OHIO BRICKLAYERS HEALTH AND WELFARE FUND

SUMMARY PLAN DESCRIPTION & PLAN DOCUMENT

EFFECTIVE AS OF JANUARY 1, 2019

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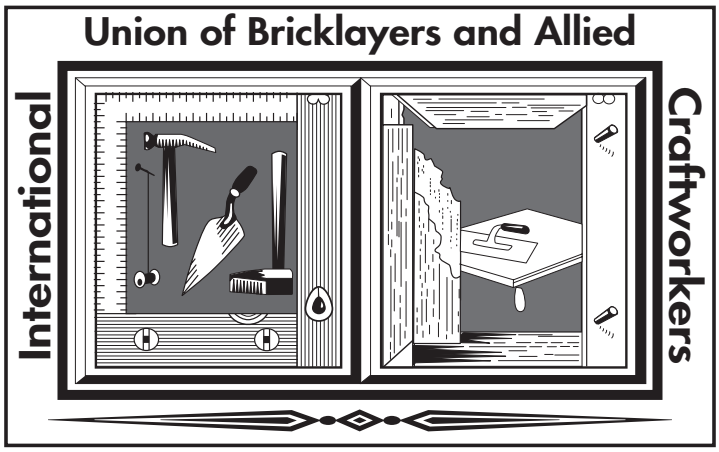
OHIO BRICKLAYERS HEALTH AND WELFARE FUND



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for the

OHIO BRICKLAYERS HEALTH AND WELFARE FUND
HEALTH AND WELFARE FUND

The Ohio Bricklayers Health and Welfare Fund (Fund) has established and continues to maintain this Group Health Plan (Plan) for the benefit of its employees and their eligible dependents as provided in this Summary Plan Description (SPD) and all future Summaries of Material Modifications (SMMs) and certificates of coverage as required by the Employee Retirement Income Security Act of 1974 (ERISA).

It is important that all participants understand that all benefits under this Plan are provided on a self-funded basis, which means that payment for benefits is ultimately the sole financial responsibility of the Fund and paid directly from the assets of the Trust and not an insurance company. Certain administrative services with respect to the Plan, such as claims processing, are provided under a services agreement.

While the Board of Trustees intends to continue to maintain the Plan indefinitely, there is no guarantee of future benefits for any participant or beneficiary. The Board of Trustees reserves the right to modify, merge or terminate the Plan as necessary. Any changes in the Plan, as presented in this SPD, must be properly adopted by the Board of Trustees, and material modifications must be timely disclosed in writing and included in or attached to this document. A verbal modification of the Plan, or promise having the same effect, made by any person will not be binding with respect to the Plan.

This Plan Document/SPD, effective and restated January 1, 2019 supersedes all previously Summary Plan Descriptions and Plan Documents. This Document constitutes the "Plan Document" required by ERISA § 402.

Services are subject to all provisions of the Plan, including the limitations and exclusions.

EFFECTIVE AS OF JANUARY 1, 2019

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CONTACT INFORMATION

Contact the Plan Administrator/Fund Office for general questions related to Plan benefits, including medical, prescription drug, dental, vision, mental health and other benefits. For additional information and assistance, contact the service provider (e.g., Sav Rx).

Service providers are subject to change. The information in the table below is effective January 1, 2019.

Contact…	For…	Phone Number	Website
Fund Office (BeneSys)	General medical claims and benefits-related questions, including eligibility, dependent information and coverage options Weekly Disability Benefits Medical Reimbursement Account, Life & Accidental Death and Dismemberment (AD&D) Benefits	1-833-289-4921	www.benesys.com
Sav-Rx	Prescription Drug Benefits	1-877-228-3108	www.savrx.com
HealthLink	Precertification of Certain Benefits	1-877-284-0102	www.healthlink.com

IMPORTANT PLAN INFORMATION

1. Name of Plan: Ohio Bricklayers Health and Welfare Fund

2. Purpose of the Plan: The Plan is maintained for the purpose of providing life insurance, weekly disability income, and medical expense benefits for sickness or injury and is administered in accordance with the Collective Bargaining Agreements (CBA) between employers and a union affiliated with the International Union of Bricklayers and Allied Craftsman (AFL-CIO). Copies of the agreements may be obtained on written request and is available for examination.

3. Board of Trustees and Named Fiduciaries:

Ohio Bricklayers Health and Welfare Plan

Union Appointed Trustees	Management Appointed Trustees
Kenneth Kudela Director – OADC 5171 Hudson Drive Hudson, OH 44236	Tom Kahler Mosser Construction Inc. 122 South Wilson Ave Fremont, Ohio 43420
Leroy Hunter W.V. ADC 19 Middletown Road Whitehall, WV 26554	Royce Kohman 122 South Wilson Avenue Fremont, Ohio 43420
Fred Hubbard BAC Local #18 1550 Chase Avenue Cincinnati, OH 45223	Nicholas Weisbrod Weisbrod Masonry 308 Bradley Avenue Cincinnati, OH 45215

4. Employer Identification Number: 31-6064918

5. The Plan number assigned for government reporting purposes is 501.

6. The Plan provides medical benefits for participating employees and their enrolled dependents.

7. The Plan is contract administered.

8. Plan benefits described in this SPD/ Plan Document are effective January 1, 2019.

9. The Plan year is May 1 through April 30 of each year.

10. Service of legal process may be served upon the Plan Administrator as shown above, or the following agent for service of legal process below, or any Trustee as named above.

Legal Agent for Service: Ledbetter Parisi LLC
5078 Wooster Road, Suite 400
Cincinnati, OH 45226

11. This is a self-funded health benefit plan. The cost of the Plan is paid with employer contributions and the investment income derived from those contributions. Employee self-payments are permitted in limited situations. Benefits under the Plan are provided through a Taft-Hartley Trust and are used to fund payment of covered claims under the Plan plus administrative expenses. The amount of the employer contributions is stated in the current, applicable CBAs.

12. Each employee of the employer who participates in the Plan receives an SPD, which is this booklet. This SPD will be provided to employees by the Board of Trustees. It contains information regarding eligibility requirements, termination provisions, exclusions and limitations, a description of the benefits provided, and other Plan information.

13. The Plan benefits and/or contributions may be modified or amended from time to time, or may be terminated at any time by the Board of Trustees. Significant changes to the Plan, including termination, will be communicated to Participants as required by applicable law.

14. Upon termination of the Plan, the rights of the participants to benefits are limited to claims incurred and payable by the Plan up to the date of termination. Plan assets, if any, will be allocated and disposed of for the exclusive benefit of the participating employees and their dependents covered by the Plan, except that any taxes and administration expenses may be made from the Plan assets.

15. The Plan does not constitute a contract between the employer and any covered person and will not be considered as an inducement or condition of the employment of any employee. Nothing in the Plan will give any employee the right to be retained in the service of the employer, or for the employer to discharge any employee at any time.

16. If the Plan is required to operate in a different manner to comply with federal and/or state laws and/or regulations, the applicable federal laws and regulations will control.

17. Benefits and coverage can never be guaranteed by telephone conversations. Complete written documentation of the facts of a situation is needed to determine how all Plan provisions will apply. Final decisions will be confirmed in writing as required by federal law.

18. Anyone who intentionally includes false or misleading information on any enrollment material, claims submission, or other written material pertaining to the Plan, in an attempt to defraud or deceive is guilty of insurance fraud. Any Participant who engages in an activity intended to defraud this Plan, as determined by the Board of Trustees, that Participant and his or her Dependents will immediately lose heath care coverage along with all amounts in the Dollar Bank/HRA retroactively from the date of the fraud. The Participant and/or Dependent who engages in such activity will face disciplinary action and/or prosecution. Furthermore, any Participant or Dependent who receives money from the Plan or has benefits paid on his or her behalf which he or she is not entitled to will be required to fully reimburse the Plan. If not fully reimbursed the Trustees have the right to: (a) offset the unpaid amount against any future medical claims for which the Participants and/or Dependent(s) may be entitled to have paid for by the Plan and/or (b) retain Employer Contributions to the Plan made on behalf of the Participant while said Participant was suspended.

19. The Trustees are responsible for the administration of the Plan and have the discretionary authority to interpret the provisions of the Plan. This discretionary authority shall include, but shall not be limited to, the power to construe any disputed or doubtful terms of the Plan as amended from time to time.

20. The Plan is administered and operated by the Plan Administrator in its sole and absolute discretion. The Plan Administrator, and any duly authorized delegate thereof, has the complete authority to administer, apply and interpret the Plan and any related documents and to decide all matters arising in connection with the operation or administration of the Plan. All determinations made by the Plan Administrator with respect to any matter arising under the Plan and any other Plan document are final and binding on all parties, subject to every participant's rights under law and under the provisions of the Plan.

DEFINITIONS

A

Actively at Work means an employee reports for work at his usual place of employment and is able to perform all the usual, customary duties of his occupation on a regular, full-time basis. An employee may also be considered "actively at work" even though he does not report to work if he can perform all customary work duties.

Administrator/Plan Administrator means the individual or organization(s) selected by the Board of Trustees to handle claims and day-to-day administration on behalf of the Fund.

Alternative medicine means an approach to medical diagnosis, treatment or therapy that has been developed or practiced not using the generally accepted scientific methods in the United States of America. For purposes of this definition, alternative medicine shall include, but is not limited to: acupressure, acupuncture, aroma therapy, ayurveda, biofeedback, faith healing, guided mental imagery, herbal medicine, holistic medicine, homeopathy, hypnosis, macrobiotics, naturopathy, ozone therapy, reflexotherapy, relaxation response, rolfing, shiatsu and yoga.

Apprentice means an employee whose terms and conditions of employment are covered by an International Union of Bricklayers and Allied Craftsman (AFL-CIO) Union CBA and whose training is supervised by the Ohio Kentucky Administrative District Council of BAC JATC, or the West Virginia Administrative District Council JATC.

Authorized Representative means a person designed in writing by a claimant to act on his behalf in filing claims, receiving documents, and appealing benefit determinations under the Plan. The Plan will recognize a representative only when the Claimant appoints such representative in writing and fully explains the extent to which the representative is entitled to act upon the Claimant's behalf.

B

Beneficiary means you and your covered dependent(s), or legal representative of either, and anyone to whom the rights of you or your covered dependent(s) may pass.

Bodily injury means injury due directly to an accident and independent of all other causes.

Brand name medications means a medication that is manufactured and distributed by only one pharmaceutical manufacturer, or as defined by the national pricing standard used by the Prescription Benefits Manager.

C

Calendar year/Benefit year means a period of time beginning on January 1 and ending on December 31 of the same year.

Claimant means a covered person (or authorized representative) who files a claim.

Collective Bargaining Agreement (CBA) means a negotiated labor agreement between a union affiliated with the International Bricklayers and Allied Craftworkers and an employer or employer association requiring the employer or association to make contributions to the Fund on behalf of its bargaining unit employees.

Concurrent care decision means a decision by the Plan to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by the Plan (other than by Plan amendment or termination) or a decision with respect to a request by a claimant to extend a course of treatment beyond the period of time or number of treatments that has been approved by the Plan.

Concurrent review means the process of assessing the continuing medical necessity, appropriateness, or utility of additional days of hospital confinement, outpatient care, and other health care services.

Confinement means being a resident patient in a hospital or a qualified treatment facility for at least 15 consecutive hours per day.

Contributions means payments made to the Fund by contributing employers on behalf of their employees. Contributions may also include, where applicable, payments made directly by eligible employees and their dependents to purchase coverage pursuant to Plan rules.

Copayment (prescription drug) means the amount to be paid by you toward the cost of each separate prescription or refill of a covered prescription drug when dispensed by a pharmacy.

Copayment (medical services) means the amount to be paid by you toward the cost of medical services, subject to all Plan provisions.

Cosmetic or reconstructive surgery means any surgical procedure performed primarily to improve physical appearance, or to change or restore bodily form without materially correcting a bodily malfunction, or to prevent or treat a mental/nervous disorder through a change in bodily form.

Covered expense means services incurred by you or your covered dependents due to bodily injury or sickness for which benefits may be available under the Plan. Covered expenses are subject to all provisions of the Plan, including the limitations and exclusions.

