehabilitation, by any name called (see definition in Section 2 of this Booklet).
15. Charges for an abortion performed for any reason other than to prevent the death of the mother, except that the Plan will cover charges for treatment of the complications of an abortion and charges for treatment of spontaneous abortions.
16. Charges for in vitro fertilization, artificial insemination, or any other artificial means of conception.
17. Charges incurred in connection with the pregnancy of anyone other than a covered employee or the spouse or dependent of a covered employee.
18. Charges for the child of a dependent including newborn charges incurred during maternity hospitalization.
19. Charges for the surrogate pregnancy of any person.
20. Charges for external devices or vascular surgery to correct blockage of blood flow to the penis for treatment of erectile dysfunction. Injections and insertions for erectile dysfunction are limited to four per month, only after unsuccessful use of oral medication for a 60-day period.
21. Charges for care or treatment due to any act of war, declared or undeclared.
22. Charges arising from or in connection with the covered individual's service in the uniformed services of the United States or of any other country.
23. Charges for the treatment of any illness or injury that arises out of or in the course of any employment for any employer or any self-employment or for which the individual is entitled to benefits under any worker's compensation or occupational disease law or which the individual receives any settlement from a worker's compensation carrier or a self-insured employer. Once a work-related injury is alleged, the Plan does not pay benefits until:

    a. an Administrative Law Judge (ALJ) determines the injury is not work-related, or

    b. until the worker's compensation claim is dismissed and the Plan receives medical evidence that the injury is not work-related.

    The Plan may pay the charges described in this paragraph during the pendency of a Covered Individual's workers' compensation case if the Covered Individual executes a lien in favor of the Plan. The lien will require full reimbursements of amounts paid out by the Plan in connection with the work-related injury if the Covered Individual is successful in the workers' compensation case. The Plan's enforcement rights will be as set forth in Section 11, subsection G.
24. Charges for custodial care or general housekeeping services (see definition in Section 2 of this Booklet).
25. Charges for the treatment of any injury or illness that occurs during or as a result of the covered individual's engaging in conduct that constitutes a serious crime, as determined by the Plan and the Trustees.
26. Charges for personal comfort items, including but not limited to: television, newspaper, telephone, books, slippers, etc.
27. Charges incurred by your dependent spouse or child who has medical benefits provided by or through his or her own employer or union, or his or her parent's employer or union, unless the type and amount of benefits provided by or through that employer or union, when that plan of the other employer or union is primary under this Plan's coordination of benefits rules, are not affected by the fact the dependent is also covered under this Plan.
28. Charges which are not listed as covered by this Plan.
29. Charges for a virtual colonoscopy.
30. Charges for services, supplies, care, drugs or treatment related to gene therapy.

G. Additional Terms, Conditions and Limitations Applicable to Specific Benefits

In addition to the terms, conditions, limitations and exclusions set forth in Section 8F above and 8H that follows, the specific benefits described in this Section are subject to the additional terms, conditions and limitations set forth in this Section.

1. Prescription Drug Benefits

a. Prescription Drug Benefits

(1) Generally. The Trustees have retained the services of a pharmacy benefit manager (PBM) (see Section 14H). The PBM has an extensive network of pharmacies at which you will use your prescription card to obtain your prescription medication upon your payment of the appropriate co-payment. The PBM has contracted with these network pharmacies to provide drugs at a discount. It is to your benefit to use a network pharmacy.

If you use a non-network pharmacy, you must pay for your prescription and then file a claim for reimbursement. You may obtain a claim form from the Plan Office, from your shop steward, or in some cases, from your employer. The Welfare Plan will reimburse you for the "covered cost" of the covered prescription drugs you obtain at a non-network pharmacy minus the applicable co-payment. However, the "covered cost" is the lesser of the amount a network pharmacy would charge or the amount the non-network pharmacy actually charged you. If the non-network pharmacy charges more than a network pharmacy, you will have to pay the difference.

You will receive a prescription drug card that has all of the relevant telephone numbers on it. You will also be provided with a list of participating pharmacies and you can call the Plan Office or the pharmacy benefits manager to determine whether a particular pharmacy is in the network. You will also be able to obtain long-term maintenance drugs from the mail-order pharmacy.

(2) Retail Pharmacy Benefits. As indicated above, in order to receive your prescription at a network retail pharmacy, you will present your card and prescription to the pharmacist at a participating pharmacy. You will be required to pay the pharmacist a co-payment for each prescription. You may not obtain any more than a 30-day supply for a single co-payment.

The amount of your co-payment depends on whether you receive a generic drug, a preferred brand-name drug, a brand-name drug that is not on the preferred list, or a brand-name drug when a generic is available. You will be provided with a list of the preferred brand-name drugs.

As you will note, your co-payment is lower for generics than for brand-name drugs, for preferred brand-name drugs than for other brand-name drugs, and is higher for a brand-name drug if a generic is available. Thus, if you encourage your doctor to prescribe generic or preferred drugs, you will save money.

Co-Payments. Your co-payments for prescription drugs you obtain at a participating pharmacy will be as follows:

	You Pay:
Generic Drug	20% of the charge with a minimum co-payment of $8.00 and a maximum co-payment of $100.00
Preferred Brand-Name Drug	20% of the charge with a minimum co-payment of $20.00 and a maximum co-payment of $100.00
Non-Preferred Brand Name Drug	20% of the charge with a minimum co-payment of $35.00 and a maximum co-payment of $100.00
Brand-Name Drug if Generic is available	50% of the charge for formulary and non-formulary brand drugs

Please Note: If you obtain prescription drugs at a non-network pharmacy, you will be required to pay for your prescription and submit a claim to the PBM for reimbursement. If your claim

is otherwise payable, you will be reimbursed for the covered cost less the applicable co-payment. The covered cost is the lesser of the amount you actually paid or the amount that would have been charged by a network pharmacy. You may get a claim form from the Plan Office, from your shop steward, or in some circumstances, from your employer.

(3) Mail-Order Benefits. The Plan's prescription drug benefits program contains a mail-order component for long-term maintenance drugs. After you fill two consecutive 30-day prescriptions for long-term maintenance drugs at a retail pharmacy, you are required to use the mail-order benefits program to obtain a 90-day supply of long-term maintenance prescription drugs. Your co-payments will be as follows:

	You Pay:
Generic Drug	13.33% of the charge with a minimum co-payment of $16.00 and a maximum co-payment of $200.00
Preferred Brand Name Drug	13.33% of the charge with a minimum co-payment of $40.00 and a maximum co-payment of $200.00
Non-Preferred Brand Name Drug	13.33% of the charge with a minimum co-payment of $70.00 and a maximum co-payment of $200.00
Brand-Name Drug if Generic is available	50% of the charge for formulary and non-formulary brand drugs

The phone number and other information you need to use the mail-order program is on your prescription card.

(4) Immunizations. The Plan will cover at 100% immunizations recommended by the ACIP or the USPSTF that are administered at Network pharmacies including, but not limited to, poliomyelitis, rubella, mumps, tetanus, pertussis, diphtheria, flu, hepatitis A and B, and human papilloma virus (HPV), when administered in accordance with generally accepted medical guidelines. Travel vaccines are not covered under the pharmacy benefit. In addition, the Plan will cover at 100% the out-of-network administration of COVID-19 vaccinations as recommended by the ACIP or the USPSTF, through the end of the Public Health Emergency.

(5) Special Rules for Certain Antihistamines (Often Used to Treat Allergies). The Plan will treat all non-sedating antihistamines (such as Clarinex) as non-preferred brand name drugs. Thus, you will have a minimum retail co-payment of $35 for each 30-day supply of such non-sedating antihistamines. The Plan will not pay any benefits at all for antihistamines that are over the counter.

(6) Policy Regarding Stolen Medications. The Plan will cover a refill of a non-narcotic prescription with a valid police report stating that the prescription was reported stolen. No refills of narcotic prescriptions will be provided under this policy. One stolen refill per calendar year will be allowed.

(7) Coordination of Drug Benefits. If a person covered under this Plan is also covered by another health plan which provides prescription drug benefits and which, under the coordination of benefits rules set out at Section 8I of this Booklet, pays its benefits before this Plan pays its benefits, that covered person will not be eligible for drug benefits as described here. Rather, that person should submit a claim to the other health plan or use the other health plan's benefits first, and if the other health plan does not pay the cost in full, may submit a paper claim to this Plan for the balance due. See Section 12C of this Booklet which describes the procedures for filing claims.

(8) Drug Co-Pays and Plan Deductibles. The co-pay amounts do not count toward the regular major medical deductibles and co-insurance.

(9) Prior Authorization for Compound Drugs. Prescriptions for compound drugs that cost $375 or more require prior authorization when filled at a retail pharmacy or through a mail-order pharmacy. You or the pharmacy filling your prescription must contact the Pharmacy Benefit

Manager (see Section 14H) to receive prior authorization. If either you or the pharmacy fail to obtain prior authorization for a compound drug prescription with a cost of $375 or more, you will be responsible for the full cost of the compound drug.

b. Specialty Drug Benefits

(1) Generally. The PBM is the Network pharmacy provider for specialty drugs and establishes the allowable cost for specialty drugs based on published standards. If you fill your Specialty Drug prescription from another source, the allowable cost as established by the PBM will be the maximum amount covered by the Plan.

Specialty Drugs means those drugs, therapies, and ancillary items determined by the PBM as having one or more of several key characteristics, including but limited to: indication for the treatment of chronic and or life-threatening disease states; requiring administration by inhalation, infusion, injection, insertion or orally; requiring patient surveillance, counseling, or monitoring in conjunction with use; or requiring special handling in distribution.

(2) Co-Payment and Out-of-Pocket Amounts. Specialty Drugs will be covered under the prescription drug benefit as follows:

- The Plan will pay the first 50% of the cost of the medication filled through the PBM's specialty pharmacy. The PBM will then assist you in applying for any available copay assistance and coupons from pharmaceutical manufacturers and for payment from any other plans.
- If payment from other sources is received, the Plan will pay the remaining cost of the medication after the third-party payments are applied and you will not be required to pay any amount for the drug.
- If no payment is available from other sources, you will be responsible for paying a 20% co-payment up to a maximum of $150.00 per month for each Specialty Drug. There is also a separate annual $3,250.00 maximum for all Specialty Drugs combined. This means that after you have paid $3,250.00 in co-payments for Specialty Drugs during a calendar year, for the rest of the calendar year the Plan will cover 100% of the allowable cost as established by the PBM. Please note, the amounts you pay for Specialty Drugs will not be included in determining whether you have reached the annual out-of-pocket maximum that applies to other Major Medical Benefits under the Plan.

  After you have reached $500,000.00* in Specialty Drug benefits, the co-payment increases to 50% for all Specialty Drug benefits you receive beyond $500,000.00, and the monthly and annual out-of-pocket limits no longer apply.