Covered person means the eligible employee or any of the eligible employee's eligible dependents or an eligible retiree or any of the eligible retiree's eligible dependents.

Custodial care means services provided to assist in the activities of daily living that are not likely to improve your condition. Examples include, but are not limited to, assistance with dressing, bathing, toileting, transferring, eating, walking and taking medication. These services are considered custodial care regardless if a qualified practitioner or provider has prescribed, recommended or performed the services.

D

Dental injury is an injury caused by a sudden, violent, and external force that could not be predicted in advance and could not be avoided. Dental injury does not include chewing injuries.

Dentist means only a legal qualified dentist or physician licensed to perform any dental procedure rendered by him or her.

Dependent or eligible dependent shall mean and include all of the following:

- Your lawful spouse; common law marriages documented with the Administrator prior to 1992; and
- Your dependent child as follows:

- The Plan will provide dependent coverage for dependents up to the end of the month the dependent turns age 26, regardless of marital status, student status, residency, or financial dependency. These rules apply to: sons, daughters, step children, adopted children, including children placed for adoption, foster children and grandchildren.
- For grandchildren the following additional rules must be met; the grandchild is covered if:
  - the grandchild is in the member's legal custody and resides with the member for the majority of the calendar year; and the grandchild is legally claimed as a dependent on the Participant's or spouse's federal income tax return; or
  - the grandchild is covered under a Court Order entered in the Participant's or spouse's divorce, dissolution or separation action which obligates the Participant or spouse to provide primary medical insurance coverage for such child.

Coverage can continue beyond age 26 if children are physically or mentally handicapped. The Trustees will request proof of the continued existence of the incapacity from time to time. The following conditions must be met:

a) The dependent is mentally or permanently physically handicapped; and
b) the dependent is incapable of self-sustaining employment; and
c) the dependent meets all of the qualifications of a "dependent" as determined by the United States Internal Revenue Department; and
d) the dependent remains unmarried and principally dependent upon the Participant or Participant's spouse for support.

Coverage will end on the last day of the calendar month in which a child or spouse no longer meets the definition of eligible dependent.

Dispensing limit means the monthly drug dosage limit and/or the number of months the drug usage is needed to treat a particular condition.

Drug list means a list of prescription drugs, medicines, medications and supplies approved by the Prescription Benefit Manager. This list is subject to change.

Durable medical equipment (DME) means equipment that: 1) can withstand repeated use; 2) is *medically necessary* and is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; and 3) is not disposable or non-durable.

E

Eligible Dependent. Please see "dependent."

Eligible Employee means an individual who meets the definition of an employee and who has met the eligibility requirements for being eligible to receive the applicable Plan benefits provided for eligible employees.

Eligible Retiree or "Retiree" means a retired employee who has met the Plan's eligibility requirements for being eligible to receive the retiree benefits provided under the Plan.

Emergency means a medical condition which includes mental health /substance use disorders which requires immediate medical attention in the nearest medical facility, whether or not a PPO facility or provider, and which can reasonably be expected to lead to death, serious dysfunction of any bodily organ or part or other serious medical consequences if the person takes the time to seek treatment in a PPO facility/provider. The condition must be severe, sudden in onset and be the result of severe accidental injury or involve one or more of the major organ systems of the body.

Employee means:

1. Employees who are employed by Employers who are signatory to the Trust Agreement or who signify their intention to be bound by the Trust Agreement by signing a Collective Bargaining Agreement or Assent of Participation and by making payments into the Fund and are represented for the purposes of collective bargaining under a common employment related bond meaning that an Employee must maintain Active Employee Status or Active Retired Status. The term "Active Employee Status" and "Active Retired Status" means that the member is current in their financial obligations to the Union.

2. Elected or appointed Officers or Employees of the Union, its State Affiliate, or International Organization, or any Association entering into contractual relations with the Union; providing that the Trustees agree to accept such Officers or Employees, and further providing that in the case of Officers and/or Employees, contributions hall be paid in the same amount per hour provided for other Employees in the Collective Bargaining Agreement.

3. A person, represented by or under the jurisdiction of the Union, who shall be employed by a Governmental Unit or Agency, and on whose behalf payment of contributions shall be made at the times and at the rate of payment equal to that paid by an Employer, as defined in Section 1.6, in accordance with a written agreement, ordinance, or resolution.

4. Employees, if any, of the Trust Fund or the Benefit Office or any ancillary Trust Fund which is jointly administered by the sponsoring parties who are proposed and accepted for such benefits by the Trustees, and further providing that contributions shall be paid in the same amount per hour as provided for other Employees in the Collective Bargaining Agreement. As to such personnel as are Employees of the Trust Fund or any ancillary Trust Fund jointly administered by the sponsoring parties, the Trustees of the respective Fund shall be deemed to be an Employer within the meaning of the Trust Agreement, and may provide benefits for said Employees out of said Trust Fund.

5. An Officer or salaried Employee of an Employer, providing that the Trustees agree to accept such Officer or salaried Employee; and further providing that in the same amount per hour provided for other Employees in the Collecting Bargaining Agreement, and in the same amounts required for eligibility under the Plan, or at the rate determined by the Trustees as being the cost of the Plan, whichever is higher.

    a) The designation of Employee in this sub-section, regarding Officers or salaried Employees of an Employer, shall be available only for Officers or Salaried Employees of an Employer who are currently eligible under the Plan and who continue eligibility by making continuous contributions in a timely fashion as outlined below. If continuous monthly contributions shall ever not be paid when due, such a defined Employee shall lose the right to contribute into the plan on his/her behalf and shall thereafter lose eligibility when all accrued eligibility and COBRA extension rights have expired. Once such a defined Employee loses eligibility, said Employee may not re-enter the Plan without the permission of the Trustees.

    b) The Fund does not allow owners to participate in the Fund. Owners are defined as follows (this includes the interest of spouses):
        - A sole proprietor who is a Contributing Employer, and the spouse of a sole proprietor; or
        - A partner in a partnership which is a Contributing Employer, regardless of the size of the partnership interest; a spouse of any partner is also considered an owner; or
        - Anyone who, alone or with a spouse, owns more than 100% or more of the stock of a corporation which is a Contributing Employer; or

- Anyone else whose ownership interest in a Contributing Employer would, in the opinion of the Trustees, jeopardize the status of the Health and Welfare Fund or violate the Employee Retirement Income Security Act of 1974 (ERISA).

Employer or Contributing Employer means and shall be deemed to include any person, firm, association, partnership or corporation employing Employees working under the Collective Bargaining Unit of the Union as well as Employers who employed persons represented for purposes of Collective Bargaining by the Union and who signify their intentions to be bound by the provisions of the Restated and Amended Agreement and Declaration of Trust by signature thereto, or by signing an Assent of Participation, and by making payments into the Fund hereby created. This term also includes the OHIO BRICKLAYERS AND AFFILIATED UNIONS, as an employer for those Employees working in full time capacities of the Union. The term "Employer" as used in this Plan shall be further deemed to include the Trust itself.

Expense incurred means the fee charged for services provided to you. The date a service is provided is the expense incurred date.

Experimental, investigational or for research purposes means the use of any treatment, medical procedures, facility, equipment, drugs, drug devices or supplies generally regarded as experimental or unproven or investigative in nature by recognized medical professionals or appropriate governmental agencies. Appropriate governmental agencies shall be interpreted as limited to the rulings and approved policies as set by Medicare and the U.S. Food and Drug Administration.

Experimental Procedure means any medical procedure, equipment, treatment or course of treatment, or drugs or medicines that is meant to investigate and is limited to research. This term also means techniques that are restricted to use at those centers that are capable of carrying out disciplined clinical efforts and scientific studies. "Experimental Procedure" also includes procedures which are not proven in any objective manner to have therapeutic value or benefit. Any procedure or treatment whose effectiveness is medically questionable is also deemed experimental.

The Plan determines "experimental" through studies, opinions and reference to or by the American Medical Association, the Federal Drug Administration, The Department of Health and Human Services, the National Institutes of Health, the Council of Medical Specialty Societies or any other medical association or federal program or agency that has the authority to approve medical testing and treatment.

F

Family member means you or your spouse, or you or your spouse's child, brother, sister, parent, grandchild or grandparent.

Free-standing surgical facility means a public or private establishment licensed to perform surgery and which has permanent facilities that are equipped and operated primarily for the purpose of performing surgery. It does not provide services or accommodations for patients to stay overnight.

Fund means the Ohio Bricklayers Health and Welfare Fund.

G

Generic medication means a drug that is manufactured, distributed and available from several pharmaceutical manufacturers and identified by the chemical name, or as defined by the national pricing standard used by the Prescription Benefit Manager.

H

Hospice Care means a program of care, established and reviewed by the qualified practitioner attending the patient and the hospice care agency, that provides pain-free and alert existence for the terminally ill patient during the last months of life, either through in-patient or home care. It offers supportive care to the families of the hospice patient's medical and social needs, and a description of the care to meet those needs.

Hospice Facility means a licensed facility or part of a facility that principally provides hospice care, keeps medical records of each patient, has an ongoing qualify assurance program and has a physician on call at all times. A hospice facility provides 24-hour-a-day nursing services under the direction of an R.N. and has a full-time administrator.

Hospital means only an institution which meets all of the following requirements:

a) Maintains permanent and full-time facilities for bed care of five (5) or more resident patients; and

b) Has a physician and surgeon in regular attendance; and

c) Continuously provides 24-hour-a-day nursing service by registered graduate nurses; and

d) Is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of injured or sick persons; and

e) Is operating lawfully in the jurisdiction where it is located; and

f) Has adequate facilities for major surgical operations on its premises.

The definition of a hospital shall also include any alcoholism/drug dependency facility which shall be further defined as follows:

a) An alcoholism/drug dependency facility shall mean a facility which is licensed and operated in accordance with the laws of the applicable state in which treatment is provided, which is open at all times and is operated primarily for the purpose of providing rehabilitation services for alcoholics and drug addicts, which has a full time physician or psychologist on the staff and full time staff of trained counselors with a minimum of one (1) counselor for each fifteen (15) resident patients, continuously provides twenty-four (24) hours a day nursing services by registered nurses, maintains patient's records on the course of treatment and the covered person's progress including discharge summary and follow-up programs, and has a contracting arrangement with a physician.

For the purpose of paying benefits for nervous or mental disorders, "Hospital" also means a place other than a convalescent, nursing or rest home which has accommodations for resident bed patients, facilities for the treatment of nervous or mental disorders, a resident psychiatrist always on duty, and which as regular practice charges the patient for the expense of confinement and shall include a tax-supported institution of the State of Ohio. In no event shall this term include an institution which is primarily a place for persons with mental disease or derangement or an institution, or any part of an institution otherwise meeting this definition, which is primarily engaged in providing care as a rest home, nursing home or facility, convalescent home or facility. Expenses incurred for charges by an institution not meeting this definition are not covered.

L

Legend drug means any medicinal substance on which the label, under the Federal Food, Drug and Cosmetic Act, is required to bear the legend: "Caution: Federal law prohibits dispensing without prescription."

M

Mail order pharmacy means a pharmaceutical vendor designated by the Prescription Benefit Manager who is properly licensed to dispense and deliver covered prescriptions through the mail.

Maintenance care means any service or activity which seeks to prevent bodily injury or sickness, prolong life, promote health or prevent deterioration of a covered person who has reached the maximum level of improvement or whose condition is resolved or stable.

Maximum allowable fee for a service means the lesser of:

1. The fee most often charged in the geographical area where the service was performed;

2. The fee most often charged by the provider;

3. The fee determined by comparing charges for similar services to a national database adjusted to the geographical area where the services or procedures were performed; or

4. The fee determined by using a national relative value scale. Relative value scale means a methodology that values medical procedures and services relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the service, as adjusted to the geographic area where the services or procedures were performed.

Maximum benefit means the maximum amount that may be payable for each covered person, for expense incurred. The applicable maximum benefit is shown on the Schedule of Benefits. No further benefits are payable once the maximum benefit is reached.

Medically necessary or medical necessity means services, treatments, supplies or confinement provided by a Hospital or Physician which must be generally recognized as effective and essential for treatment of the injury or illness and which are:

a) consistent with the symptoms or diagnosis and treatment of the condition, disease, ailment or injury; and
b) appropriate according to standards of good medical practice in the United States; and
c) not solely for the convenience of the Employee, Dependent, Physician, or Hospital; and
d) the most appropriate which can be safely provided to the Employee or Dependent; and
e) in addition, services treatments, supplies or confinement shall not be considered Medically Necessary if they are experimental procedures or investigational or primarily limited to research.

Medicare means the Health Insurance for the Aged Program under Title XVIII, Parts A and B of the Social Security Act, as enacted or amended.

Mental disorder means a mental, nervous, or emotional disease or disorder of any type as classified in the most current Diagnostic and Statistical Manual of Mental Disorders, regardless of the cause or causes of the disease or disorder.

N

Non-Occupational means with respect to an injury, an injury which does not arise out of and in the course of any employment for wage or profit; and with respect to disease, means a disease in connection with which the person is entitled to no benefits under any Workers' Compensation law or similar legislation.

Non-participating pharmacy means a pharmacy which has not entered into an agreement with the Prescription Benefit Manager or has not been designated by the Prescription Benefit Manager to provide services to covered persons.

O

Orphan drug means a drug or biological used for the diagnosis, treatment, or prevention of rare diseases or conditions, which:

1. Affects less than 200,000 persons in the United States; or

2. Affects more than 200,000 persons in the United States, however, there is no reasonable expectation that the cost of developing the drug and making it available in the United States will be recovered from the sales of that drug in the United States.

Orthotic means a custom-fitted or custom-made braces, splints, casts, supports and other devices used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body when prescribed by a qualified practitioner.

P

Participant shall mean the following persons:

a) The term *"Employee" and/or "Active Employee" and/or Participant and/or Active Participant* means each of the following:
   - All the Employees working in the collective bargaining unit of the union and represented for the purpose of collective bargaining of the union under a common employment related bond who are employed by Employers who are signatory to the Fund's trust agreement or who signify their intentions to be bound by such trust agreement by signing an assent of participation and by making payments into the Fund; and
   - An officer or salaried Employee of the Employer, elected or appointed officers or Employees of the union, its state affiliate or international organization, or any association entering into contractual relations with the union; providing that the trustees agree to accept such officers and Employees.

b) The term *"Active Retiree"* means new retirees (retirement date effective on and after March 1, 2011) who are in good standing with the Union as required of Active Employees.

c) The term *"Active Retiree and/or Retiree and/or Retired Employee"* means prior Active Employee who has retired under the Ohio Bricklayers' Pension Plan or another bricklayer pension fund affiliated with the International Union of Bricklayers and Allied Craftsmen (AFL-CIO).

Participating pharmacy means a pharmacy that has entered into an agreement with or has been designated by the Plan Administrator to provide services to covered persons.

Pharmacy means a licensed establishment where prescription medications are dispensed by a pharmacist.

Pharmacist means a person who is professional qualified to prepare and dispense medicinal drugs.

Physician means a duly licensed doctor of medicine authorized to perform a particular medical or surgical service within the lawful scope of his practice and shall also include any other health care provider or allied practitioner as mandated by state law.

Plan; Plan of Benefits; Benefit Plan means the Plan or program of welfare benefits provided by the Ohio Bricklayers Health and Welfare Fund as explained in this SPD/Plan Document.

Plan Year means the period of May 1 through April 30 of each year. This year is only for administrative purposes, as the Benefit Year is the year in which your benefits accrue.

Post-service claim means any claim for a benefit under a group health plan that is not a pre-service claim.

Precertification means the process of assessing the medical necessity, appropriateness, or utility of proposed non-emergency hospital admissions, surgical procedures, outpatient care, and other health care services.

Predetermination of benefits means a review by the Plan Administrator of a qualified practitioner's treatment plan, specific diagnostic and procedure codes and expected charges prior to the rendering of services.

Prescription means a direct order for the preparation and use of a drug, medicine or medication. The drug, medicine or medication must be obtainable only by prescription. The prescription must be given verbally, electronically or in writing by a qualified practitioner to a pharmacist for the benefit of and use by a covered person. The prescription must include:

1. Name and address of the covered person for whom the prescription is intended;

2. Type and quantity of the drug, medicine or medication prescribed, and the directions for its use;

3. Date the prescription was prescribed; and

4. Name, address and DEA number of the prescribing qualified practitioner.

Prescription Benefit Manager means the individual or organization selected by the Board of Trustees to handle the day-to-day administration of the prescription drug benefits under this Plan.

Pre-service claim means a claim with respect to which the terms of the Plan condition receipt of a Plan benefit, in whole or in part, on approval of the benefit by the Plan Administrator in advance of obtaining medical care.

Prior authorization means the required prior approval from the Prescription Benefit Manager for the coverage of prescription drugs, medicines, medications, including the dosage, quantity and duration, as appropriate for the covered person's age and gender.

Protected health information means individually identifiable health information about a covered person, including: (a) patient records, which includes but is not limited to all health records, physician and provider notes and bills and claims with respect to a covered person; (b) patient information, which includes patient records and all written and oral information received about a covered person; and (c) any other individually identifiable health information about covered persons.

Q

Qualified beneficiary under COBRA law means an employee, employee's spouse or dependent child covered by the Plan on the day before a qualifying event.

Qualified Medical Child Support Order (QMCSO) means a court order that creates or recognizes the existence of an alternate recipient's right to receive benefits that a participant or beneficiary is eligible to receive under a medical plan.

Qualified practitioner means a practitioner, professionally licensed by the appropriate state agency to diagnose or treat a bodily injury or sickness, and who provides services within the scope of that license.

Qualified treatment facility means only a facility, institution or clinic duly licensed by the appropriate state agency and is primarily established and operating within the scope of its license.

Qualifying event means an event that causes an employee, spouse and/or dependent child to become a qualified beneficiary. See the section entitled "Continuation of Medical Benefits (COBRA)" for more information.

R

Reasonable and Customary means charges that are determined by comparing actual provider charges with the usual charges for those services and supplies within the geographical area where the point of services is rendered.

Reciprocity means the arrangement by which contributions for hours that are worked outside the jurisdiction of Ohio Bricklayers Health and Welfare Fund can be transferred back to this Fund.

Rehabilitation Center means a facility that provides services of non-acute rehabilitation. All services are provided under the direction of a psychiatrist, a psychologist or a medical doctor with a specialty in rehabilitation and physical medicine. The facility is staffed around the clock by registered nurses and it does not provide services of a custodial nature. The facility must be Medicare certified licensed by the State Department of Health as a "special hospital" and accredited by the Joint Commission on Accreditation of Healthcare Organizations. It is also accredited by the Commission on Accreditation of Rehabilitation Facilities.

Retiree means a Participant who has retired from the Ohio Bricklayers Pension Plan or any other Bricklayers and Allied Craftsman Pension Plan while an active Participant and eligible under this Health and Welfare Plan. Retirees may continue coverage under the Plan so long as he or she was eligible for coverage at the time of retirement and he or she maintains "Active Retired Status" with the Union, just as Employees, as defined in the Plan, are required to maintain "Active Employee Status" with the Union for participation.

S

Self-administered injectable drug means an FDA approved medication that a person may administer to himself/herself by means of intramuscular, intravenous, or subcutaneous injection, and intended for use by you.

Self-payments mean payments made to the Fund by eligible employees, eligible retirees and eligible dependents on their own behalf for the purposes of maintaining coverage under the Plan in accordance with the applicable eligibility rules.

Services means procedures, surgeries, examinations, consultations, advice, diagnosis, referrals, treatment, tests, supplies, drugs, devices or technologies.

Sickness means a disturbance in function or structure of your body that causes physical or mental signs or symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of your body.

Skilled nursing facility means only an institution licensed as a skilled nursing facility and lawfully operated in the jurisdiction where located. It must maintain and provide:

1. Permanent and full-time bed care facilities for resident patients;

2. A physician's services available at all times;

3. 24-hour-a-day skilled nursing services under the full-time supervision of a physician or registered nurse (R.N.);

4. A daily record for each patient;

5. Continuous skilled nursing care for sick or injured persons during their convalescence from sickness or bodily injury; and

6. A utilization review plan.

A skilled nursing facility is not a rest home, a home for care of the aged, or engaged in the care and treatment of mental disorders, chemical dependence or alcoholism.

T

Total disability or totally disabled means:

1. There is medically determinable physical or mental impairment that makes you unable to engage in any further work in a job classification of the type specified in a Collective Bargaining Agreement (affiliated with the International Union of Bricklayers and Allied Craftsmen, AFL-CIO); and

2. You have received a determination of Total and Permanent Disability from the Social Security Administration or from medical providers or medical board approved by the Board of Trustees.

3. For Dependents, "Total Disability" means the inability by reason of sickness or injury to engage in the normal activities of a person in good health of the same age and sex.

Trustees or Board of Trustees means the individuals appointed and designated according to the terms of the Trust Agreement of the Ohio Bricklayers Health and Welfare Fund to administer this Plan of benefits together with such individuals' successors.

U

Unindentured Worker means an employee whose terms and conditions of employment are covered by an International Union of Bricklayers and Allied Craftsman (AFL-CIO) CBA but who has not yet been admitted into the Ohio Kentucky Administrative District Council of BAC JATC or West Virginia Administrative District Council JATC.

Union means the International Union of Bricklayers and Allied Craftsman (AFL-CIO).

Urgent care claim means a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

1. Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

2. In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

3. Generally, whether a claim is a claim involving urgent care will be determined by the Plan Administrator. However, any claim that a physician with knowledge of a claimant's medical condition determines is a "claim involving urgent care" will be treated as a "claim involving urgent care."

Utilization review means the process of assessing the medical necessity, appropriateness, or utility of hospital admissions, surgical procedures, outpatient care, and other health care services. Utilization review includes precertification and concurrent review.

Y

You and your means you as the employee and any of your covered dependents, unless otherwise indicated.

ELIGIBILITY RULES

THE TRUSTEES OF THE PLAN HAVE THE AUTHORITY AND ALL DISCRETION TO INTERPRET, CONSTRUE AND APPLY THE PROVISIONS OF THE BENEFIT TRUST FUND IN DETERMINING YOUR ELIGIBILITY AND ENTITLEMENT TO BENEFITS. BENEFITS UNDER THIS PLAN WILL BE PAID ONLY IF THE PLAN ADMINISTRATOR DECIDES IN ITS DISCRETION THAT THE PARTICIPANT IS ENTITLED TO THEM.

INITIAL AND CONTINUED ACTIVE ELIGIBILITY

You will become initially eligible for coverage on the first day of the month which follows a period of twelve (12) or less consecutive months during which your Employer contributions to the Fund on your behalf less any assessments set by the Trustees equal, in total, the monthly premium rate for Active Family Coverage for the Standard Plan. The current assessment is $.25 per reported hour. This assessment is set by the Trustees to help insure the financial integrity of the Fund. For example, if your contribution rate is $5.00 the amount credited to your eligibility is $4.75 and $.25 goes into the general assets of the Fund.

Note: The 12-consecutive month period is a rolling period. If eligibility is not earned in 12 consecutive months, the contributions for the first month are lost by the participant (these contributions revert to the general assets of the Fund) and the next 12 consecutive months are used for eligibility.

Example: Assume the active family premium rate for the Standard Plan is $750 per month and this is the first time you are working:

If you work in January and $750 in contributions is paid into the Fund by your employer in February, you will be eligible for benefits on March 1st.

If you work a few hours in January and only $300 is paid to the Fund you have not earned any eligibility as of yet. However, if you work in February and March and you are credited with $200 for February and $250 for March, you now have a total of $750 and you will be eligible for benefits on May 1st.

You only receive credit toward eligibility if the contributions are received by the Plan.

You may continue your coverage for each month period thereafter by having contributions from covered employment credited to your account in an amount sufficient to meet the cost of the Plan as is assessed by the Trustees from time to time. You may also be able to make timely monthly self-payment or COBRA payment for continuation coverage. There are separate rules concerning self-payment and COBRA coverage which are explained later this this SPD/Plan Document.

An Employee who has become eligible for coverage but fails to meet the definition of Active Status under the Plan because he is not a member in good standing with the Union is unable to participate in the Plan. If the Employee attains Active Status within six months of the date that he is initially eligible for coverage, he will be permitted to enroll in the Plan. The coverage will be retroactive to the first date of eligibility.