  *The Plan includes all amounts incurred for Specialty Drugs in calculating the $500,000, regardless of where obtained or administered, except for Specialty Drugs administered at an in-patient facility.
- Coupons, copay assistance, and other forms of financial assistance and any amounts you do not pay do not count toward the Specialty Drug out-of-pocket maximums.
- Certain "limited distribution" drugs may only be purchased from specific pharmacies. The PBM will direct you to the appropriate pharmacy if this applies to your medication. For "limited distribution" specialty drugs purchased from other specialty pharmacies, you will be responsible for paying a 20% co-payment up to a maximum of $150 per month for each Specialty Drug. The limited distribution specialty pharmacy should assist you in applying for any available copay assistance and coupons from pharmaceutical manufacturers.

(3) Special Rules for Cancer Treatments. Specialty drugs used for the treatment of cancer or used to minimize the side effects of cancer treatment are no longer subject to deductibles or co-payments and are not included in determining whether you have reached the specialty drug 50%

co-payment level. However, they are still subject to the PBM's established maximum allowable cost.

If you have any questions regarding your specialty drug benefits, please feel free to contact the PBM or the Fund Office for more information.

c. Exclusions from Prescription Drug Benefit

The following are <u>not</u> covered under the Prescription Drug Benefit:

(1) Any drugs or medicines that are excluded under the limitations and exclusions set forth at Section 8F of this Booklet that apply to all comprehensive major medical benefits;

(2) Drugs or medicines that are taken or administered while the covered individual is a patient in a hospital, skilled nursing facility, convalescent hospital, nursing home, rest home, sanitarium or similar institution. If otherwise covered, charges for such items will be covered as regular major medical expenses subject to the regular deductibles and co-insurance.

(3) Drugs or medicines that are administered or dispensed by the doctor prescribing the drugs or medicine. If otherwise covered, charges for such items will be covered as regular major medical expenses subject to the regular deductibles and co-insurance;

(4) Immunization agents or biological sera, other than as described in Section 8G14 above;

(5) Blood or blood plasma. If otherwise covered, charges for such items will be covered as regular major medical expenses subject to the regular deductibles and co-insurance;

(6) Services or appliances. If otherwise covered, charges for such items will be covered as regular major medical expenses subject to the regular deductibles and co-insurance;

(7) Drugs or medicines prescribed for cosmetic or preventive purposes;

(8) Drugs or medicines for which the covered individual is not required to pay;

(9) Experimental drugs and drugs labeled "Caution – Limited by Federal Law to Investigative Use," even if the covered individual is required to pay for them;

(10) Oral medication for erectile dysfunction, except for four pills each month, subject to your physician's letter of medical necessity. Injections and insertions for erectile dysfunction are limited to four per month, only after unsuccessful use of oral medication for a 60-day period;

(11) Smoking Cessation drugs, except for a 180-day supply no more often than once every 365 days;

(12) Drugs prescribed in connection with dental treatment, with the exception of fluoride treatments as required by the ACA, unless the treatment was covered under the major medical provisions of this Plan;

(13) Appetite suppressants or other drugs for the treatment of overweight or obesity; and

(14) Drugs which may be purchased without a prescription.

2. Temporomandibular Joint Dysfunction

Charges for any diagnosis or treatment of temporomandibular joint dysfunction are subject to deductibles and co-insurance.

3. Preventive Care

The Plan will pay at 100% for preventive care services if provided by a Network Provider. The usual deductible, copays and co-insurance apply if preventive services are provided by a Non-Network Provider with the exception that that the reasonable cost of COVID-19 vaccinations that have been recommended by ACIP or the USPSTF, and the accompanying office visit, will be paid at 100% until such time as determined by the Trustees in accordance with applicable law.

Preventive services are those described in the United States Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the CDC, and HRSA Guidelines, including the American Academy of Pediatrics *Bright Futures* periodicity guidelines, and include the following:

a. Routine Physical examinations, including routine wellness and laboratory tests;

b. Physician's charges for Well Child Care;

c. Well Woman/ Man Care, including:

- breast and pelvic exams;
- routine mammograms; and
- annual PSA test.

d. Inoculations and immunizations including, but not limited to, poliomyelitis, rubella, mumps, tetanus, pertussis, diphtheria, flu, hepatitis A and B, and human papilloma virus (HPV) when administered in accordance with generally accepted medical guidelines.

4. Chiropractic/Manual Manipulation of Spinal Skeletal System

The Plan covers medically necessary outpatient services for the manual manipulation (with or without the application of treatment modalities including but not limited to heat, cold, diathermy and ultrasound) of the spinal skeletal system and/or surrounding tissue rendered by or under the supervision of a Licensed Chiropractor within the scope of his license, or in the presence of a licensed doctor of medicine or osteopathy, physical therapist or occupational therapist. The covered therapy services include but are not limited to skeletal manipulations, x-rays, laboratory tests, ultrasound treatments, hot/cold packs and other medically necessary treatment modalities.

The Plan deductibles and co-insurance are applied to Chiropractic/Manual Manipulation of the Spinal Skeletal System. Chiropractic/Manual Manipulation services are further limited to:

a. One visit per day.

b. No more than 30 visits per year.

5. Replacement of Organs or Tissue

a. Generally

The Plan will treat as covered the Allowable Charges incurred for the organ and tissue transplants and replacements listed in this Section 8G5 and the Allowable Charges incurred for the treatment of complications arising from the listed transplants or replacements. However, as with all treatments, an organ or tissue transplant or replacement will be covered only if it is medically necessary and it is not experimental or investigative in general or with reference to the illness for which the covered individual is being treated.

No organ or tissue replacements or transplants except those listed in subsections b. and c. of this Section 8G5 will be covered.

b. Transplants and Replacements Covered on a Regular Basis

The charges incurred for the following transplants and replacements are covered on the same basis as the charges incurred for any other covered treatments:

(1) cornea transplants;

(2) artery or vein transplants;

(3) joint replacements;

(4) heart valve replacements;

(5) implantation of prosthetic lenses in connection with cataracts; and

(6) prosthetic by-pass or replacement vessels.

c. Transplants and Replacements Subject to Limitations

The charges incurred for the following transplants and replacements are covered on the same basis as the charges incurred for any other covered treatment, **except** the amount the Plan will pay for **any and all** charges related to these procedures, is limited to the maximum per procedure listed in the table below.

The maximum applies to each type of transplant and all charges incurred (except anti-rejection drugs) as a result of the transplant or replacement or complications arising from the transplant or replacement. Transplant donor expenses are included in the transplant maximum.

	Network	**Non-Network**
Transplants	15% Co-insurance after Deductible	Not Covered
Heart	$375,000 Maximum Benefit per Procedure	Not Covered
Lung-Single	$325,000 Maximum Benefit per Procedure	Not Covered
Lung-Double	$400,000 Maximum Benefit per Procedure	Not Covered
Heart/Lung	$575,000 Maximum Benefit per Procedure	Not Covered
Kidney	$185,000 Maximum Benefit per Procedure	Not Covered
Pancreas	$175,000 Maximum Benefit per Procedure	Not Covered
Kidney/Pancreas	$240,000 Maximum Benefit per Procedure	Not Covered
Bone Marrow/Stem Cell-Autologous	$250,000 Maximum Benefit per Procedure	Not Covered
Bone Marrow/Stem Cell-Allogeneic	$265,000 Maximum Benefit per Procedure	Not Covered
Bone Marrow/Stem Cell-Tandem	$285,000 Maximum Benefit per Procedure	Not Covered
Liver	$375,000 Maximum Benefit per Procedure	Not Covered
Three Organ Transplant	$600,000 Maximum Benefit per Procedure	Not Covered
Transplant Donor Expenses	Donor expenses for a live or cadaver donation to a Plan participant are covered in the benefit maximum.	Not Covered
Benefit Limit	Per procedure limit starts 5 days prior to and ends 270 days after the transplant. The benefit limit applies to Phase 3 and Phase 4 transplant charges, including the transplant procedure and post-transplant care. Pharmacy costs are not included in the transplant limit.	Not Covered

d. Special Rules for Transplant Donors

If a transplant procedure is subject to one of the maximums listed in the preceding table, the transplant donor expenses are included in the transplant maximum. Under the Plan, the donation of an organ or tissue by a Covered Individual for transplanting into another person is considered to be an illness of the person receiving the donation. The donation of an organ or tissue by another person

for transplanting into a Covered Individual will be considered an illness of the recipient (Covered Individual). Such donor expenses are subject to all of the rules and limitations that apply to other expenses under the Plan. The Plan will treat as covered the Allowable Charges incurred in the donation and during the 31 days after the donor transplantation, subject to the application of any applicable transplant maximum as discussed above.

6. Physical, Occupational, and Speech Therapies

The Plan will pay for Physical Therapy, Occupational Therapy and Speech Therapy as follows:

a. Physical Therapy

The Plan will pay physical therapy charges for treatment or services rendered by a licensed physical therapist for conditions resulting from an injury or illness which are subject to significant improvement through short-term therapy. The therapy must be in accord with a Physician's exact order as to type, frequency and duration of treatment. Covered expenses do not include therapy provided by a chiropractor, recreational programs, work hardening, maintenance therapy or supplies used in physical therapy. Coverage for physical therapy ordered by a chiropractor is subject to the chiropractic maximums at Section 8G4 of this Booklet.

b. Occupational Therapy

The Plan will pay occupational therapy charges for treatment or services rendered by a registered occupational therapist for conditions resulting from an injury or illness which will improve a body function through short-term therapy. The therapy must be in accord with a Physician's exact order as to type, frequency and duration of treatment. Covered expenses do not include therapy provided by a chiropractor, recreational programs, work hardening, maintenance therapy or supplies used in occupational therapy. Coverage for occupational therapy ordered by a chiropractor is subject to the chiropractic maximums at Section 8G4 of this Booklet.

c. Speech Therapy

The Plan will pay speech therapy charges for services rendered by a physician or licensed speech therapist to restore or rehabilitate speech lost or impaired by illness (other than a functional nervous disorder) or by surgery due to an illness. If the speech loss or impairment is due to a congenital anomaly, any available surgery to correct the anomaly must have been performed prior to the speech therapy in order for the therapy services to be covered.

d. Combined Annual Maximum

The benefits for Physical Therapy, Occupational Therapy and Speech Therapy are combined under one annual limit. The annual benefit for any or all of these therapy services is limited to 60 visits per calendar year.

7. Home Health Care Expenses

You may contact the medical Network Provider for pre-certification of home health care services. Further, you should contact the Plan Office so the Medical Case Manager can review the proposed home health care plan and help insure it is appropriate.

a. Generally

The Allowable Charges for medically necessary home health care services and supplies are covered to the extent they are listed below and meet all of the conditions set out below.

b. Conditions

(1) The charges are for services which are medically necessary for the treatment of a covered individual who is totally disabled and who, in the opinion of the attending physician, would otherwise have been admitted to or kept in a hospital or skilled nursing facility; provided:

(a) the covered individual is under the direct care of a legally qualified physician,

(b) the plan of treatment for the home health care is established in writing by the attending physician prior to the commencement of such treatment,

(c) the plan of treatment for home health care is certified by the attending physician at least once every month, and

(d) the covered individual is examined by the attending physician at least once every 60 days.