Contributions from a working owner for himself or herself will not be credited until all hours have been credited and paid by the working owner for his or her collectively bargained employees for the contribution period.

DEPENDENT ELIGIBILITY

Your eligible Dependent(s) become covered when you do. If you acquire one or more Dependents after your coverage starts and while you are eligible, special enrollment rules, as discussed below, apply. If you are eligible, your eligible Dependents are also covered. See the definitions section for more information on who qualifies as your Dependent.

INITIAL COVERAGE SELECTION

The Plan Administrator will provide you with an Enrollment Form once you become initially eligible. Coverage does not become effective until the eligible Employee submits the completed Enrollment Form. The Board has the right to deny any claims incurred prior to the submission of a completed Enrollment Form.

You must select the "Standard Plan" or "Base Plan" as well as single coverage or family coverage at the time of enrollment. If you fail or refuse to make such selection within 30 days of notice of coverage, you will be deemed to have made the selection as follows:

1. If you are single at the time of initial eligibility, you will be automatically enrolled into Single coverage in the "Standard Plan" with the Dollar Bank requirement equal to the Single Standard premium rate.

2. If you are married at the time of initial eligibility, you will be automatically enrolled into Family coverage in the "Standard Plan" with the Dollar Bank requirement equal to the Family Standard premium rate.

3. If your marital status is not known at the time of initial eligibility, you will be automatically enrolled into Family coverage in the "Standard Plan" with the Dollar Bank requirement equal to the Family Standard premium rate.

Additionally, the following policies will apply:

- In no case will adjustment from Family to Single coverage class and premium amount be made more than 12 months prior to the request.

- The Fund Office will hold all claims until a properly completed coverage selection form is received by the Fund Office along with an updated yearly informational form.

CHANGING COVERAGE SELECTION

You may change your coverage selection **only** under the following circumstances.

1. **Open Enrollment:** During the Open Enrollment Period you can change between Single or Family Coverage and/or between the Standard and Base Plans. Open Enrollment occurs during the month of November to be effective January 1 of the next year.

2. **Special Enrollment:** You can change your coverage section between Single and Family Coverage and between the Standard and Base Plans, upon application to the Trustees, should there be a change in your marital or family status.

   A marital or family status change includes:
   - Marriage
   - Legal Separation
   - Birth of a child

- Spouse loses a job or health coverage
- Divorce
- Adoption

A change in coverage class will **not** be permitted if the spouse loses health coverage due to his or her failure to pay for the coverage or for cause, for example filing a fraudulent claim.

If your marital or family status changes during the year, a change in your coverage class can be made, but it must be made within thirty (30) days after the change in status. For the birth, adoption, or placement for adoption of a dependent the coverage will date back to the date the dependent was acquired, so long as the request was made within thirty (30) days of the event. If the request is not made within thirty (30) days, the coverage will not retroactively back date and you will not be able to enroll the dependent until the Open Enrollment Period. For all other family status changes, coverage will be effective the first day of the month after the Fund Office is notified in writing of the request. The Fund Office must be notified in writing within thirty (30) days or you will not be eligible to enroll the dependent and must wait until the Open Enrollment Period.

3. **CHIP or Medicaid:** If you or a dependent loses state health coverage under Medicaid or the Children's Health Insurance Program (CHIP) or becomes eligible for premium assistance through Medicaid or a state CHIP program, you can change your coverage between Single and Family Coverage and between the Standard and Base Plans. Your written request for a change in coverage class must be made and received by the Fund Office within **60 days** of the event.

Additionally, the following policies will apply:

- In no case will adjustment from Family to Single coverage class and premium amount be made more than 12 months prior to the request.

- The Fund Office will hold all claims until a properly completed coverage selection form is received by the Fund Office along with an updated yearly informational form.

DUPLICATE ELIGIBILITY

In the event that one participant in the Plan is legally married to another participant in the Plan, they can elect to be covered as one family under the same coverage and be charged accordingly. In these situations, the participants must do the following:

1. Notify the Fund Office of the situation and request to be covered as one family under one of the participant's names, and

2. One of the participants must request in writing to waive active coverage and to be classified as a "dependent participant." The dependent participant will be covered under their spouse's coverage.

In such case, the dependent participant will not be charged a separate monthly premium and unless specifically elected as detailed below, will not receive the benefits which only active employees receive, for example:

1. Life Insurance and Accidental Death and Dismemberment Benefit

2. Loss of Time Weekly Benefit

Effective January 1, 2019, the spouse who is classified as the "dependent participant' may elect to purchase coverage for the Life Insurance and Accidental Death and Dismemberment Benefit and/or the Loss of Time Weekly Benefit. For additional details about purchasing this coverage, please contact the Benefit Office.

The change in the status from active participant to dependent participant and the change in coverage will be effective the first of the month after the Fund Office is notified in writing and receives all of the proper documents.

For all persons who have selected to be classified as dependent participant, contributions allocated to the Dollar Bank/HRA on their behalf will accumulate in their Dollar Bank/HRA. The Dollar Bank/HRA balance of both the dependent participant and their spouse (active participant) will be managed as one balance. Monthly amounts required for eligibility will be deducted first from the active participant's Dollar Bank/HRA and then from the Dollar Bank/HRA of the dependent participant.

CONTINUATION OF ELIGIBILITY

You will continue to be eligible and covered for each monthly period after establishing eligibility by having contributions from covered employment credited to your account in an amount sufficient to meet the cost of the Plan as assessed by the trustees from time to time for your class of coverage. However, if you do not have sufficient contributions, there are various ways you can continue eligibility.

1. **Self-Payments**

   a) **Full Self-Payment.** If you have achieved eligibility under this Plan, but will lose such eligibility because of unemployment, insufficient contributions, or insufficient Dollar Bank/HRA credits, you will have the right to make full-self payments to this Fund for a maximum of twenty-four (24) months to maintain such eligibility, provided you are available for work under a collective bargaining agreement of a union affiliated with the International Union of Bricklayers and Allied Craftsmen (AFL-CIO).

   b) **Partial Self-Payment.** The Plan has no limits on the number of months you can make a partial self-payment, provided you are available for work under a collective bargaining agreement of a union affiliated with the International Union of Bricklayers and Allied Craftsmen (AFL-CIO).

As for both Full and Partial Self-Payment, if you are not available for work under a collective bargaining agreement of a union affiliated with the International Union of Bricklayers and Allied Craftsmen (AFL-CIO) you will only have the COBRA continuation option described later in this SPD, and you will not be eligible for self-payment.

Failure to Self-Pay on Time. The Plan Administrator will send out a bill on the 1st day of the month preceding the month for which coverage will be provided. If the self-payment is not made on the last day of the preceding month than the coverage terminates and the Participant is no longer considered an Eligible Employee. The only continuation coverage thereafter will be available under the COBRA provision of this Section. If you are eligible to make a self-pay contribution (Full or Partial) but choose not to make such self-pay or fail to make payment on time, you will be terminated as an Active participant. This will result in your Dollar Bank/HRA balance as of the end of the prior month being reduced to zero after twelve (12) months of continuous ineligibility and you will need to meet the Plan's initial eligibility requirements to become eligible again. The 12-month period in which the balance can be used to re-establish eligibility begins to run from the first day of the month in which coverage is lost. Dollar Bank/HRA balances cannot be used to obtain coverage under COBRA.

Example: You are eligible for benefits for the month of August and have $100 in your Dollar Bank/HRA. You work in July and $200 in contributions are contributed by your Employer in August. You now have $300 toward your September Eligibility ($100 *Dollar Bank/HRA* + $200 *Contributions*). You need to make a Partial Self-Payment for September eligibility.

The Plan Administrator sends you a Self-Payment Notice on August 1st. You decide NOT to make the self-payment for September eligibility. Your eligibility for benefits terminates effective August 31st. You will forfeit the $100 in your Dollar Bank/HRA if you do not re-establish eligibility by the following September. The $200 in contributions from July hours will be put into your Dollar Bank/HRA and used to re-establish eligibility.

2. **Dollar Bank/Health Reimbursement Account**

You will remain eligible in the Plan so long as the balance in your Dollar Bank/HRA equals or exceeds the monthly cost of the coverage you have selected. More information on the Dollar Bank is found below.

3. **Reciprocal Contributions**

You can retain eligibility when working under a Collective Bargaining Agreement outside the jurisdiction of the Fund if you properly enroll in the Electronic Reciprocal Transfer System (ERTS), maintained by the International Union of Bricklayers and Allied Craftworkers. It is important you properly enroll on the ERTS system prior to traveling outside the jurisdiction to ensure all contributions will be reciprocated to this Fund. More information on the reciprocal rules can be found below.

4. **Temporary Disability**

When you become disabled, but do not qualify for Total and Permanent Disability, your Dollar Bank will be given credit toward continuing eligibility in the amount of contribution necessary to maintain eligibility to a maximum period of three (3) months during such disability. In no event will the monthly credit exceed the amount of the contributions necessary to maintain eligibility for your class of coverage. This benefit is prorated based on actual days of disability (i.e. seven (7) days of disability is entitled to twenty-five (25%) of the monthly amount needed for eligibility). You must provide immediate notice of the temporary disability in writing.

5. **Total and Permanent Disability**

If you become Totally and Permanently Disabled as outlined below, you may maintain eligibility provided you meet all the rules below and the rules for "Continuation During Retirement" (See the section, Continuation During Retirement). All of the following conditions must be met to maintain eligibility when you are totally and permanently disabled:

- Your Total and Permanent Disability must be a medically determinable physical or mental impairment that makes you unable to engage in any further work in a job classification of the type specified in a Collective Bargaining Agreement (affiliated with the International Union of Bricklayers and Allied Craftsmen AFL-CIO); and
- You must have received a determination of Total and Permanent Disability from the Social Security Administration or from medical providers or a medical board approved by the Trustees; and

As a Totally and Permanently Disabled Employee you may maintain eligibility by providing proof of the disability to the Fund Office prior to the loss of eligibility. If you have applied to Social Security for a disability award and you have not received a determination from Social Security prior to the loss of your eligibility, you will be permitted to continue to be covered under the Plan until you receive a determination from Social Security or a determination is made by the Board of Trustees. The Fund can request proof that your claim is pending with Social Security. In this situation, the coverage class for which you can maintain coverage will be the coverage class for Actives. Your change to a Retiree coverage class will be effective the first day of the month after the date of the onset of disability or the first day of the month after the Board of Trustees has sufficient evidence of the disability (whichever is later).

Your Retiree coverage when you are totally and permanently disabled runs concurrently with any COBRA continuation rights you may be entitled to as a result of your loss of employment or reduction of hours. If you elect Active COBRA coverage in lieu of Retiree coverage when you are Totally and Permanently Disabled, you will be terminated from the Plan and will not be eligible for re-instatement, unless you satisfy the Initial Eligibility requirements.

You must make monthly Self-Payments to the Fund. Such monthly Self-Payment amounts must be made on a timely basis and in an amount as established by the Board of Trustees. Failure to make a timely Self-Payment will result not only in loss of all coverage but also the loss of re-instatement rights and privileges.

6. **Retirement**

Retiree coverage in the Plan is not an accrued benefit and is not vested. The Trustees reserve the right at any time and in their sole discretion to increase the retiree contribution rate, to reduce plan benefit coverage for Retirees and their Dependents, and to completely terminate plan benefit coverage for Retirees and their Dependents.

A Retired Employee can continue coverage after retirement, as long as he was eligible for coverage in this Plan at the time of retirement and meets the following criteria.

If you have retired under the provisions of the Ohio Bricklayers Pension Fund or another bricklayer fund affiliated with the International Union of Bricklayers and Allied Craftsmen (AFL-CIO), you may continue under this Plan and maintain eligibility for coverage as established by the Board of Trustees by making monthly Self-Payments into the Fund. **Failure to make a timely Self-Payment will result not only in loss of all coverage but also the loss of reinstatement rights and privileges for Retiree coverage**

Coverage Classes. Coverage classes available will be according to the following classifications:

- Retiree and/or Surviving Spouse (Family and no one on Medicare)
- Retiree or Surviving Spouse (Single and not on Medicare)
- Retiree and Surviving Spouse (One on Medicare and one not on Medicare)
- Retiree and/or Surviving Spouse (Single on Medicare)
- Retiree and Spouse (Family on Medicare)

A change in coverage class will not be permitted if the spouse loses health coverage due to his or her failure to pay for the coverage or for cause, for example filing a fraudulent claim.

If your marital or family status changes during the year, a change in your coverage class can be made, but it must be made within thirty (30) days after the change in status. The Special Enrollment rules are outlined above.

For those eligible for Medicare coverage, this Plan becomes secondary to Medicare Part "A" and Part "B" Coverage.

IMPORTANT: Benefits are payable based on what Medicare pays under Medicare Part "A" and "B" whether or not you have registered for and/or enrolled in Medicare Parts "A" and "B". **IT IS YOUR RESPONSIBILITY TO ENROLL IN MEDICARE WHEN ELIGIBLE TO DO SO!**

Medicare Eligible Persons should see the "Schedule of Benefits for Medicare Supplemental Coverage" later in this booklet concerning prescriptions.

Your Supplemental Retiree coverage when you are Medicare Eligible runs concurrently with any COBRA continuation rights you may be entitled to as a result of your loss of employment or reduction of hours. If you elect Active COBRA coverage in lieu of Supplemental Retiree coverage when you are Medicare eligible you will not be eligible for any Supplemental Retiree benefits under the Plan. Your coverage will terminate effective the date of your retirement and you will only be entitled to COBRA continuation coverage.

The Dollar Bank may be used to pay for retiree coverage (see terms below) and once the Dollar Bank is exhausted, the Retiree may self-pay for coverage. The Plan Administrator will send a bill out on the 1st day of the month preceding the month for which coverage will be provided. If the self-payment is not made on the last day of the preceding month, the coverage will terminate.

Retiree and the Dollar Bank/Health Reimbursement Account.
You may use your Dollar Bank/HRA to pay for the costs of retiree coverage. The Dollar Bank/HRA usage is expressly conditioned on the Retiree maintaining his status as an Active Retiree which means you must remain in good standing with the Union. Additional information is outlined below.

Alternate Coverage and Dollar Bank/Health Reimbursement Account. Retirees may decline retiree coverage under the Plan because they are eligible for coverage in another Plan (for example, a spouse's plan.) So long as the Retiree maintains "Active Retiree" status by remaining in good standing with the Union, the Retiree is able to continue using the Dollar Bank for eligible medical costs. See "HEALTH REIMBURSEMENT ACCOUNT" section for information on medical costs eligible for reimbursement. Additional information on the Dollar Bank/HRA and retiree coverage is outlined below.

Retiree Return to Work. If a Retiree returns to work and contributions are received by the Plan on their behalf, the Retiree will receive credit for contributions less any assessment of their eligibility in the Plan and the Retiree will remain in their coverage class. Unless eligible for Medicare, they will not be moved back to the coverage class for Actives.

7. COBRA

You and your Eligible Dependents may be eligible to continue coverage under the Plan through COBRA. See the COBRA section later in this SPD/Plan Document for more information about COBRA coverage.

8. Family and Medical Leave Act

If you are granted a leave of absence by the employer as required by the Federal Family and Medical Leave Act (FMLA), you may continue to be covered under the Plan for the duration of the leave under the same conditions as other employees who are covered by the Plan. Coverage will continue for up to 12 weeks of unpaid full-time leave during a 12-month period for one of the following purposes, with the exception that military caregiver leave may be allowed for up to 26 weeks:

- To care for a newborn child, or upon the placement of the child with the employee for adoption or foster care, so long as such leave is completed within 12 months after the birth or placement;

- To care for a spouse, child, foster child, adopted child, stepchild, or parent who has a serious health condition;

- For the employee's own serious health condition;

- Military Care Giver Leave to care for a parent, spouse, child, or relative to whom the Employee is next of kin when the family member is a veteran who served in the Armed Forces (including a member of the National Guard or Reserves) at any time during the period of five years before the date the veteran undergoes the medical treatment, recuperation or therapy;

- To care for a service member whose serious injury or illness was incurred before the active duty but was aggravated by military service in the line of active duty. For veterans, a serious illness or injury is a "qualifying injury or illness" that was incurred in the line of duty on active duty in the Armed Forces and that manifested itself before or after the service member became a veteran. Only where the serious injury or illness rises to the level of a subsequent injury or illness will an employee be entitled to take leave for the same covered service member; or

    - Qualifying Exigency Leave covers members of the regular Armed Forces who are deployed to a foreign country. For members of a regular component of the Armed Forces, covered active duty means duty during deployment to a foreign country. For members of the Reserves, it means duty during deployment to a foreign country under a call or order to active duty pursuant to specified provisions of federal law. In order for an Employee to qualifying exigency leave, Employee's spouse, son, daughter or parent must be on "covered active duty." The following circumstances constitute "qualifying exigencies" under the regulation:

        - Short-notice deployment;
        - Military events and related activities;
        - Childcare and school activities;
        - Financial and legal arrangements;
        - Counseling;
        - Rest and recuperation;
        - Post-deployment activities; and
        - Additional activities not encompassed in the foregoing categories but agreed to by the employer and employee.

In order to qualify for FMLA leave, all conditions for eligibility must be satisfied. The combined total of FMLA leave that may be taken in the 12-month period is 26 weeks, regardless of the reason for such leave. All costs of FMLA coverage will be treated as a charge to the Plan rather than any particular employer.

9. **Surviving Spouse Coverage Continuation.** The following rules apply regarding coverage for the surviving spouse of a deceased participant:

- **Surviving Spouse of Active Employee** – A spouse eligible for coverage at the time of the participant's death, will be entitled to continue eligibility. The surviving spouse may use the deceased participant's Dollar Bank/HRA to pay for this continuation of coverage. Once the Dollar Bank/HRA balance is used and coverage under the Active Plan ends, the surviving spouse will receive COBRA rights for up to thirty-six (36) months.

- **Surviving Spouse of Retiree** – A spouse who was eligible at the time of a retiree's death, will be entitled to continue to make self-payments. This Plan becomes supplementary to Medicare at the earliest date the person is eligible to register and enroll in Medicare. If there is a balance in the Dollar Bank/HRA, the surviving spouse may use it for payment of coverage.

RESCISSION OF COVERAGE

Your coverage may be terminated retroactively due to cases of fraud or intentional misrepresentation, or missed self-contributions, including COBRA continuation coverage contributions. If you fail to notify the Fund Office of a divorce or of a child who is no longer eligible, this will be considered a non-payment of contributions. Coverage will terminate retroactively to the date of the event, and you will be responsible for any claims paid from the date of the event.

The Plan does not rescind health coverage once you are covered under the Plan, unless you (or persons seeking coverage on your behalf) perform an act, practice, or omission that constitutes fraud or you make an intentional misrepresentation of material fact (as prohibited by the terms of the Plan); and in other instances that may be prescribed in the Treasury Regulations.

In the event that you are suspected of fraudulently obtaining coverage for yourself or eligible dependents, the Fund, at the discretion of the Board of Trustees, may offset future benefits, terminate benefits, bring a civil action and/or refer the case for criminal prosecution.

For purposes of the Plan, a rescission means a cancellation or discontinuance of Plan coverage that has a retroactive effect. A cancellation or discontinuance of coverage is not a rescission if the cancellation or discontinuance is attributable to a delay in administrative record keeping if you do not pay any self-contributions for coverage after termination of employment. A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required self-contributions toward the cost of coverage (including COBRA continuation coverage contributions). A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage is effective retroactively to the date of divorce or the date a dependent was no longer eligible under the Plan.

RECIPROCITY

You may have contributions made on your behalf reciprocated (forwarded) to the Ohio Bricklayers Health and Welfare Fund when working under a Collective Bargaining Agreement outside the jurisdiction of this Fund, if:

1. There is a reciprocal agreement between the Ohio Bricklayers Health & Welfare Fund and the other fund; and

2. You have enrolled on the Electronic Reciprocal Transfer System and provided both funds with a written request to have the contributions made on your behalf reciprocated.

You should complete the ERTS paperwork immediately upon working in another Fund's area so that you do not lose credit for any time worked. Contact the Local Union Office or the administration office of the other plan or call your Fund's office for help. Most reciprocal agreements have deadlines concerning the transferring of contributions. If you wait too long to apply, benefits may be lost.

Late Reciprocity. As a general rule, you will not receive credit for hours worked in another area until reciprocated contributions are received by this Fund. However, If a contributing Employer has paid contributions on your behalf to another health and welfare fund, and the contributions have not been reciprocated back to this Fund in a timely manner, which you need for eligibility, credit shall be given to you for purposes of your continued eligibility based on the eligibility rules of the Plan, provided that all of the following conditions have been satisfied:

- Your Employer is signatory to a Collective Bargaining Agreement or Assent of Participation with a Union affiliated with the International Union of Bricklayers and Allied Craftsmen.

- There is a Reciprocity Agreement in effect between the plan to which payment has made and this Plan.

- Contribution payment has been made to the affiliated health and welfare plan associated with this reciprocal agreement.

- You have request reciprocity transfer of the contribution back to this Fund as your Home Fund in a timely manner (see the section on Reciprocity).

- The reason why contributions have not been transferred to this Fund is because of some delay in the reciprocity transfer of funds and not because of any issues or dispute which could jeopardize the transfer of contributions.

- The other fund cooperates with this Fund and provides the Fund Office will all necessary information so that proper credit can be given to you.

Application of Reciprocal Contributions. Often times there can be a substantial delay between the month work was performed and the month reciprocal contributions are received by this Plan.

The Trustees have adopted a policy concerning the application of reciprocal transfers:

- Hours and contributions for work in the prior twelve (12) months will be credited to members for the current reporting month(s) unless members elect via written request to have such hours credited to the month(s) in which the hours were actually worked, and

- Unless approved on appeal by the Board, for any hours older than 12 months, members will be given the credit in the current reporting months, the hours will not be credited to the month(s) in which they were worked.

TERMINATION OF COVERAGE

TERMINATION OF ELIGIBILITY FOR BENEFITS FOR ACTIVE EMPLOYEES AND RETIREES

Employee/Retiree coverage terminates on the earliest of the following:

1. The last day of the current coverage month if your total contributions, plus any reciprocity are insufficient to qualify you for the next coverage month; or

2. If you are making regular self-payment, the last day of coverage month for which you made an on-time self-payment (see Continuation of Coverage During Self-Pay Period);

3. If you are making COBRA payments, the last day of the coverage month for which you made an on-time COBRA payment, or the date of the occurrence of any of the events stated in the termination of COBRA coverage, whichever occurs first (see COBRA section);

4. The date you enter full-time military, naval, or air service, subject to USERRA and federal regulations;

5. The date the Plan is amended eliminating coverage for the class of Employees or Retirees on which you are a member; or

6. The last day of the current coverage month when you no longer meet the definition Active Employee or Active Retiree; or

7. The last day of the current coverage month when you request termination of coverage for yourself and/or your dependents; or

8. The date the Plan is terminated; or

9. The date of your death.

TERMINATION OF ELIGIBILITY FOR BENEFITS FOR DEPENDENTS

Dependent(s) coverage will end under this Plan on the first to occur of the following dates unless the Dependent is entitled to COBRA Coverage and an on-time COBRA Election and Self-Payment is made by or on behalf of the Dependent:

1. The same date the Participant's eligibility for benefit terminates for reasons other than his death; or

2. The date such Dependents ceases to be included within the definition of the term "Dependent" within the Plan; or

3. The date that the Dependent enters full-time military, naval, or air service;

4. The date the Dependent becomes eligible for benefits as an Active Employee under the Plan; or

5. The date of expiration of the period for which the last Self-Payment or COBRA payment is made on-time;

6. The date the Plan is amended eliminated coverage for Dependents of the class of Employees or Retirees for which the Participant is a member;

7. The date the Plan is terminated;

8. The date of the Dependent's death.

IF YOU OR ANY OF YOUR COVERED DEPENDENTS NO LONGER MEET THE ELIGIBILITY REQUIREMENTS, YOU ARE RESPONSIBLE FOR NOTIFYING THE PLAN ADMINISTRATOR OF THE CHANGE IN STATUS. COVERAGE WILL NOT CONTINUE BEYOND THE LAST DATE OF ELIGIBILITY EVEN IF NOTICE HAS NOT BEEN GIVEN TO THE PLAN ADMINISTRATOR. YOU AND YOUR COVERED DEPENDENTS WILL BE RESPONSIBLE FOR REIMBURSING ANY IMPROPERLY PAID BENEFITS.