(2) Further, such charges are covered only if they are for services which are provided by a home health agency which is an agency or organization meeting the following requirements:

(a) it is primarily engaged in and is federally certified, if required, as a Home Health Agency and is duly licensed, if such licensing is required, by the appropriate licensing authority to provide nursing and other therapeutic services (as listed in c below);

(b) its professional service policies are established by a professional group associated with such agency or organization, including at least one legally qualified physician and at least one registered nurse, to govern the services it provides;

(c) it provides for full-time supervision of such services by a legally qualified physician or by a registered nurse;

(d) it maintains a complete medical record of each patient; and

(e) it has an administrator.

c. Covered Charges

Provided the above conditions are met, charges which are incurred for one or more of the following are covered as home health care expenses:

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

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

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

(4) social work, performed by a licensed social worker, if licensing is required by the state in which the social work is performed (if licensing is not required by the state, the social worker must have at least a Master's degree in social work with at least one year of clinical social work experience);

(5) nutrition services performed by a licensed nutritionist, if licensing is required by the state in which the nutrition services are performed; and

(6) special meals.

The normal co-insurance and deductibles will be applied to covered charges for covered home health care services.

Note: The maximum payment per visit is $40. (Each time a representative of a home health care agency comes to your home is a visit. In addition, each four hours of service rendered by a home health care agency representative will be treated as a separate visit.) Covered charges are subject to the normal deductible and co-insurance.

Note: If services are performed by a registered nurse and those services performed can only be performed by a registered nurse, the covered charges will be the Allowable Charges for such services.

8. Hospice Care Expenses

You may contact the medical Network Provider for pre-certification of hospice services.

a. Definition of Hospice

A "Hospice" is an agency that provides counseling and medical services and may provide room and board to terminally ill patients and which meets the following tests:

(1) It has obtained any required state or governmental certificate of need approval and any required licenses;

(2) It provides service 24 hours each day, seven days each week;

(3) It is under direct supervision of a doctor, has a nurse coordinator who is a registered nurse, has a social service coordinator who is licensed and has a full-time administrator;

(4) It has as its primary purpose the provision of hospice services; and

(5) It maintains written records of services provided to patients.

b. Covered Charges

The Allowable Charges for the Hospice services listed below will be covered if the covered individual's doctor certifies the individual is terminally ill and expected to live no longer than six months, and if the services are rendered in a Hospice or in the covered individual's home.

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

(2) Services and supplies furnished by the hospice while the individual is covered;

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

(4) Home health aide services;

(5) Nutrition service and special meals.

The normal co-insurance and deductibles will apply to the covered charges for covered hospice services.

In addition, 50% of the cost of up to 15 visits per family for counseling services by a licensed social worker or licensed pastoral counselor for the covered individual's spouse and children and the covered individual's parents, if the covered individual is a child, will be covered provided such services are furnished within six months after the covered individual's death.

9. Pregnancy-Related Expenses

Medical expenses arising in connection with pregnancy are covered as for any other illness with respect to the covered employee, the covered spouse of a covered employee, and the dependent child of a covered employee.

10. Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital stay in connection with childbirth for the mother or child to less than 48 hours in connection with a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact the Plan Office.

11. Reconstructive Surgery Following Mastectomy

Pursuant to federal law, if you or a dependent is receiving benefits for a mastectomy and elect to have reconstruction, the Plan will treat as covered the Allowable Charges of medical and surgical treatment in connection with that reconstruction. The Plan will provide coverage for:

- Reconstruction of the removed breast;
- Surgery and reconstruction of the other breast to produce symmetrical appearance;
- A prosthesis;
- All physical complications, including lymphedemas, at all stages of mastectomy.

The appropriate treatment will be determined in consultation with the covered person and her doctor.

12. Treatment of Mental Health Issues and Substance Use Disorder

As with most covered services, only medically necessary treatments of mental health issues or Substance Use Disorder are covered. In addition, benefits for treatment of mental health issues or Substance Use Disorder are subject to the Plan's co-payments, co-insurance and deductible provisions.

13. Bariatric Surgery Benefit

Bariatric surgery is a surgical procedure for treatment of morbidly obese patients. Morbid Obesity is defined as being 100 pounds over your ideal body weight which would be equivalent to a body mass index of 40 or greater. Bariatrics is the branch of medicine that deals with the causes, prevention and treatment of obesity.

a. Conditions Required for the Procedure to be Eligible as a Covered Expense

In order for bariatric surgery to be determined as an eligible expense, the following conditions must be met.

If your bariatric surgeon recommends bariatric surgery, he or she will prepare a letter to obtain preauthorization from the Plan. The goal of this letter is to establish the medical necessity of bariatric surgery and gain approval for the procedure. The Plan has adopted the following minimum requirements to be met before authorizing bariatric surgery:

(1) The specific type of bariatric surgery procedure has been determined to be appropriate for the treatment of morbid obesity by the Centers for Medicare and Medicaid Services; and

(2) The patient is greater than 100 pounds overweight or 100% over his or her ideal body weight; and

(3) The patient is at least 18 years of age and has completed bone growth; and

(4) The patient has a body-mass index (BMI) of at least 40; and

(5) The patient is being treated by his or her physician for at least one of the following complicating conditions: Diabetes, Hypertension, Cardiovascular Disease, Pulmonary/Respiratory Disease or Degenerative Joint Disease; and

(6) The patient has been on a documented medically supervised diet and exercise program for at least one year immediately preceding the request for the procedure without successful weight loss (this requirement will not apply to any person weighing in excess of 500 pounds); and

(7) No surgical procedure will be authorized without the evaluation and approval of the Fund Office; and

(8) The type of bariatric procedure must be performed by a Medicare-approved facility.

b. Recommendations for Patients Seeking Pre-Authorization of Bariatric Surgery

Keep track of every visit you make to a healthcare professional for obesity-related issues or visits to supervised weight loss programs. Make note of other weight loss attempts made through diet centers and fitness club memberships. Keep good records, including receipts.

c. Payment of Charges

If all of the above conditions are met, the Plan will pay for 60% of the charges at an approved facility and Network Provider. These charges are excluded from the annual out-of-pocket maximum and are subject to a lifetime maximum of $50,000, including any charges incurred as a result of complications from the procedure. The Plan will not pay any charges incurred at an unapproved facility or Non-Network Provider.

14. Treatment of Erectile Dysfunction

Prior to receiving benefits for Erectile Dysfunction, you must meet the following medical necessity criteria:

a. Conditions Required for the Treatment to be Covered

(1) Be under current treatment for at least one of the following medical conditions: diabetes, metabolic syndrome, neurological disease, kidney disease, multiple sclerosis, Parkinson's disease, hormonal disorder, atherosclerosis, heart or vascular disease, depression, morbid obesity, or

(2) Have sustained a traumatic pelvic or spinal cord injury, or

(3) Have undergone surgery or treatment for prostate, bladder or certain other cancers, or

(4) Be taking certain prescription medications with side effects or interactions that cause Erectile Dysfunction.

b. Treatment Options

(1) Oral Medications – maximum of four doses per month in accordance with the Plan's formulary.

(2) Injected or Inserted Medications – a maximum of four injections or insertions per month, only after unsuccessful use of oral medication for a 60-day period.

The Plan will <u>not</u> provide coverage for external devices or vascular surgery to correct blockage of blood flow to the penis.

c. Penile Implants

The treatment of Erectile Dysfunction by means of a penile implant is covered by the Plan only under the following conditions:

(1) The benefit is payable only when services are provided by Network Providers,

(2) The treatment is determined to be medically necessary and is pre-certified by the Plan, and

The maximum benefit amount for the procedure is $21,000. This includes follow-up and post-operative visits and services, including medically necessary removal of the implant, if they occur within 90 days of the procedure. Medically necessary services, including removal of the implant, which occur after 90 days following the procedure are not subject to the maximum benefit amount and will be covered under the standard medical benefits of this Plan.

15. Ambulance Benefit

All Non-Network ambulance charges are to be reimbursed at the Network level. There is a $30,000 benefit maximum per incident. An incident is an accident, an episode of illness or a similar event requiring care or treatment that is covered by the Plan. Charges are limited to Allowable Charges.

16. Hearing Aids

The Plan covers the cost of one hearing aid per ear during a five (5) year period up to a maximum benefit of $2,000 for both ears (regardless of whether purchased individually or in a pair). The limitation of one hearing aid per ear per five (5) year period does not apply to hearing aids for newborns.

17. COVID-19

Effective March 18, 2020 and until such time as determined by the Trustees in accordance with applicable law, COVID-19 testing performed by Network and Non-Network Providers shall be covered at 100% with no co-pay and no deductible as long as such testing is:

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

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

H. Coordination of Benefits Under this Plan with Other Coverage

1. Medicare Benefits

This Plan will pay as the Primary Plan (as defined below) for all active employees of contributing employers and the eligible dependents of such active employees regardless of the age of such active employees and their dependents.

For all other individuals entitled to Medicare, this Plan will be the Secondary Plan (as defined below) and Medicare will be primary. **Further, to the extent you or your dependent is eligible to enroll in Medicare, this Plan will adjudicate its claims as if you are covered by both Medicare Parts A and B**. This means that even if you choose not to enroll in Medicare A or choose not to pay for Medicare Part B, the Plan will pay only what it would pay if you had chosen both parts of Medicare.

There are special coordination rules for individuals who have end stage renal disease. Generally, if an individual first becomes eligible for Medicare by virtue of having end stage renal disease, this Plan will be primary for the first 30 months of the individual's Medicare eligibility. Thereafter, Medicare becomes primary.

2. Coordination of Benefits Generally

a. Benefits Subject to this Provision

All comprehensive major medical benefits provided under this Plan are subject to this provision.

b. Effect on Benefits

Coordination of Benefits (COB) means that the benefits provided by this Plan will be coordinated with the benefits provided by any other plans covering the individual for whom claim is made. If this Plan is a Secondary Plan, the benefits payable under this Plan may be reduced, so that a covered individual's total payment from all plans will not exceed 100% of the total Eligible Expenses. This Plan will pay the individual's out-of-pocket costs, not to exceed this Plan's regular benefits if greater.

c. Primary and Secondary Plan

"Primary Plan" means the Plan which pays benefits or provides services first under the Order of Benefit Determination Rules below. The Primary Plan does not reduce its benefits because of duplicate coverage.

"Secondary Plan" means any Plan which provides coverage for the individual for whom claim is made and which is not a Primary Plan.

d. Eligible Expense

"Eligible Expense" means any necessary, Allowable Charge which is covered, in whole or in part, under one or more plans covering the individual for whom claim is made.

If benefits under the Primary Plan are reduced because the covered individual does not comply with the Primary Plan's rules regarding pre-certification or second surgical opinions or because the covered person did not use a Network Provider under the Primary Plan, the amount by which the benefits are reduced is not an eligible expense under any of the plans. If the primary plan is a closed panel plan (meaning only services provided by specific providers are covered) and the covered person uses a non-panel provider, the secondary plan will pay as primary, unless use of a non-panel provider is paid for or provided for under the closed panel plan.

If a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an Eligible Expense and a benefit paid.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Eligible Expense under the above definition unless the private room is medically necessary.

e. Claim Determination Period

"Claim Determination Period" is the period of time during which Eligible Expenses are compared with total benefits payable to determine how much each Plan will pay. The Claim Determination Period is a calendar year.

f. Plans Considered for COB

A "plan" is any arrangement which provides medical coverage for the individual for whom a claim is made and with which coordination is allowed. The definition of plan in a contract or description of benefits must state the types of coverage that will be considered in applying the COB provisions of that contract or plan of benefits. The right to include a type of coverage is limited by the rest of this definition. Separate parts of the plan for members of a group that are provided through separate contracts or arrangements that are intended to be part of a coordinated package of benefits are considered one plan, and there is no coordination with the separate parts of the plan. For example, if an employer-provided plan of medical benefits is made up of a base plan or contract and a major medical plan or contract, this Plan will treat those two components as a single coordinated plan for purposes of these COB rules.

COB applies to the following plans:

(1) Group insurance or individually purchased health insurance or other medical benefits plans;

(2) Other arrangements, whether insured or uninsured, covering medical expenses of individuals in a group;

(3) Plans designed to pay a fixed-dollar benefit per day while the individual is hospital confined, but which, at the time of claim, allow the individual to elect an alternate benefit. COB will be applied only to the portion of the daily benefit which exceeds $100 per day.

(4) Blue Cross and Blue Shield plans;

(5) Plans of other hospital or medical service organizations;

(6) Group practice plans;

(7) Pre-payment plans;

(8) Coverage under Federal Government plans or programs, including Medicare;

(9) Coverage required or provided by law. COB will not apply to state programs which provide benefits for individuals unable to pay for their care;

(10) Individual no-fault auto insurance, by whatever name called;

(11) Medical payments coverage under any auto or property insurance policy;

(12) HRA, FSA, or HSA as defined in Section 2 Definitions.

Note: This Plan is always a Secondary Plan to benefits provided under any mandatory No-Fault Auto Insurance Act in the state in which the covered individual resides.

g. Order of Benefit Determination

Any plan which does not have a COB or similar provision and any plan that provides it is always secondary will pay its benefits first.

When all plans involved contain COB or similar provisions, the first of the following rules that describes the situation determines the order in which the plans pay their benefits.

(1) Non-Dependent or Dependent

The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree, is primary, and the plan that covers the person as a dependent is secondary.

However, when a person is covered as the dependent of his or her spouse who is actively employed and is also covered as a retiree or former employee, the Medicare statute and regulations provide that Medicare is primary to the plan that covers the person as other than a dependent and secondary to the plan that covers the person as a dependent. In such circumstances, the plan that covers the person as a dependent pays first, Medicare pays second, and the plan that covers the person as other than a dependent pays last.

(2) Child Covered Under More Than One Plan

(a) The primary plan is the plan of the parent whose birthday is earlier in the calendar year if:

(i) The parents are married;

(ii) The parents are not separated (whether or not they ever have been married); or

(iii) A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

(b) If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

(c) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary. This subparagraph shall not apply with respect to any claim determination period or plan year during which benefits are paid or provided before the entity has actual knowledge.

(d) If the parents are separated (whether or not they were ever married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents' spouse (if any) is:

(i) The plan of the custodial parent;

(ii) The plan of the spouse of the custodial parent;

(iii) The plan of the non-custodial parent; and then

(iv) The plan of the spouse of the non-custodial parent.

(3) Active or Inactive Employee

The plan that covers a person as an employee who is neither laid off nor retired (or that employee's dependent) is primary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of that individual's spouse as an active worker will be determined under Subsection g(1).

(4) Spouse or Child

The plan that covers a person as the Spouse of an active employee pays before the plan that covers the person as a Dependent Child of an active employee.

(5) Continuation Coverage

If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary.

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

(6) Longer or Shorter Length of Coverage

If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is primary.

(a) To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the covered person was eligible under the second within twenty-four (24) hours after the first ended.

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

(i) A change in the amount or scope of a plan's benefits;

(ii) A change in the entity that pays, provides or administers the plan's benefits; or

(iii) A change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

(c) The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

(7) If none of the preceding rules determines the primary plan, the allowable expenses shall be shared equally between the plans.

h. Operation of COB

In order to make this COB provision work properly:

(1) Upon request, the covered individual is required to furnish to the Plan complete information concerning all plans which cover the individual for whom claim is made.

(2) As permitted by law, the Plan may, without the covered individual's consent:

(a) Obtain information from all plans which may cover the individual; and

(b) Release to such other plans any information it has with respect to any individual.

(3) If payments which should have been made by this Plan have been made under any other plans, this Plan may reimburse such other plans to the extent necessary to make this provision work. Any such payment will be a benefit paid under this Plan.

(4) If this Plan has paid benefits which result in payment in excess of the amount necessary under this Plan to make this provision work, this Plan has the right to recover such excess payments from:

(a) any person;

(b) any insurance company; or

(c) any other organization

to or for or with respect to whom such payments were made.

i. Prescription Drug COB

If with respect to a covered individual, another health plan pays first under these COB rules, that person may not obtain prescription drugs under this Plan's drug card program or mail order program. Rather, that person should claim benefits for prescription drugs or obtain prescription drugs under the other plan first, and then submit a claim to this Plan for any amounts not paid by the other plan. See Section 12C of this Booklet for information on how to file a claim when another plan pays first.

j. Special Rules for Plans that Attempt to Shift Liability

(1) When a Primary Plan is a group health plan containing a sub plan/no loss provision, this Plan will not pay as the Secondary Plan until the Primary Plan has exhausted its benefits under any no loss or similar provisions.

(2) If another plan is primary under this Plan's rules, and it contains a provision that has the effect of capping its benefits for an individual covered under this Plan and of shifting coverage liability to this Plan in a manner designed to avoid the usual operation of this Plan's coordination of benefits rules, this Plan shall not be liable to provide benefits until the other plan provides its customary benefits as the Primary Plan with regard to such cap.

(3) As indicated above in f. "Plans Considered for COB," the definition of plan includes one with separate contracts or arrangements that are intended to be part of a package of benefits. If more than one carrier or entity provides benefits under such a plan with component parts, this Plan will not deal separately with multiple carriers or entities; rather, those multiple carriers or entities will be required to select one of their number to comply with these coordination of benefits rules on behalf of all of the carriers or entities that provide any part of the benefits that has separate components.

I. Gender-Neutral Coverage.

In making coverage decisions, the Plan does not consider the gender of the individual seeking benefits.

SECTION 9. PLAN'S RIGHTS TO SUBROGATION AND REIMBURSEMENT*

A. Generally

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

B. Definitions

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

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

C. Plan's Right to Reimbursement

If this Plan pays out benefits to or on behalf of a covered person in connection with an illness or an injury for which a third party may be responsible, such benefits are paid on the express condition that the covered person (and his or her dependents, to the extent the dependents recover damages in connection with the injury or illness to the covered person) must reimburse the Plan for the benefits it paid out from any amount the covered person (or his or her dependents) recovers from any third party or parties.

The description or characterization of any recovery from any third party does not affect the Plan's right to reimbursement. By accepting benefits from the Plan, the covered person and his or her dependents acknowledge the Plan's right to reimbursement and agree to make such reimbursement and agree to hold any recovery received from a third party in trust for the Plan, to the extent of the amount of benefits the Plan paid out in connection with that injury or illness. The covered person and his or her dependents must reimburse the Plan in full from any recovery from any third party or parties for benefits the Plan paid in connection with the injury or illness before any other amounts are deducted from the recovery paid by the third party or parties. However, the Plan's reimbursement may be reduced by its proportionate share of the attorney's fees and costs incurred by the covered person (or his or her dependents) in connection with the recovery, but in no event will the Plan's reimbursement be reduced by more than one-third for fees and costs.

D. Plan's Right to Subrogation

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

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

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* **Please Note**: This Section does not apply to work-related injuries other than in the situation described in Section 8F26. Other than as set forth in Section 8F26, the Plan does not pay medical expenses associated with work-related injuries.

caused by another person and the Plan pays out benefits for the treatment of your injury, the Plan could, on its own, sue the person who caused the accident or, if you sued that person, the Plan could join in your lawsuit.

The amount of the Plan's subrogation interest is equal to the amount it paid out in connection with the injury or illness, plus the attorney's fees and costs it incurs in pursuing the claim against the third party or parties.

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

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

E. Covered Person's Responsibilities

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

1. Notify the Plan when he or she suffers an injury or illness for which a third party may be required to compensate the covered person;
2. Provide the Plan with any and all documents and information regarding the injury or illness the Plan may request;
3. Execute an agreement setting forth the Plan's rights and the covered person's obligations and the obligations of his or her dependents under these subrogation and reimbursement provisions. If the covered person is represented by an attorney, that attorney must also sign the subrogation agreement;
4. Provide the Plan with notice if the covered person asserts a claim or claims against any third party and keep the Plan informed as to the status of such claim or claims;
5. Notify the Plan or its designee prior to settling any claim to which this Plan is subrogated;
6. Notify the Plan of any compensation the covered person or his or her dependents receive from any third party in connection with the injury or illness and immediately reimburse the Plan for the benefits it paid out from such compensation from the third party or parties upon receipt of such compensation;
7. Cooperate fully with the Plan in its efforts to protect and exercise its rights to subrogation and reimbursement; and
8. Take no actions to compromise or impair the Plan's rights to reimbursement or subrogation.

If the covered person or his or her dependents fail to comply with these obligations, the Plan will not pay out benefits in connection with that injury or illness. If the covered person or his or her dependents fail to reimburse the Plan for the benefits it paid out from any recovery they receive from the third party or parties as required, the Plan may withhold future benefits due the covered person and his or her covered family members or may take any other such action necessary to enforce the Plan's right to reimbursement.

F. Rejection of "Make-Whole" Doctrine

This Plan specifically rejects the "make-whole" doctrine. The Plan's rights to reimbursement and subrogation do not depend on whether the covered person or his or her spouse recovers from third parties monies sufficient to fully compensate the covered person or his or her dependents for their losses.

G. Plan's Enforcement of These Provisions

In the event the covered person or his or her dependents fail to fulfill his or her obligations under these reimbursement and subrogation provisions, the Plan may take any action the Trustees deem necessary to enforce the Plan's rights under these provisions. The Plan may refuse to pay benefits in connection with the injury or illness if the covered person or his or her dependents fail to fulfill his or her obligation to provide information and documents or fails to execute the required reimbursement and subrogation agreement. If the

Plan does pay benefits and the covered person or his or her dependents later fails to fulfill his or her duties, the Plan may withhold future benefits from the covered person and his or her family members, may bring an action against the covered person and his or her dependents, or may recoup amounts it paid out from the providers to whom such amounts were paid or any other sources. Should the Trustees bring legal action to enforce the Plan's rights under these reimbursement and subrogation provisions, and succeed in whole or in part in such action, the covered person or his or her dependents shall pay the legal fees and costs the Trustees incur in that action.

Challenges and/or enforcement of this provision and of any executed reimbursement agreement relate to an employee benefit plan and must be brought exclusively in accordance with the provisions of ERISA in the federal courts of the United States. State laws relating to liens, subrogation, and reimbursement are not applicable.

H. Future Claims Relating to the Same Injury or Illness

Once the covered person's claims against the third party or parties are resolved, the Plan will not pay out any additional benefits in connection with the injury or illness caused by the third party until the total claims that would otherwise be covered under the Plan exceed the total amount of compensation paid to or on behalf of the covered person and his or her spouse by the third party or parties. In such a situation only the excess portion of the otherwise covered claims will be treated as covered.