DOLLAR BANK/HEALTH REIMBURSEMENT ACCOUNT

Contributions received on your behalf in excess of the cost of the Plan will be credited to a notational account in your name, also known as the "Dollar Bank." This account will be used to maintain your eligibility in the event future contributions should be insufficient to meet the monthly cost of the Plan, or to maintain eligibility for your surviving spouse and Dependent children if you should die. It can also be used to pay amounts not reimbursed by the Plan to the extent described under the "HEALTH REIMBURSEMENT ACCOUNT" as described later in this SPD/Plan Document. In this SPD, the terms "Dollar Bank" and "Health Reimbursement Account" are often used interchangeably. As explained in the HEALTH REIMBURSEMENT ACCOUNT section, once you have accumulated a certain amount in your Dollar Bank, those dollars become eligible for IRS approved expenses, once you have reached that threshold, your "Dollar Bank" becomes an HRA. The Dollar Bank or HRA are not vested benefits and cannot be converted to cash.

The Dollar Bank is only available to those who share a common employment related bond and are members in good standing with the Union. Participants who sever the common employment related bond or are no longer members in good standing with the Union will forfeit their Dollar Bank. Additional circumstances that impact the Dollar Bank are outlined below.

1. **Disability or Death**

If you become Totally Disabled, any accumulated excess in your Dollar Bank account will be used to maintain the coverage. If you die, your Surviving Spouse and/or Eligible Dependents may maintain the coverage in effect at the time of your death until the money in the Dollar Bank is exhausted. Coverage may then be continued under COBRA rules for up to 36 months (see COBRA section).

2. **Change in Status**

Should there be a change in your status, other than your death or disability, so that you no longer are available for work as an Employee as defined in the Plan, your coverage will terminate the end of the month in which the change of status occurred (see COBRA section). Thereupon, all credits in your Dollar Bank will be terminated. The balance in such account will revert to the Plan. Additional exceptions to this rule are listed below:

- **Transferred or Promoted.** If you are transferred or promoted so that contributions are no longer required, any excess Dollar Bank will be used to continue coverage as long as your Employer is signed to the Collective Bargaining Agreement with a Union affiliated with Bricklayers and Allied Craftsmen Industry. If the Employer provides alternative health care coverage, your coverage under the Plan will terminate at the end of the month just prior to the effective date of the alternative health care coverage. You will have COBRA rights under this Plan. Additionally, you will be able to use any remaining Dollar Bank balance under the rules of the Health Reimbursement Account. However, in the event the Employer is not signed to the Collective Bargaining Agreement any excess Dollar Bank shall be terminated and revert to the Plan at the end of the month during which your status is changed.

- **Retired.** If you retire, any accumulated excess in your Dollar Bank may be used to maintain your coverage. If you temporarily withdraw from retirement by working for a contributing employer, all new contributions will be credited to the Dollar Bank. You will remain in the coverage class selected at retirement, unless the person is eligible for Medicare.

  Additionally, if you have alternate health care coverage, you can terminate coverage in this Plan and use any balance in the Dollar Bank under the rules of the Health Reimbursement Account. Once you terminate coverage in this Plan, coverage cannot be reinstated.

However, if you temporarily withdraw from retirement by working for an Employer not signed to a Collective Bargaining Agreement any excess Dollar Bank balance shall be terminated and revert to the Fund and you will lose eligibility for any coverage under this Plan and cannot be reinstated in the Retiree coverage class, even if you return to work under a Collective Bargaining Agreement.

- **Transfer to a New Local.** If an Eligible Participant elects to transfer to a different home local that is affiliated with the International Union of Bricklayers and Allied Craftsmen (AFL-CIO) and the local's health plan has a similar dollar bank eligibility system, the member can request (in writing) a transfer of the Dollar Bank balance to his new health plan. The Ohio Bricklayers Health & Welfare Fund may transfer the balance, provided the transfer does not adversely impact the financial integrity of this Plan, and the other fund will accept the transfer, and the member will receive full eligibility credit for the amount transferred. Coverage in this Plan will terminate the last day of the month just prior to the effective date of coverage in the participant's new home fund. Any Dollar Bank Credits not transferred will be added to the reserves of the Plan.

  If an eligible Participant elects to transfer to a different home local that is affiliated with the International Union of Bricklayers and Allied Craftworkers but the local's health plan will not accept the transfer of the Dollar Bank and/or the member will not receive full eligibility credit for the amount transferred, coverage in this Plan will terminate the last day of the month just prior to the effective date of coverage in the Participant's new home fund. Any Dollar Bank balance can be used under the rules of the Health Reimbursement Account.

- **Leaving Bricklaying Trade.** If you leave the trade and are no longer affiliated with the Bricklayers and Allied Craftsmen, the coverage will terminate the first of the month following your departure. However, the accumulated Dollar Bank balance can be used under the Health Reimbursement Account. The Participant may be eligible for COBRA under this Plan.

- **Leaving Covered Employment.** If you are no longer employed by an employer signed to the Collective Bargaining Agreement but remain working in the bricklaying and masonry industry, your coverage will terminate at the end of the month in which the change occurs and any excess balance in the Dollar Bank will be terminated and revert to the Plan. You may be eligible for COBRA under this Plan.

- **Local Union Withdraws from the Plan.** If your Local Union withdraws from the Plan, you coverage will terminate at the end of the month in which this change occurs or as stated and agreed to a withdrawal agreement. The Plan shall transfer such portion of the Dollar Bank balance to your new health plan, as shall be in the best interest of the participants remaining in this Fund and will not jeopardize the financial integrity of this Plan. In no event will more than fifty (50%) percent of the Dollar Bank balance be transferred. The Dollar Banks of the Local group shall be reduced by the total claims paid for the Local group of participants after termination of coverage. Such transfer shall occur six (6) months after the withdrawal. The remaining balance in the Reserve Eligibility Account shall be terminated and revert to the Plan. There is no guarantee of any transfer or credit.

- **Terminate Employment with a Contributing Employer but Maintain Membership in the International Union of Bricklayers and Allied Craftsmen.** If you terminate employment with a contributing Employer but maintain membership in the BAC, the accumulated Dollar Bank balance can be used for eligibility for coverage so long as you continue to qualify as an Employee under the Plan.

- **Employment under a Companion Agreement with the Union.** If you take a position as an employee of a state, county, or city government organization which is signed to a project or labor agreement with the Union, coverage in this Plan will continue until the month for which alternate health care coverage is provided by the state, county, or city government organization. Any Dollar Bank balance can be used under the rules of the Health Reimbursement Account program as long as you remain employed in the above circumstances.

- **Loss of Active Employee or Active Retiree Status.** Active Employees or Active Retirees will forfeit their Dollar Bank balance if they fail to remain in good standing with the Union and therefore do not meet the definitions of Active Employees and Active Retirees. All credits in the Active Employee or Active Retiree's Dollar Bank shall be terminated and the balance shall revert to the Plan. Additionally, your coverage will be terminated at the end of the month in which the change in your status occurred.

  Retirees or Active Employees who have forfeited their Dollar Bank because they failed to remain current in their financial obligation to the Union and therefore did not meet the definition of Active Retiree or Active Employee, can recapture the Dollar Bank balance which was lost if the individual re-qualifies as an Active Retiree or Active Employee as defined in the Plan within 6 months of loss of status as an Active Retiree or Active Employee. This date being the date that coverage was terminated as an Active Retiree or Active Employee. If this condition is met, coverage will be reinstated as an Active Retiree or Active Employee back to the date of termination of coverage. The appropriate monthly premiums will be deducted from the member's Dollar Bank balance. If the Dollar Bank balance is insufficient, the member will be allowed to make monthly self-payments for the prior months of coverage in question.

PRECERTIFICATION

Precertification is a review process where physicians, nurses and/or pharmacists work with your physician to determine whether a procedure, treatment or service is a covered benefit.

This provision will not provide benefits to cover a confinement or service which is not medically necessary or otherwise would not be covered under the Plan. Precertification is not a guarantee of coverage.

After you or your qualified practitioner have provided Health Link with your diagnosis and treatment plan, Health Link will:

1. Advise you by telephone, electronically, or in writing if the proposed treatment plan is medically necessary; and

2. Conduct concurrent review as necessary.

If your admission is precertified, benefits are subject to all Plan provisions and are payable as shown on the Schedule of Benefits.

If it is determined at any time your proposed treatment plan, either partially or totally, is not a covered expense under the terms and provisions of the Plan, benefits for services may be reduced or services may not be covered.

NOTIFICATION REQUIREMENTS

If you or your dependents are to receive a service which requires precertification, you or your doctor must contact Health Link within the stated time period by telephone or in writing:

Health Link
877-284-0102
800-510-2162 (fax)
Phone Hours: 8:00am to 5:00pm CST

PENALTY FOR NOT OBTAINING PRECERTIFICATION

If you fail to obtain pre-certification, the Plan will reduce the normal benefits associated with such service by ten percent (10%). The penalty does not count toward your deductible or out-of-pocket maximums.

BENEFITS REQUIRING PRECERTIFICATION

- Inpatient Services (Medical, Surgical, Behavioral); Note: Pre-certification is not required for inpatient maternity coverage for a mother and her newborn child not in excess of forty-eight (48) hours following a vaginal delivery and ninety-six (96) hours following a cesarean section. If the length of stay is to be in excess of these periods, pre-certification must be obtained.

- Surgical Procedures (Ambulatory)

- Ancillary Services

- Durable Medical Equipment

- Diagnostic Imaging (Ambulatory)

SCHEDULE OF BENEFITS

The Medical Plan is a comprehensive major medical health plan. That means that in each calendar year the majority of benefits are subject to a deductible, co-pay or co-insurance (i.e., you must pay a portion of the benefits). These terms are explained below.

COST SHARING

The deductible is the amount of your initial expenses you are required to pay in a calendar year before the Plan begins to pay. Co-payments for prescriptions do not apply toward your deductible or major medical out of pocket maximums. Prescription co-payments only apply to the Prescription Drug Out of Pocket Maximum. There is no deductible for Prescription Drug payments.

The deductible applies only once in any calendar year. Any expenses incurred in the last three (3) months of any calendar year and used to satisfy the deductible of that year, will also be applied to reduce the deductible of the next calendar year.

If you and one or more of your Dependents or if two or more of your Dependents, while covered under this Plan, are injured in the same accident, only one deductible amount will be charged. This combined deductible amount will also apply to future re-allocations of the deductible amount.

Once the deductible is satisfied, the Plan will pay eighty (80% within PPO) or seventy (50% for Non-PPO) percent of most eligible expenses up to the out-of-pocket maximum. See Schedule of Benefits.

COVERED AND NON-COVERED EXPENSES

Benefits are payable only if services are considered to be a covered expense and are subject to the specific conditions, limitations and applicable maximums of the Plan. The benefit payable for covered expenses will not exceed the maximum allowable fee(s).

A covered expense is deemed to be incurred on the date a covered service is received.

One copayment will be taken per visit per qualified practitioner.

If you incur non-covered expenses, whether from a provider that participates in the PPO network (PPO Provider) or a provider that does not participate in the network (Non-PPO Provider), you are responsible for making the full payment to the health care provider. The fact that a qualified practitioner has performed or prescribed a medically appropriate procedure, treatment, or supply, or the fact that it may be the only available treatment for a bodily injury or sickness, does not mean that the procedure, treatment or supply is covered under the Plan.

PPO AND NON-PPO PROVIDERS

The covered person has two (2) levels of benefits available – PPO Provider benefits and Non-PPO benefits. You may select any provider to provide your medical care, however, in most cases, if you receive services from a PPO Provider, you will incur lower out-of-pocket costs. You are responsible for any applicable deductible, coinsurance and/or copayment.