SECTION 10. ENROLLMENT AND CLAIMS REQUIREMENTS

A. Enrollment and Updates

You must complete an individual enrollment form in order to activate your and your dependents' eligibility for benefits, including a newly acquired dependent. You may obtain the enrollment form from the Welfare Plan Office, your employer or shop steward. Return the completed form to your employer who will forward it to the Welfare Plan Office.

As indicated above in Section 3 of this Booklet, in order to enroll your dependents, you may be required to furnish proof of their status as eligible dependents. If you have any questions about your dependents' eligibility, please contact the Welfare Plan Office.

You will also be required to complete a Member Information Update Form updating information about yourself and your eligible dependents. The Welfare Plan Office will make these forms available to you. Benefits will not be paid until the Plan Office has received the Member Information Update Form.

Your failure to promptly complete and submit a required form can cause the delay of benefits. Further, if you fail to provide a required form within the time limit for filing a particular claim, that claim will not be covered.

Children will also be enrolled as required by any qualified medical child support order on the date the Welfare Plan Office receives such an order. (See definition of a qualified medical child support order in Section 2 of this Booklet). If you would like information about the Plan's procedures for processing a QMCSO, call the Welfare Plan Office.

B. Filing of Claims and Supporting Documentation

1. Generally

a. Member Information Update Form

You may obtain any necessary Member Information Update forms from the Welfare Plan Office, your employer or your shop steward.

b. Time for Submission of Claims

Claim and appeal procedures for life and accidental death and dismemberment benefits are described in the Certificate of Coverage issued by The Guardian Life Insurance Company.

You must submit a claim for any other benefits within one year after the loss for which benefits are claimed or within one year after you incur the expense for which benefits are claimed. The claim should be accompanied by all supporting documentation. No claim for any benefits will be considered if it is received by the Welfare Plan Office more than one year after the loss for which benefits are claimed.

A claim is considered submitted when the appropriate claims administrator receives the required documents.

2. Weekly Disability Benefits

You may obtain the claim form for weekly income benefits from the Welfare Plan Office, your employer or your shop steward or from the website www.d9trusts.org. **The form must be completed by you, your employer, and your physician and must be returned to the Welfare Plan Office. The completed claim form must be submitted no later than one year after the disability commences. The completed claim form should be accompanied by all supporting documentation.**

3. Comprehensive Major Medical Benefits

a. Medical Benefits

Generally, you will not be required to submit a claim for medical benefits. Your doctor, hospital or other provider will forward the bills to the medical Network Provider or to the Welfare Plan Office. Receipt of such bills will be regarded as receipt of a claim. In some circumstances, the Welfare

Plan Office will contact you for additional information. You should provide any such information as soon as possible after requested.

b. Prescription Drug Benefits

In order to file a claim for reimbursement for amounts you have paid for prescription drugs, you should obtain a prescription drug claim form from the Plan Office, your employer or your shop steward. You must complete the prescription drug claim form and send it, along with the pharmacy prescription receipt or the itemized pharmacy billing statement, to the Welfare Plan Office. You should use this procedure when for any reason you have not used the drug card or mail-order service or when you believe the amount you were required to pay when using the drug card or mail-order service was in excess of the amounts set out in this Booklet, or if you are denied a drug by a network pharmacy or the mail-order service. You may obtain Prescription Drug Claim Forms on our website www.d9trusts.org.

All claims for comprehensive major medical benefits must be submitted within one year from the date you received the service or supply for which claim is being made. The claim should be accompanied by all completed documentation. If the Plan Office does not receive the claim and all documentation necessary for the Plan to decide the claim within this one-year period, the claim will be denied as untimely. The required documentation includes: itemized bills; paid receipts if you are seeking reimbursement; the original enrollment forms and annual updates reflecting the individual in question is covered; EOB's from primary plan, if any; subrogation and reimbursement questionnaire and agreement; and any other documents and information requested by the Plan Office.

4. Additional Information or Examination May be Required

The Welfare Plan Trustees and Life Insurance carrier reserve the right and opportunity to require the submission of additional information regarding a claim for benefits and reserve the right to examine the person whose illness is the basis of a claim as often as necessary during the duration of the condition for which a claim is made.

C. Payment of Claims

1. Generally

The benefits payable on account of your death will be paid to your beneficiary. Accidental death benefits will be paid to the beneficiary you designate, and dismemberment benefits will be paid to you. Benefits payable on account of the death of a dependent will be paid to you. Weekly disability benefits will be paid directly to you. Medical benefits will be paid directly to the doctor, hospital or other provider who provided the services unless you prove you paid the provider, in which case the reimbursement will be made to you or to the person indicated in a QMCSO or applicable law governing the payment of benefits.

The Trustees reserve the right to allocate the deductible amounts to any eligible charges and to apportion the benefits to you and any assignees.

2. Plan's Right to Recover Overpayments or Mistaken Payments

If a payment for a claim filed by or for you or one of your dependents is found to be more than the amounts payable under the terms of the Plan or is found to have been made in error, then a refund of the excess of the erroneous payment may be requested. If a requested refund is not paid or if none is requested, the Trustees of the Welfare Trust may take whatever action they deem necessary to recover the overpaid or mistakenly paid amounts, including, but not limited to, reducing benefits payable for future claims filed by or for you or your dependents to offset the overpaid or mistakenly paid amounts or bringing a legal action against you to collect the overpayment. If it is necessary for the Trustees to institute legal proceedings to collect an overpayment and they prevail, you will be responsible for paying the reasonable attorney's fees and costs they incur in connection with such action.

SECTION 11. CLAIMS REVIEW AND APPEAL PROCEDURES

A. Death and Accidental Death and Dismemberment Benefits

Claim and appeal procedures for life and accidental death and dismemberment benefits are described in the Certificate of Coverage issued by The Guardian Life Insurance Company.

B. Disability Benefits – Weekly Income and Extensions of Coverage

1. Initial Decision

The Plan will evaluate and make a decision with respect to a claim for a disability benefit within 45 days after you submit such a claim. This 45-day limit may be extended twice by up to 30 days each time. The Plan will, prior to the expiration of the original 45-day period, or first 30-day extension, notify you of the reason for the delay and the date by which a decision can be expected. The Plan will also explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision, and the additional information needed to resolve the claim. You will be given 45 days to provide such additional information. (The Plan's time limits are tolled while the Plan is waiting for you to provide additional information.)

If your claim is denied, you will be provided a written notice that includes:

i. the specific reason for the denial;
ii. the specific Plan provisions upon which the denial is based;
iii. a description of any additional material or information necessary for you to perfect a claim;
iv. a description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse determination on appeal;
v. an explanation of the Plan's basis for disagreeing with or not following: 1) the views presented by you to the Plan of the health care and/or vocational professionals who treated or evaluated you; 2) the views of medical or vocational experts whose advice was obtained by the Plan in connection with your claim for benefits, without regard to whether the advice was relied upon by the Plan; and 3) a disability determination by the Social Security Administration regarding you;
vi. a copy of the Plan's specific rules, guidelines or protocols, standards or other similar criteria that were relied upon in making the adverse benefit determination or a statement that such rules, guidelines or protocols, standards or other similar criteria do not exist;
vii. if the decision was based on a determination of medical necessity or an exclusion for experimental treatment or similar exclusion, a statement that an explanation of the scientific or clinical judgment for the decision will be provided free of charge upon request; and
viii. 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 for benefits.

2. Appeal

You may appeal from the denial of a claim for a disability benefit within 180 days after you are notified of the denial. To appeal, you should write to:

Board of Trustees
District No. 9, I.A.M.A.W. Welfare Trust
12365 St. Charles Rock Road
Bridgeton, Missouri 63044

You may include any comments, documents or information you wish. The Plan will provide to you, free of charge, upon your request, copies of all documents, records and other information relevant to your claim.

The Board of Trustees will review all comments, documents, records and other information you submit with your original claim or with your appeal. The Trustees will not afford deference to the initial adverse benefit determination. If the original denial was based in whole or in part on a medical judgment, the Trustees will consult with a health care professional who has appropriate training and experience in the relevant field of

medicine and who is not the same expert or the subordinate of any expert the Plan consulted in connection with the original denial. The Trustees will identify upon request the identity of any medical or vocational experts consulted in connection with their determination.

If the Trustees on appeal will rely on new or additional evidence or on new or additional rationales in issuing an adverse determination on appeal, the Trustees will notify you sufficiently in advance of their determination on appeal to allow you a reasonable opportunity to respond.

The Trustees will review and decide your appeal no later than the date of the next regularly scheduled meeting of the Board of Trustees following their receipt of your appeal, unless your appeal is received within 30 days of that meeting. In such case, the Trustees will decide no later than the date of the second meeting following receipt of your appeal. If special circumstances require further time, the Trustees will notify you prior to the commencement of the extension of the need for such extension, the reasons for the extension and the date as of which a decision will be made. In such case, the Trustees will decide no later than the third meeting following the Trustees' receipt of the appeal.

You will be notified, in writing, of the Trustees' decision not later than five days after they make it. If the decision is adverse to you, the notice will include the same categories of information set forth in Section 13B1, above, except for Section 13B1c. In addition, the written notice will describe any contractual limitations period that applies to your right to bring a civil action under Section 502(a) of ERISA, including the calendar date on which such right will expire and will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office."

C. Medical Benefits

1. Initial Decision

All medical benefits will be paid as soon as administratively possible. You will be notified of an initial decision within certain timeframes, which differ for the different types of claims as described in the following paragraphs:

a. Urgent Care Claim

A medical benefit claim is considered an urgent care claim if the application of the time periods for making a non-urgent care claim determination could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim.

If your medical benefit claim is an urgent care claim, you will be notified of the benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim, 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, you will be notified as soon as possible, but not later than 24 hours after receipt of the urgent care claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by you. You will be afforded a reasonable amount of time, taking the circumstances into account, but not less than 48 hours, to provide the specified information.

You will be notified of the determination as soon as possible, but in no case later than 48 hours after the earlier of (1) receipt of the specified additional information, or (2) the end of the period afforded you to provide the specified additional information.

b. Concurrent Care Claim

If the Plan has approved a concurrent or ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse benefit determination. In such a case, you will be notified of the adverse benefit determination 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 reduction or termination of the benefit.

If you request an extension to a previously approved concurrent or ongoing course of treatment involving an urgent care claim beyond the approved period of time or number of treatments, your request shall be decided as soon as possible, taking into account the medical exigencies. You will be notified of the benefit determination within 24 hours after receipt of the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

c. Request for Prior Authorization or Other Pre-Service Medical Benefit Claim

A medical benefit claim is considered a request for prior authorization or other pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the benefit in question.

In the case of a request for prior authorization of a medical benefit or other pre-service medical benefit claim, the Plan will notify you of the benefit determination within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim. If, due to matters beyond the control of the Plan, the Plan needs additional time to process the claim, the time for notifying you of the benefit determination may be extended for up to 15 days, provided that within 15 days after the Plan receives the claim, the Plan notifies you of those special circumstances and when it expects to make its decision. However, if such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and you will be afforded at least 45 days from receipt of the notice to provide the specified information.

d. Post-Service Benefit Claim

A benefit claim is considered a post-service claim if it is a request for payment of services which you have already received.

In the case of a post-service benefit claim, the Plan will notify you of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Plan needs additional time to process the claim, the Plan may extend the time for notifying you of its benefit determination on a one-time basis for up to 15 days, provided that within 30 days after the Plan receives the claim, it notifies you of those special circumstances and the date by which it expects to make a decision. However, if such a decision is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days from receipt of the notice to provide the specified information.

e. Calculation of Time Periods

For purposes of these time periods relating to the Plan's initial benefit determination, the period of time during which an initial benefit determination is required to be made begins at the time a claim is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to your failure to submit all information necessary, the period for making the determination is "frozen" from the date the notification is sent to the you until the date you respond to the request for additional information.

f. Manner and Content of Denial of Initial Benefit Claims

If the Plan makes an adverse benefit determination, it must provide to you, in writing or by electronic communication, a notice that includes:

i. the specific reason(s) for the adverse benefit determination, including the denial code and its corresponding meaning;

ii. reference to the specific Plan provision(s) on which the adverse benefit determination is based;

iii. information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable). The diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning are also available upon request;

iv. a description of any additional information or material that you must provide in order to perfect the claim, and an explanation of why the additional material or information is necessary;

v. a description of the Plan's internal and external review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under a federal law called "ERISA" following any denial on review of the initial denial;

vi. if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, and that a copy of such rule, guideline, protocol or other similar criterion will be provided to you upon request and without charge;

vii. if the adverse benefit determination is based on the Medical Necessity standard, that the treatment is Experimental or Investigational, or a similar exclusion or limit, either: (i) an explanation of the scientific or clinical judgment applying the exclusion or limit to your medical circumstances; or (ii) a statement that such an explanation will be provided to you upon request and without charge;

viii. 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 for benefits;

ix. in the case of an adverse benefit determination concerning an urgent care claim, a description of the expedited review process applicable to such claim; and

x. contact information for any applicable office of health insurance consumer assistance or ombudsman established under Public Health Services Act Section 2793 to assist individuals with the internal claims and appeals and external review processes.

NOTE: With regard to an urgent care claim, the information described in this subsection may be provided to you orally within the permitted time frame, provided that a written or electronic notification in accordance with this subsection is furnished to you no later than 3 days after the oral notification.

2. Appeal

a. Filing an Appeal

If your claim is denied or you disagree with the amount of the benefit, you have the right to have the initial decision reviewed. You must follow the appeals procedure before you file a lawsuit under ERISA, the federal law governing employee benefits. The procedure for filing an appeal will be described in the EOB and is described below.

All requests for review of initially denied urgent care claims, concurrent care claims, and prior authorization or other pre-service claims (including all relevant information) must be submitted to the Fund Office. All requests for review of initially denied post-service claims (including all relevant information) must be submitted to the Board of Trustees at the following address:

Board of Trustees
District No. 9, I.A.M.A.W. Welfare Trust
12365 St. Charles Rock Road
Bridgeton, Missouri 63044

Written appeals must be filed within 180 days from the date of the decision. If a claim is denied and an appeal is not requested within 180 days from the date you were notified of the denial of your claim, the denial of the claim will be final.

For urgent care claims, your appeal may be made orally by calling the Fund Office at (314) 739-6442.

When filing or appealing a claim, you may authorize a representative to act on your behalf. However, you must provide notification to the Fund Office authorizing this representative. A health care provider

that has knowledge of your medical condition may act as your authorized representative for urgent care claims.

Your written appeal must explain the reasons you disagree with the decision on your claim and you may provide any supporting documents or additional comments related to this review. When filing an appeal, you may:

- Submit additional materials, including comments, statements or documents; and
- Request to review all relevant information (free of charge). A document, record or other information is considered relevant if it:
  - Was relied upon by the Plan in making the decision;
  - Was submitted, considered, or generated in the course of making the decision (regardless of whether it was relied upon); or
  - Demonstrates compliance with the claims processing requirements.

b. Review on Appeal

The Plan will review your appeal in accordance with the following provisions:

i. The Plan will provide a review that does not afford deference to the adverse initial benefit determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the adverse initial benefit determination that is the subject of the appeal, nor is a subordinate of the individual who made the adverse initial determination.

ii. If the denial was based on medical judgment, the appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial benefit determination. The professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither an individual who was consulted in connection with the adverse initial benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

iii. If the denial was based on medical judgment, the Plan will identify to you, upon request, the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse initial benefit determination, without regard to whether the advice was relied upon in making the adverse initial benefit determination.

iv. In the case of a requested review of an adverse initial benefit determination of an urgent care claim, the review process shall meet the expedited deadlines described below. Your request for such an expedited review may be submitted orally or in writing and all necessary information, including the Plan's determination on review, shall be transmitted between the Plan and you by telephone, facsimile or other available similarly expeditious method.

v. The Plan will afford you an opportunity to review and receive, without charge, all relevant documents, information and records relating to the claim for benefits and to submit issues and comments relating to the claim for benefits in writing to the Plan. All comments, documents, records and other information submitted by you relating to the claim will be considered regardless of whether the information was submitted or considered in the initial benefit determination.

c. Deadlines for Appeal Decisions

The Plan will give you its decision on appeal in accordance with the following provisions:

i. *Urgent Care Claims*. A determination will be made as soon as possible, but not later than 72 hours from receipt of your appeal. The decision on the appeal is final and not subject to further review under the Plan’s internal claim review procedures.

ii. *Concurrent Care Claims*. A determination will be made before the termination of your benefit. The decision on the appeal is final and not subject to further review under the Plan's internal claim review procedures.

iii. *Pre-Service Claims*. A determination will be made within 15 calendar days from receipt of your appeal. The decision on the appeal is final and not subject to further review under the Plan's internal claim review procedures.

iv. *Post-Service Claims*. A determination will be made at the Board of Trustees' next regularly scheduled meeting if your appeal is received at least 30 days before that meeting. If your appeal is received within 30 days of the Board of Trustees' next regularly scheduled meeting, the determination will be made at the second regularly scheduled meeting following receipt of your appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your appeal may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached. The decision of the Board of Trustees on the appeal is final and not subject to further review under the Plan's internal claim review procedures.

d. Calculation of Time Periods

For purposes of the time periods specified in this subsection, the period of time during which a benefit determination on appeal is required to be made begins at the time the level of an adverse initial benefit determination is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a benefit determination or review accompanies the request for appeal review. If a period of time is extended due to your failure to submit all information necessary, the period for making the determination shall be "frozen" from the date the notification requesting the additional information is sent to you until the date you respond to the request for additional information.

e. Manner and Content of Notice of Decision on Review

If the determination on appeal is adverse to you, you will receive a notice containing the following information:

i. the specific reason(s) for the adverse benefit determination, including the denial code and its corresponding meaning;

ii. reference to the specific Plan provision(s) on which the adverse benefit determination is based;

iii. information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable). The diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning are also available upon request;

iv. a description of the Plan's external review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under a federal law called "ERISA";

v. if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, and that a copy of such rule, guideline, protocol or other similar criterion will be provided to you upon request and without charge;

vi. if the adverse benefit determination is based on the Medical Necessity standard, that the treatment is Experimental or Investigational, or a similar exclusion or limit, either: (i) an explanation of the scientific or clinical judgment applying the exclusion or limit to your medical circumstances; or (ii) a statement that such an explanation will be provided to you upon request and without charge;

vii. 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 for benefits;

viii. contact information for any applicable office of health insurance consumer assistance or ombudsman established under Public Health Services Act Section 2793 to assist individuals with the internal claims and appeals and external review processes; and

ix. the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and, if your benefit is an insured benefit, your State insurance regulatory agency."

3. External Review Procedure

a. Deadline for External Review

If you receive notice of an adverse benefit determination or final adverse internal appeal determination involving medical judgment or a rescission of coverage, you may file a request for an external review within 4 months after the date you receive notice of the adverse benefit determination or final adverse internal appeal determination.

Your request for an external review should be sent to the Fund Office unless you are specifically instructed otherwise in the appeal determination notice that is sent to you. If there is no corresponding date 4 months after the date of receipt of the notice, then the request must be filed by the first day of the fifth month following your receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date falls on a Saturday, Sunday, or Federal holiday, the filing deadline is extended to the next day that is not a Saturday, Sunday or Federal holiday.

b. Preliminary Review

Within 5 business days following receipt of your request for an external review, the Plan will complete a preliminary review of the request to determine whether:

i. you are covered or were covered under the Plan at the time the health care item, service or other benefit was requested;

ii. the adverse benefit determination or final adverse internal appeal determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;

iii. you have exhausted the Plan's internal appeal process, unless you are not required to exhaust the internal appeal process under federal regulations; and

iv. you have has provided all of the information and forms required to process an external review.

c. Notice of Preliminary Review

Within one (1) business day after completion of the initial review, the Plan will issue to you a notice in writing regarding your eligibility for external review. If your request for external review is complete but not eligible for external review, the notice will include the reasons for your ineligibility and contact information for the Employee Benefits Security Administration (toll-free 866-444-3272). If your request for external review is not complete, the notice will describe the information or materials needed to make the request complete and you will be allowed to perfect your request for external review within the 4-month filing period or within the 48-hour period following your receipt of the notice, whichever is later.

d. Review by Independent Review Organization

i. If your request for external review is eligible for submission to an Independent Review Organization (IRO), the Plan will assign your request for external review to an IRO to evaluate your eligibility for external review and will conduct the external review in accordance with procedures established under federal law. The IRO will be assigned in accordance with the Plan's rules, which provide an assignment or rotation method that ensures independence and against a bias towards the Plan. The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits.

ii. Upon receipt of your request for external review, the IRO will timely notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date you receive this notice additional information that the IRO will consider when conducting the external review. The IRO may, but is not required to, accept and consider additional information submitted after 10 business days.

iii. Within 5 business days after the date of assignment to the IRO, the Plan will provide to the IRO any documents and any information considered in making the adverse benefit determination or final adverse internal appeal determination. Failure by the Plan to provide documents cannot delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or the final adverse internal appeal determination. Within one (1) business day after making the decision, the IRO will notify you and the Plan.

iv. Upon receipt of any information submitted by you in accordance with subsection c above, within one (1) business day the assigned IRO will forward that information to the Plan. Upon receipt of that information, the Plan may reconsider its adverse benefit determination or final adverse internal appeal determination that is the subject of the external review. Reconsideration by the Plan cannot delay the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final adverse internal appeal determination and provide coverage or payment. Within one (1) business day after making such a decision, the Plan will provide written notice of its decision to you and the assigned IRO. The assigned IRO will terminate the external review upon receipt of the notice from the Plan.

v. The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

vi. The IRO will review all information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO must observe the terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's applicable standards for clinical review criteria, including Medical Necessity, appropriateness, health care setting, level of care and effectiveness of a covered benefit, unless the criteria are inconsistent with the terms of the Plan or with applicable law. In addition to the documents and information provided, the assigned IRO will consider the following, to the extent available and to the extent the IRO considers them appropriate, in reaching an external review decision:

a. your medical records;

b. the attending health care professional's recommendation;

c. reports from appropriate health care professionals and other documents submitted by the Plan, you, or your treating health care provider;

d. appropriate medical practice guidelines, including evidence-based standards; and

e. the opinion of the IRO's clinical reviewer or reviewers based on the documents and information provided and to the extent the clinical reviewer or reviewers consider those documents and information appropriate.

f. The IRO will provide written notice of the final external review decision to the claimant and the Plan within 45 days after the IRO receives the request for external review. The IRO's external review decision will contain:

(i) a general description of the reason for the request for external review, including, where applicable, information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(ii) the date the IRO received the assignment to conduct the external review and the date of the IRO's decision;

(iii) references to the evidence or documentation, including the specific coverage provisions and evidence-based standards that were considered in reaching the IRO's decision;

(iv) a discussion of the principal reason or reasons for the IRO's decision, including the rationale for the decision and any evidence-based standards that were relied on in making the decision;

(v) a statement that the determination is binding except to the extent that other remedies may be available under state or Federal law, as applicable, to either the Plan or to you;

(vi) a statement that judicial review may be available to you; and

(vii) current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Public Health Services Act Section 2793 to assist individuals with the external review processes.