If you receive services from a Non-PPO Provider, you will pay a larger share of the costs. As Non-PPO Providers do not have contractual arrangements with the Plan Administrator to accept discounted or negotiated fees, they may bill you for charges in excess of the maximum allowable fee. You are responsible for charges in

excess of the maximum allowable fee in addition to any applicable deductible, coinsurance and/or copayment. Any amount you pay to the provider in excess of your coinsurance or copayment will not apply to your out-of-pocket limit or deductible.

PARTICIPATING PROVIDER DIRECTORY

The Trustees have selected the Anthem PPO Network and encourage you to use the Anthem PPO Network providers for your health care needs. The Trustees are not recommending any doctor or hospital for your care. The selection of a doctor and hospital is each person's choice and responsibility. However, using PPO Network providers allows you to take advantage of an enhanced coinsurance percentage and a significantly discounted bill.

Information is available online for the Anthem PPO Network at: www.anthem.com

Due to the possibility of health care providers changing status, please check, if your provider(s) is still in the PPO network, prior to obtaining services.

This schedule of benefits is for all eligible persons who are not eligible for Medicare. Persons eligible for Medicare, see the "Schedule of Benefits Medicare Supplemental Coverage".

These deductibles and out-of-pocket maximums for PPO Provider benefits and Non-PPO Provider benefits are separate and distinct. The deductibles are included in the Out-of Pocket Maximums.

Benefit Levels for Claims at PPO Providers		**Standard Plan**	**Base Plan**
Deductibles:	Individual	$1,000	$3,250
	Family	$2,000	$6,500
Coinsurance:	Member Coinsurance	20%	20%
	Plan Coinsurance	80%	80%
Medical Out-of-Pocket Maximum:	Individual	$3,000	$6,500
	Family	$6,000	$13,000
Benefit Levels for Claims at Non-PPO Providers			
Deductibles:	Individual	$2,000	$6,500
	Family	$4,000	$13,000
Coinsurance:	Member Coinsurance	50%	50%
	Plan Coinsurance	50%	50%
Medical Out-of-Pocket Maximum:	Individual	$5,000	$7,750
	Family	$10,000	$15,500

The following benefits apply to both the "Standard Plan" and the "Base Plan" on a combined basis. These are not separate benefit maximums.

As the appropriate government agencies have not yet defined what "essential health benefits" means, the Plan will act in good faith to interpret and apply that term in a reasonable and consistent manner to comply with the restrictions against lifetime and annual limits under the federal health care reform law.

Lifetime Maximum (for all essential health benefits)	There is no Lifetime Maximum for essential health benefits

Lifetime Maximum (for non-essential health benefits except for all other non-essential health benefits which have a separate lifetime maximum benefit listed in this Schedule of Benefit.	$2,000,000
Manipulation Care Benefits	Deductibles and Co-insurance applies
Maximum Amount Payable Per Calendar Year	$3,000
LiveHealth Online	$10 co-pay/visit
Mental/Nervous Disorder and Drug Dependency and Alcohol Abuse Benefit	Deductibles and Co-Insurance applies

Dental Care/ Pediatric Oral Care Benefit
The maximum annual (calendar year) benefit per person is $200
*This benefit is NOT subject to the deductible or Coinsurance

For pediatric patients only (children up to age 18), the $200 annual maximum for dental services/pediatric oral care does not apply. Note, that orthodontics is not covered under this dental/pediatric oral care benefit.

Eye Care

The Plan will pay up to $100.00 (one hundred dollars) per person per calendar year for one eye care visit. The $100.00 (one hundred dollars) benefit may be used for eyeglasses or contact lenses at the option of the participant. This benefit is available to all eligible members (active, retiree and COBRA) and their eligible dependents. *The $100.00 (one hundred dollars) maximum also applies for pediatric patients.* This benefit is NOT subject to the deductible or coinsurance.

Children (under the age of 19) are entitled to one eye exam annually and one pair of glasses every two (2) years. The annual exam and bi-annual pair of glasses do not count toward the $100.00 calendar year maximum. The bi-annual pair of glasses only includes the glasses, not the eyeglasses frames.

FOR EMPLOYEES AND RETIREES ONLY:
Life Insurance $10,000.00

Accidental Death and Dismemberment Benefit
(Principal Sum) $10,000.00

FOR EMPLOYEES ONLY:
Loss of Time Weekly Benefit..... $250.00
Maximum Number of Weeks Payable 20

ROUTINE PREVENTIVE CARE (Outpatient)

The following preventive care benefits are available at no cost to the Participant when received from a PPO provider. Preventive care services received from a Non-PPO Provider will be subject to copayment, coinsurance, and deductible requirements. These benefits are subject to change based on the recommendations of the U.S. Task Force on Preventive Benefits.

Covered Preventive Services for Adults, age 19 years and older

Immunizations
Immunization vaccines for adults – doses, recommended ages, and recommended populations vary:

- Haemophilus influenzae type B
- Hepatitis A
- Hepatitis B
- Herpes Zoster (Shingles)
- Human Papillomavirus (HPV)
- Influenza
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Tetanus, Diphtheria, Pertussis
- Varicella (Chicken Pox)

Cancer Related

- BRCA-Related Cancer: Risk Assessment, Genetic Counseling and Genetic Testing for individuals at increased risk
- Breast Cancer Mammography Screening for individuals ages 40 to 74
- Breast Cancer: Medications for Risk Reduction for individuals age 35+ at increased risk
- Cervical Cancer Screening for individuals age 21 to 65
- Colorectal Cancer Screening for adults age 50 to 75
  **The Plan will cover the Cologuard at-home test at 100% for participants who are at least age 50, limited to one (1) test every five (5) years, unless your provider has determined that more frequent testing is medically necessary.*
- Lung Cancer Screening for adults age 55 to 80 with history of smoking
- Skin Cancer Prevention: Behavioral Counseling for children, parents of young children, adolescents and young adults (persons aged 6 months to 24 years) with fair skin type

Chronic Conditions

- Abdominal Aortic Aneurysm Screening for men age 65 to 75 who have ever smoked
- Abnormal Blood Glucose and Diabetes Mellitus (Type 2) Screening for adults aged 40 to 70 who are overweight or obese; Counseling Services for all adults with abnormal blood glucose.
- Aspirin for the Prevention of Cardiovascular Disease and Colorectal Cancer for adults aged 50 to 59 years with risk factors.
- Depression Screening for all adults, including pregnant and postpartum individuals.
- Hepatitis B Screening for adults at increased risk
- Hepatitis C Screening for adults at increased risk
- Hypertension (High Blood Pressure) Screening for adults
- Latent Tuberculosis Infection for asymptomatic adults 18 years and older at increased risk
- Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions for adults with body max index (BMI) of ≥30
- Osteoporosis Screening for individuals aged 65+, Postmenopausal individuals younger than 65 at increased risk
- Statin Use for Prevention of Cardiovascular Disease (CVD) for adults aged 40 to 75 without history of CVD who have 1 or more risk factors and a calculated 10-year CVD event risk of 10%+.

Health Promotion

- Alcohol Misuse Screening and Counseling for adults
- Healthful Diet and Physical Activity for Cardiovascular Disease (CVD): Behavioral Counseling for overweight or obese adults with additional CVD risk factors
- Falls Prevention in Older Adults for community-dwelling adults, age 65+ at increased risk for falls
- Interpersonal, Domestic, and Intimate Partner Violence Screening and Counseling for individuals
- Tobacco Smoking Cessation: Behavioral and Pharmacotherapy Interventions for adults
- Well-Woman Preventive Visits

Sexual Health

- Chlamydia Screening for sexually active individuals under 24 years, and older individuals at increased risk
- Contraceptive Services and Counseling for individuals with reproductive capacity; generic when available; no coverage for abortifacient drugs
- Gonorrhea Screening for sexually active individuals under 24 years, and older individuals at increased risk
- HIV Infection Counseling and Screening for individuals
- HIV Infection Screening for adults age 15 to 65. Younger and older individuals at increased risk.
- STI Counseling for adults at increased risk; all sexually active individuals
- STI Counseling for sexually active individuals
- Syphilis Screening for adults and adolescents at increased risk

Pregnancy Related

- Bacteriuria Screening for pregnant individuals
- Breastfeeding: Primary Care Interventions for pregnant and postpartum individuals
- Breastfeeding Support, Supplies, and Counseling for pregnant and postpartum individuals
- Depression Screening for adults, including pregnant and postpartum individuals.
- Folic Acid Supplements to Prevent Neural Tube Defects for individuals planning or capable of pregnancy
- Gestational Diabetes Screening for pregnant individuals
- Gestational Diabetes Screening for pregnant individuals
- Hepatitis B Screening for pregnant individuals
- HIV Infection Screening for pregnant individuals
- Maternal Depression screening for mothers of infants at 1, 2, 4, and 6-month visits
- Preeclampsia Preventive Aspirin for pregnant individuals at increased risk
- Preeclampsia Screening for pregnant individuals
- Rh Incompatibility screening for all pregnant individuals and follow-up testing for individuals at higher risk
- Syphilis Screening for pregnant individuals
- Tobacco Smoking Cessation: Behavioral Interventions for pregnant individuals who smoke

Covered Preventive Services for Children

Immunizations

Immunization vaccines for children – doses, recommended ages, and recommended populations vary:

- Haemophilus influenzae type B
- Hepatitis A
- Hepatitis B
- Human papillomavirus (HPV)
- Inactivated Polio

- Influenza
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Rotavius
- Tetanus, Diphtheria, Pertussis
- Varicella (Chicken Pox)

Cancer Related

- Cervical Dysplasia Screening at 21 years
- Skin Cancer Prevention: Behavioral Counseling for children, parents of young children, adolescents and young adults (persons aged 6 months to 24 years) with fair skin type

Chronic Conditions

- Anemia Screening based on risk factors and age
- Autism Screening for children at 18 and 24 months
- Bilirubin Concentration Screening for newborns
- Blood Pressure Screening for children over 3 years, and under 3 years based on risk factors
- Blood Screening for newborns
- Critical Congenital Heart Defect Screening for newborns
- Depression Screening for adolescents beginning routinely at age 12
- Dyslipidemia Screening for all children once between 9 and 11 years and once between 17 and 21 years, and more often for children at higher risk of lipid disorders
- Hematocrit or Hemoglobin Screening for all children
- Hemoglobinopathies or Sickle Cell Screening for newborns
- Hepatitis B Screening for adolescents at high risk
- Hypothyroidism Screening for newborns
- Iron Supplements for children ages 6 to 12 months at risk for anemia
- Lead Screening for children at risk of exposure and based on age
- Maternal Depression screening for mothers of infants at 1, 2, 4, and 6-month visits
- Obesity Screening and counseling
- Phenylketonuria (PKU) Screening for newborns
- Tuberculin Testing for children at higher risk of tuberculosis and based on age

Health Promotion

- Alcohol, Tobacco, and Drug Use Assessments for adolescents
- Behavioral Assessments for children throughout childhood
- Body Mass Index (BMI) Measurements for children over 2 years
- Developmental Screening for children under age 3 and Developmental Surveillance throughout childhood
- Fluoride Chemoprevention Supplements for children without fluoride in their water source
- Fluoride Varnish for all infants and children as soon as teeth are present
- Gonorrhea Preventive Medication for the eyes of all newborns
- Head Circumference and Weight for Length Measurement for infants and young children
- Hearing Screening for children based on risk factors and age
- Height and Weight Measurements for all children
- Interpersonal and Domestic Violence Screening for adolescents
- Medical History for all children
- Oral Health Risk Assessment for children 6 months and 9 months, and later based on risk factors
- Vision Screening for children 3 to 6 years, and throughout childhood based on risk factors

Sexual Health

- HIV Screening once between 15 and 18 years of age, and for adolescents at higher risk
- Sexually Transmitted Infection (STI) Prevention Counseling and Screening for adolescents at higher risk

Benefits will not be provided under this preventive care benefit for the treatment of any illness or injury.