4. Expedited External Review

a. Request for Expedited External Review

The Plan will allow you to make a request for an expedited external review with the Plan at the time you receive:

i. an adverse benefit determination if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal under the federal interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

ii. a final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services but has not been discharged from a health care provider's facility.

b. Preliminary Review

Upon receipt of the request for the expedited external review, the Plan will conduct the Preliminary Review described in subsection D.2 above as soon as possible, except that the Plan will complete that review as soon as possible without regard to the 5 business day time period. Upon its determination of the Preliminary Review, the Plan will send the notice described in subsection D.3 above as soon as possible.

c. Review by Independent Review Organization

Upon a determination that the request meets the threshold requirements for external review following the preliminary review, the Plan will assign an IRO in accordance with subsection D.4.a above. The Plan will provide or transmit all documents and information considered in making the adverse benefit

determination or final adverse internal appeal determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO must observe the terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's applicable standards for clinical review criteria, including Medical Necessity, appropriateness, health care setting, level of care and effectiveness of a covered benefit, unless the criteria are inconsistent with the terms of the Plan or with applicable law.

d. Notice of Final External Review Decision

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth in subsection D.4.g above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice of the expedited external review decision is not in writing, then within 48 hours after the date the notice is provided the assigned IRO will provide written confirmation of the decision to the claimant and the Plan in accordance with subsection D.4.g above.

5. After External Review

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final adverse internal appeal determination, the Plan will provide coverage or payment for the claim, including authorizing or paying benefits, as soon as possible in accordance with applicable law. The Plan reserves the right to pursue judicial review or other remedies available or that may become available to the Plan under applicable law. The Plan will provide benefits (including making payment on the claim) without delay pursuant to a final external review decision in your favor, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

If the final external review upholds the Plan's adverse benefit determination or final adverse internal appeal determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a) and subject to the limitation described in Section E.2 below.

The external review standards provide that an external review decision is binding on the Plan, as well as on the you, except to the extent other remedies are available under state or Federal law.

6. IRO Maintenance of External Review Records

After a final external review decision, the IRO will maintain records of all claims and notices associated with the external review process for a minimum of 6 years. An IRO will make such records available for examination by the claimant, the Plan, or state or Federal government oversight agency upon request, except where such disclosure would violate state or Federal privacy laws.

D. Miscellaneous Provisions Pertaining to Claims and Appeals

You may designate another person to act as your authorized representative for purposes of the Plan's claims and appeals procedures. To designate an authorized representative, you will need to fill out a form which may be obtained from the Plan Office.

Under federal law you have a right to bring a civil action under Section 502(A) of the Employee Retirement Income Security Act (ERISA) if you are dissatisfied with the decision on appeal. Before bringing such an action you must exhaust the Plan's claims and appeals procedures. Any such action under ERISA must be filed within two years of the date on which your appeal was denied.

Decisions on claims and appeals (with respect to benefits other than life and accidental death and dismemberment benefits) are uniformly made in accordance with the terms and conditions of the Plan Benefits and cannot be paid unless authorized by the Plan.

The individuals and entities charged with reviewing appeals shall have discretionary authority to rule on all appeals and their decisions shall be final and binding on all parties, including, but not limited to, employers, unions, Members, dependents and beneficiaries and their service providers. Benefits will be paid only if the reviewing party determines in its discretion that the applicant is entitled to them.

The reviewing party shall have discretion to make determinations of fact, interpret all documents and other matters pertaining to the appeal; to determine eligibility for benefits, and to exercise such authority as set forth in this Summary Plan Description.

E. Assignment of Benefits

No Covered Individual has the right to anticipate, alienate, sell, transfer, pledge, assign, or otherwise encumber any interest in benefits payable under the Plan.

Further, no Covered Individual has the right to anticipate, alienate, sell, transfer, pledge, assign, or otherwise encumber any right (legal, equitable, or otherwise) to which he or she is entitled by virtue of coverage under the Plan, including but not limited to requesting documents or filing any court proceeding.

All or a portion of benefits payable under the Plan, at the Trustees' discretion may be paid directly to the hospital or provider that rendered the services being claimed. The Plan's direct payment does not validate any attempted assignment or other action prohibited under this section.

SECTION 12. ERISA INFORMATION

A. Plan Name

District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan

B. Plan Number

501

C. Employer Identification Number

43-0648504

D. Plan Sponsor and Administrator

Joint Board of Trustees
District No. 9 International Association of
Machinists and Aerospace Workers
Welfare Trust Fund
12365 St. Charles Rock Road
Bridgeton, Missouri 63044
Phone: (314) 739-6442
Toll Free: (888) 739-6442

As of January 1, 2021, the Trustees are:

Union Trustees	Management Trustees
Dave Weaver Directing Business Representative District No. 9, I.A.M.A.W. 12365 St. Charles Rock Road Bridgeton, Missouri 63044	Don Brown Don Brown Chevrolet 2244 S. Kingshighway St. Louis, Missouri 63110
Jason Tetridick Assistant Directing Business Representative District No. 9, I.A.M.A.W. 12365 St. Charles Rock Road Bridgeton, Missouri 63044	Daniel J. Sinclair Dave Sinclair Buick/GMC 5655 S. Lindbergh Boulevard St. Louis, Missouri 63131
Joe Eccardt Business Representative District No. 9, I.A.M.A.W. 12365 St. Charles Rock Road Bridgeton, Missouri 63044	Tim Jost Fulton Iron & Manufacturing 3844 Walsh St. Louis, Missouri 63116

E. Type of Plan

The Plan is a welfare benefit plan that currently provides life, accidental death and dismemberment, weekly income, and comprehensive major medical benefits. Not all participants are eligible for all benefits.

The life insurance and accidental death and dismemberment insurance benefits are furnished in accordance with group insurance policies issued by a life insurance carrier selected by the Trustees. As of December 1, 2012, the life insurance carrier is The Guardian Life Insurance Company, 7 Hanover Square, New York, New York 10004. Under this policy, the insurance company insures your life insurance and AD&D benefits.

All of the other benefits are paid directly out of the assets of the Welfare Plan.

F. Plan Year Ends

The Plan's financial records are maintained on a plan year basis ending each June 30. However, benefit records are maintained on a calendar year basis. Thus, deductibles, annual maximums, etc., apply during each calendar year.

G. Plan Cost

The Plan Sponsor pays the cost of the Plan out of the District No. 9, I.A.M.A.W. Welfare Trust, which is funded by contributions from contributing employers. In certain instances, contributions may also be made by Plan participants directly.

From time to time the Plan receives payments from health care or service providers which are not administratively feasible to allocate to a specific claim or individual. Examples of such payments are performance guarantees and rebates. These payments are used to offset Plan expenses generally for the benefit of all participants.

H. Type of Administration

The Board of Trustees administers the overall operation of this Plan.

As indicated above, the Trustees have purchased a policy of insurance from The Guardian Life Insurance Company to provide the life and accidental death and dismemberment benefits. The address of the insurance company is as follows:

The Guardian Life Insurance Company
7 Hanover Square
New York, New York 10004

All other benefits are provided directly by the Plan from its assets.

The Trustees have entered into an agreement with a medical Network Provider, Meritain, which permits covered individuals to have access to Meritain's provider network. A current list of doctors, hospitals and other providers who are members of the network can be obtained atwww.aetna.com/docfind/custom/mymeritain. Further, Meritain performs the medical, mental health, and Substance Use Disorder pre-certification and concurrent review services/medical case management.

Meritain
P.O. Box 853921
Richardson, Texas 75085-3921
1-800-476-9971

Meritain is not financially responsible for any of the benefits provided by this Plan.

The Trustees have entered into a pharmacy benefit management agreement pursuant to which covered individuals have access to a network of pharmacies. This pharmacy benefit manager (PBM) will also process claims for reimbursement for drugs obtained outside the network. The PBM is:

Express Scripts
One Express Way
Saint Louis, MO 63121
1-877-293-8190

Express Scripts is not financially responsible for any of the benefits provided by this Plan.

I. Agent for Service of Legal Process

Legal process may be served upon the Plan Sponsor and Administrator at the above address. Additionally, service of legal process may be made upon any Trustee at the above address.

J. Collective Bargaining Agreements

The Plan is established and maintained pursuant to collective bargaining agreements, a copy of which may be obtained by written request to the Board of Trustees. Such collective bargaining agreements are also available for examination by Plan participants and beneficiaries at the Plan Office. If for any reason, you wish to review a collective bargaining agreement, please contact the Plan Office to make an appointment.

You may receive from the Plan Administrator, upon written request, information as to whether a particular employer or labor organization sponsors the Plan and, if so, you can receive the address of the employer or employee organization.

K. Board of Trustees to Interpret, Construe, and Apply Terms of Plan Documents

The Trustees of this Plan have the discretionary authority to determine, pursuant to the terms of this Summary Plan Description, the Plan Document, the Trust Agreement and other relevant documents, questions concerning eligibility for benefits, questions concerning whether the expense of any given treatment or service is a covered expense, and any other questions which may arise in the administration of this Plan. The Trustees also have the discretionary authority to interpret, construe and apply the terms of the plan documents, including any ambiguous terms. Any interpretation, construction or application shall be binding on all parties. The Trustees intend that the most deferential standard of judicial review shall apply to their decisions.

L. Termination or Amendment of the Plan or Trust

The Plan may be amended or terminated by a majority vote of the Trustees at any regular or special meeting of the Board of Trustees, subject to applicable collective bargaining agreement provisions. The benefits described in this Booklet are those currently provided by the Plan. These benefits can be altered, modified, reduced, or terminated at any time the Trustees determine, in their discretion, that such action is necessary.

Should it occur that no employers are obligated to contribute to the Trust or should the Trustees decide to terminate the Trust, any assets remaining in the Trust shall be used consistently with the purposes of this Trust. No assets of the Trust shall revert to any employer.

M. Trustees are Fiduciaries

The Trustees are fiduciaries with respect to the Plan. The Trustees in exercising their powers and duties are doing so at all times in their fiduciary capacity.

N. Participating Employers

A participant or beneficiary may receive from the Plan Administrator, upon written request, a statement as to whether a particular employer is a participating employer and the address of that participating employer.

O. Statement of ERISA Rights Required by Federal Law and Regulations

As a participant in the District No. 9, I.A.M.A.W. Welfare 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 shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office all Plan documents, including insurance contracts and collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions;

2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies;

3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

4. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage as a result of a qualifying event. You or your dependents will have to pay for this coverage. (See Section 5 of this Booklet).

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer 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. If your claim for a welfare benefit is denied, in whole or in part, you must receive a written explanation of the reason for denial and may obtain copies relating to the decision without charge. You have the right to have the insurance company or the Trustees review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you should have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

P. Trust Fund

The assets used to provide benefits are held in trust by the Board of Trustees of the District No. 9, I.A.M.A.W. Welfare Trust. Those assets can only be used to provide benefits to the employees and former employees of contributing employers, and the dependents of such employees, and to defray the reasonable administrative expenses of operating the Plan.

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SECTION 13. NOTICE OF PRIVACY AND SECURITY PRACTICES FOR DISTRICT NO. 9, I.A.M.A.W. WELFARE PLAN

This notice describes how medical information about you may be used and disclosed, how you can get access to this information, and informs you of your rights related to your health information. Please review it carefully.

We are required by law to:

1. Maintain the privacy of your health information;
2. Give you this notice of our legal duties and privacy practices with respect to health information about you; and
3. Follow the terms of the notice that is currently in effect.

The Plan's Privacy Notice was initially effective April 14, 2003. This revision is effective September 23, 2013.

A. How We May Use and Disclose Information About You

We may use your health information, as described in each category below, for treatment purposes, for payment purposes, and for health care operations. We have set out for each of these categories an example of how your health information might be used.

1. Treatment

We may use or disclose your health information to facilitate your health care treatment. For example, we might disclose information to your health care provider to assist the provider in making a determination on a course of treatment for you or we may disclose your health information to a case manager retained by the Plan.

2. Payment

We may use and disclose health information about you for purposes related to payment. For example, we may use your health information to obtain premiums or to determine our responsibility for coverage under the Plan. As another example, we may use your health information to coordinate benefits with another plan.

3. Health Care Operations

We may use and disclose health information about you in order to carry out the day-to-day health care operations of our Plan. For example, we may use health information in connection with:

-legal services; audit services; business planning and development;

-business management of the Plan, and;

-contracting for reinsurance; however, consistent with the Genetic Information Nondiscrimination Act (GINA), the Plan is prohibited from disclosing genetic information for underwriting purposes.

4. Other Potential Uses and Disclosures

In addition to the general uses and disclosures of your information discussed above, there may be other special situations where it is necessary, and permissible, for us to use or disclose your health information. These situations are discussed below.

a. Public Health Activities

For example, we may disclose information to a public health authority for the purpose of preventing or controlling disease.

b. Reporting Abuse, Neglect or Domestic Violence

For example, circumstances may arise where we need to disclose to appropriate authorities suspected abuse or domestic violence.

c. Health Oversight Activities

We may disclose health information to a health oversight agency for health oversight activities, including audits, health care fraud investigations, inspections, and other oversight activities authorized by law. For example, it may be necessary for us to disclose information pursuant to a Medicare audit.

d. Judicial or Administrative Proceedings

For example, we may disclose information pursuant to a court or agency order in a legal proceeding.

e. Law Enforcement Purposes

For example, it may be necessary for us to disclose information to law enforcement officials regarding the identification or location of suspects, fugitives or missing persons.

f. Medical Directors, Coroners, and Funeral Directors

In the event of your death, we may disclose your health information to medical directors, coroners or funeral directors. For example, disclosure may be necessary for determining a cause of death.

g. Organ and Tissue Donation

We may disclose your information to organizations handling organ and tissue donation.

h. Disclosures to Avert a Serious Threat to Health or Safety

For example, we may disclose information to appropriate authorities in order to protect the safety of an individual.

i. For Specialized Government Functions

We may disclose health information pursuant to certain governmental functions, for example, for military, veteran or national security activities.

j. Workers' Compensation

We may release information in accordance with applicable Workers' Compensation laws.

k. Disclosures to the Plan Sponsor

The Plan may disclose health information to the Trustees of the Plan in order to carry out plan administration functions.

5. All Other Uses or Disclosures

We may not use or disclose your health information for any purpose other than as described above without your specific written authorization. You may revoke any such authorization in writing at any time. However, any revocation is limited to the extent that the Plan has already taken action in reliance upon your authorization.

B. Your Rights Regarding Health Information

Federal law provides you with several rights regarding your health information:

1. Right to Inspect and Copy Your Health Information

You have the right to inspect and copy the health information that we maintain about you. You must submit any request to inspect or copy your health information in writing. All such written requests should be forwarded to:

District No. 9, I.A.M.A.W. Welfare Plan
12365 St. Charles Rock Road
Bridgeton, Missouri 63044
ATTENTION: Privacy Officer

If you request a copy of your information, we may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

2. Right to Amend Your Health Information

You have the right to request an amendment to your health information maintained by our Plan, for as long as the information is kept by our Plan. You may wish to request an amendment to your information if you feel that the information is inaccurate or incomplete.

You must make any request for amendment in writing. Your request should be submitted to:

District No. 9, I.A.M.A.W. Welfare Plan
12365 St. Charles Rock Road
Bridgeton, Missouri 63044
ATTENTION: Privacy Officer

A request must state the reason you feel the amendment is necessary.

3. Right to an Accounting of Disclosures

You have the right to receive an accounting of certain disclosures of your health information made by the Plan. This accounting does not include disclosures made pursuant to treatment, payment, healthcare operations, or pursuant to your individual authorization. You must submit a request for an accounting of disclosures in writing to:

District No. 9, I.A.M.A.W. Welfare Plan
12365 St. Charles Rock Road
Bridgeton, Missouri 63044
ATTENTION: Privacy Officer

Your request should state the time period for which you would like an accounting, which cannot go beyond the six-years prior to the date of your request. You are not entitled to an accounting of disclosures made prior to April 14, 2003.

You are entitled to one free accounting within any 12-month period. We may charge you a reasonable fee for any other accounting made within this same 12-month period. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

4. Right to Request Restrictions

You have the right to request specific restrictions on our uses and disclosures of your health information. For example, you have the right to request that we not disclose any of your health information for treatment purposes. We do not have to agree to a requested restriction. Agreeing to a restriction is within our sole discretion.

5. **Right to Request Confidential Communications**

You have the right to request that we communicate specific information to you in a certain manner or at a certain location, if you feel that the communication might otherwise place you in danger. For example, you may request that an explanation of benefits be sent to your work rather than to your home if you feel that this information may put you in danger if sent to your home.

Any request for a confidential communication must be made in writing and be accompanied by a statement that the confidential communication is necessary to avoid your personal endangerment. All requests should be submitted to:

District No. 9, I.A.M.A.W. Welfare Plan
12365 St. Charles Rock Road
Bridgeton, Missouri 63044
ATTENTION: Privacy Officer

6. Right to a Paper Copy of This Notice

You have the right to receive a paper copy of this notice at any time. To request a paper copy of this notice, please contact:

District No. 9, I.A.M.A.W. Welfare Plan
12365 St. Charles Rock Road
Bridgeton, Missouri 63044
ATTENTION: Privacy Officer

C. Revisions to This Notice

We reserve the right to change the terms of this notice. Any changes to this notice will be effective for health information that we maintain about you. Should we revise this notice, we will promptly provide you wish a new notice by mailing you a written copy of the new notice or including it in the newsletter that is sent to you periodically from the Welfare and Pension Plans.

D. Complaints Regarding Privacy Rights

If you believe your privacy rights have been violated, you have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact:

District No. 9, I.A.M.A.W. Welfare Plan
12365 St. Charles Rock Road
Bridgeton, Missouri 63044
ATTENTION: Privacy Officer

Your privacy rights will not be affected by filing a complaint. Further, you will not be retaliated against in any manner for filing a complaint.

E. HIPAA Security Measures

We will reasonably and appropriately safeguard electronic protected health information (ePHI) created, received, maintained or transmitted to us. Accordingly, the Plan has:

1. Implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI it creates, receives, maintains or transmits;
2. Ensured that there is adequate separation (or firewall) between the information that is received from the Plan and other employment information and decisions, and this separation is supported by reasonable and appropriate security measures; and
3. Ensured that any agent, including any subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information.

F. Breach Notification

The Plan is subject to the new HITECH (Health Information Technology for Economic and Clinical Health Act) breach notification rules. In the unlikely event that your protected health information is breached, as that term is defined under the new HITECH law, we will provide you with written notice of the breach. The notice will be sent without unreasonable delay and in no case later than 60 calendar days after discovery of a breach. The notice will be written in plain language and will contain the following information: 1) a brief description of what happened, the date of the breach if known, and the date of discovery; 2) the type of PHI involved in the breach; 3) any precautionary steps you should take; 4) what we are doing to mitigate the breach and prevent future breaches; and 5) how you may contact us to discuss the breach. We will also report the breach to the U.S. Department of Health and Human Services.

DISTRICT NO. 9, I.A.M.A.W. WELFARE PLAN
SCHEDULE OF BENEFITS
PLAN C3GW

Annual Deductible
Individual In-Network $250
Individual Non-Network $750
Family In-Network $750
Family Non-Network $1,500

Emergency Room Co-Payment (waived if admitted) ..... $100 per visit
Urgent Care Co-Payment ..... $50 per visit
Primary Care Provider (PCP) Office Visit Co-Payment ..... $15 per visit
Specialist Office Visit Co-Payment ..... $25 per visit

Percentage Paid of Covered Charges
..... 85% Network

..... 55% Non-Network

Specialty Drugs Out-of-Pocket per Individual (not included in Major Medical Out-of-Pocket Maximum)
After the member pays this amount per calendar year, the Plan pays 100% $3,250
However, a 50% co-pay applies to specialty drug benefits in excess of $500,000

Out-of-Pocket Maximum (Medical)
After the member pays this amount per calendar year (in addition to the deductible), the Plan pays 100%:

……..…Network $2,250/individual, $4,500/family

…… .....Non-Network $9,000/individual, $18,000/family

Weekly Income Benefit—Employee Only
Amount – 70% of weekly pre-disability earnings
From Covered Employment to a maximum of ..... $400 per week
For a maximum of ..... 26 weeks
Benefits begin
Accident ..... 1st day
Other illness or injury ..... 8th day

Life Insurance
Employee $20,000
Dependent Spouse $5,000
Dependent Child (from live birth) $2,000

Accidental Death and Dismemberment (AD&D)—Employee Only $20,000

Important Note: **Additional conditions apply to many of these benefits. Please read the appropriate portions of the Booklet with regard to specific benefits. Please not the Plan's claim limitation period in Section 13G.**

For medical, mental health, and Substance Use Disorder pre-certification, call Meritain at 800-460-6673 (Toll-Free)