PRESCRIPTION DRUG BENEFIT

The Board of Trustees have a contract with the Prescription Benefit Manager, Sav-Rx, to provide you with prescription drug benefits. The Prescription Benefit Manager has arranged with a number of retail pharmacies in your area and a mail service pharmacy to fill your prescriptions according to the rules set out in this SPD.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

	Standard Plan	**Base Plan**
For Retail, up to a 30 day supply	You Pay	You Pay
For Generic:	$15	$25
For Brand when no generic is available:	$30	$50
For Brand when there is a generic available:*	100%	100%
For Mail Order, up to a 90 day supply	You Pay	You Pay
For Generic:	$30	$50
For Brand when no generic is available:	$60	$100
For Brand when there is a generic available:*	100%	100%

*Brand name drugs can be received at the Brand co-pay if a doctor's letter is provided to the Fund Office. The letter must stipulate the medical reason why you cannot use the generic drug available.

Prescription Out-of-Pocket Maximum	**Standard Plan**	**Base Plan**
Through Sav-Rx Prescription Drug Program:		
Individual:	$4,350	$850
Family:	$8,700	$1,700
Out-of-Network:	No Out-of-Pocket Maximum	

The co-payments listed only apply toward your Prescription Out-of-Pocket Maximum. These co-payments DO NOT apply toward your deductible or your major medical Out-of-Pocket maximum or your deductible.

ADDITIONAL PRESCRIPTION DRUG BENEFIT INFORMATION

Prescriptions are only covered under the Prescription Drug Card Program with Sav- Rx. Prescriptions are not covered under the major medical portion of the Ohio Bricklayers Health & Welfare Plan.

If you purchase a prescription at a pharmacy which is not part of the Sav-Rx program or you purchase a prescription which is not covered by the Prescription Drug Card Program with Sav- Rx, you will be responsible for 100% of the cost of the prescription.

If you choose to have your prescription filled with a brand name drug when there is a generic drug available, the Fund will not cover any of the cost. You will be responsible for 100% of the cost for the prescription.

The Plan participates in the Sav-Rx Generic Therapeutic Interchange Program. In this program Sav-Rx works with you and your health care provider to determine if a generic alternative is appropriate. The decision to use a generic alternative is your health care provider's decision.

STEP THERAPY PROGRAM

The Step Therapy program begins a drug therapy for a particular medical condition with the safest and most cost-effective drug therapy before progressing to other more risky or costly therapy options. This change is to make sure you are receiving the most cost-effective therapy available, and will reduce the cost to you and to the Ohio Bricklayers' Health & Welfare Plan

The Step Therapy program adopted:

Proton Pump Inhibitors (PPI) Step Therapy Program: The PPIs are a class of drugs that inhibit the production of acid in the gastrointestinal (GI) tract. The prescription PPIs labeled by the Food and Drug Administration (FDA) for the use in the United States are Aciphex, Nexium, Prevacid, Prilosec, Protonix and Omeprazole (generic Prilosec). Prilosec OTC and Omeprazole OTC are also available over-the-counter.

You are able to get up to a 90-day supply of your PPI medication through the following options:

1. You and your doctor can choose to continue your therapy with the class of drugs known as H2 Blockers, including Zantac (Ranitidine), Axid (Nizatidine), Tagamet (Cimetidine) and Pepcid (Famotidine).

2. Another option would be to take the Prilosec OTC, which contains 20mg of Omeprazole, the exact same strength of active ingredient as the prescription version.

3. If you suffer from one of the rare hypersecretory conditions including Zollinger-Ellison Syndrome or Barrett's Esophagitis you will need to obtain Prior Authorization for continued treatment.

4. Continue with your PPI medication and pay 100% of the cost of the prescription, unless you receive Prior Authorization approval for continued treatment.

Note if after 90 days you continue your therapy and do not receive a Prior Authorization approval as stated in option #3, you will be responsible for 100% of the cost of the prescription.

PRIOR AUTHORIZATION PROGRAM

The Prior Authorization program helps to ensure that participants are receiving the appropriate drugs for the treatment of specific conditions approved by the FDA. The process involves the Sav-Rx Clinical Team contacting your physician to request information regarding your diagnosis and pertinent medical history. Some medications may require prior approval such as non-sedating antihistamines. Some drugs may be subject to quantity approval, such as pain medications. The approval criteria are based upon established consensus guidelines and FDA indications. This process is supported by physicians and pharmacists whose primary concern is providing patients with the highest quality of care while supporting the integrity of the doctor-patient relationship. Prior Authorization is repeated on at least an annual or semi-annual basis to ensure compliance and therapy continuation. Sav-Rx is committed to making this process very smooth for you and your physician.

While this program may sound complex, it is actually an effective way for Sav-Rx to help better inform you about specific medical conditions in partnership with your physician.

You may request information from the Fund Office concerning the Mail Order Program and a listing of participating pharmacy chain stores in the Prescription Drug Card Network. Many independent pharmacies are in the Network that are not on this list. If you have questions about your independent pharmacy, you can call the Fund Office.

HIGH IMPACT ADVOCACY PROGRAM

The Plan has procurement programs in place that may require participation in the High Impact Advocacy Program. This program manages the use of selected specialty medications to reduce or eliminate your out-of-pocket expense as well as reducing the cost to the Plan. In order to continue receiving your medication at the most affordable cost, *your prescription* will be filled at the Sav-Rx *pharmacy*. Sav-Rx will facilitate *your* enrollment into a manufacturer sponsored coupon program. Program medications may be discontinued from inclusion in the program at any time without notice.

PRESCRIPTION DRUG COVERAGE

Because SavRx's drug list is continually updated with prescription drugs approved or not approved for coverage, you must call the Prescription Drug Manager's toll-free customer service phone number 1-877-228-3108) or visit the Prescription Drug Manager's website at www.savrx.com to verify whether a prescription drug is covered or not covered under the Plan.

Covered prescription drugs, medicine or medications must:

1. Be prescribed by a qualified practitioner for the treatment of a sickness or bodily injury; and

2. Be dispensed by a pharmacist.

Prescription drug expenses covered under the Prescription Drug Benefit are not covered under any other provisions of the Plan. Any amount in excess of the maximum amount provided under the Prescription Drug Benefit is not covered under any other provision of the Plan.

Any expenses incurred under provisions of the Prescription Drug Benefit section do not apply toward your medical deductible or out-of-pocket limits. Any expenses incurred under the medical benefits do not apply toward your prescription drug deductible or out-of-pocket limits.

The Plan Administrator may decline coverage of a specific medication or, if applicable, drug list inclusion of any and all drugs, medicines or medications until the conclusion of a review period not to exceed six (6) months following FDA approval for the use and release of the drug, medicine or medication into the market.

PRESCRIPTION DRUG LIMITATIONS

Expense incurred will not be payable for the following:

1. Any drug, medicine, medication or supply not approved for coverage under the Plan (call the Prescription Benefit Manager's toll-free customer service phone number, 1-877-228-3108 visit the Prescription Drug Manager's website at www.savrx.com to verify whether a prescription drug is covered or not covered under the Plan);

2. Legend drugs which are not recommended and not deemed necessary by a qualified practitioner;

3. More than two fills for the same drug or therapeutic equivalent medication prescribed by one or more qualified practitioners and dispensed by one or more retail pharmacies;

4. Charges for the administration or injection of any drug;

5. Drug delivery implants;

6. Any drug, medicine or medication labeled "Caution-Limited by Federal Law to Investigational Use," or experimental drug, medicine or medication, even though a charge is made to you;

7. Any drug, medicine or medication that is consumed or injected at the place where the prescription is given, or dispensed by the qualified practitioner, excluding medications provided under the Specialty Office Medication Program;

8. Prescriptions that are to be taken by or administered to the covered person, in whole or in part, while he is a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:
   a. Hospital;
   b. Skilled nursing facility; or
   c. Hospice facility.

9. Any drug prescribed for intended use other than for:
   a. Indications approved by the FDA; or
   b. Recognized off-label indications through peer-reviewed medical literature.

10. Prescription refills:
   a. In excess of the number specified by the qualified practitioner; or
   b. Dispensed more than one year from the date of the original order.

11. Any drug for which a charge is customarily not made;

12. Therapeutic devices or appliances, including: hypodermic needles and syringes (except needles and syringes for use with insulin, and covered self-administered injectable drugs); support garments; test reagents; mechanical pumps for delivery of medication; and other non-medical substances, unless otherwise specified by the Plan;

13. Dietary supplements, nutritional products, fluoride supplements, minerals, herbs and vitamins (except pre-natal vitamins, including greater than one milligram of folic acid, and pediatric multi-vitamins with fluoride), unless otherwise specified by the Plan;

14. Injectable drugs, including but not limited to: immunizing agents, biological sera, blood, blood plasma, or self-administered injectable drugs not covered under the Plan;

15. Any drug prescribed for a sickness or bodily injury not covered under this Plan;

16. Any portion of a prescription or refill that exceeds a 30-day supply of maintenance medications, self-administered injectables or non-maintenance medications (or a 90-day supply for a prescription or refill that is received from a mail order pharmacy);

17. Any portion of a prescription refill that exceeds the drug specific dispensing limit, is dispensed to a covered person whose age is outside the drug specific age limits, or exceeds the duration-specific dispensing limit, if applicable;

18. Any drug, medicine or medication received by the covered person:
   a. Before becoming covered under the Plan; or
   b. After the date the covered person's coverage under the Plan has ended.

19. Any costs related to the mailing, sending, or delivery of prescription drugs;

20. Any fraudulent misuse of this benefit including prescriptions purchased for consumption by someone other than the covered person;

21. Prescription or refill for drugs, medicines, or medications that are lost, stolen, spilled, spoiled, or damaged;

22. Repackaged drugs;

23. Any drug or medicine that is:
    a. Lawfully obtainable without a prescription (over the counter drugs), except insulin; or
    b. Available in prescription strength without a prescription;

24. Any drug or biological that has received an "orphan drug" designation, unless approved by the Plan Administrator;

25. Any amount you paid for a prescription that has been filled, regardless of whether the prescription is revoked or changed due to adverse reaction or change in dosage or prescription;

26. More than one prescription within a 23-day period for the same drug or therapeutic equivalent medication prescribed by one or more qualified practitioners and dispensed by one or more pharmacies, unless received from a mail order pharmacy. For drugs received from a mail order pharmacy, more than one prescription within a 20-day period for a 1-30 day supply; or a 60-day period for a 61-90 day supply. (Based on the dosage schedule prescribed by the qualified practitioner);

27. Oral drugs used to treat male impotence, unless such drugs are medically necessary for the treatment of male impotence.

28. Any drug used for cosmetic purposes

29. Abortifacients (drugs used to induce abortions).

30. Any drug that does not meet the Plan's step therapy criteria (absent prior authorization to be exempted from the step therapy requirements).

SCHEDULE OF BENEFITS
MEDICARE SUPPLEMENTAL COVERAGE

The Ohio Bricklayers Plan will be secondary payor to Medicare except for prescriptions. **Prescriptions are not covered by this Plan.** Claims will be processed as if the individual is covered by Medicare if they are eligible to enroll in Medicare part "A" and part "B" but did not enroll.

Charges in excess of the Medicare approved rates and charges for expenses not covered by Medicare will not be considered eligible under the Ohio Bricklayers Plan. The only exceptions are "Special Coverage" benefits noted below which must then meet the Bricklayers Plan's Usual Customary and Reasonable (UCR) standards.

Benefits are payable based on what Medicare approve and pays under Medicare Parts "A" and "B" whether or not you have registered for and/or enrolled in these Medicare Parts. **It is the responsibility of the individual to sign up for Medicare as soon as he or she is eligible.**

LIFE AND ACCIDENT COVERAGE FOR RETIREES

Life Insurance $10,000.00

Accidental Death and Dismemberment Benefit
(Principal Sum) $10,000.00

SCHEDULE OF BENEFITS – SUPPLEMENTAL PLAN

Inpatient Hospital Services ..... $876.00 of the Medicare deductible, up to $219.00 per day for the 61st-90th day of hospitalization, up to $438.00 per day for the 91st-150th day of hospitalization, and up to 80% of eligible expenses for additional 365 days per lifetime.

Blood (Inpatient/Outpatient ..... $100 of the Medicare deductible, and Medicare copay up to 20%

Skilled Nursing Facility Care..... Up to $109.50 a day for 21st-100th days, and up to 80% for the next 100 days

Inpatient Prescription Drugs for Transplants ..... $100 of the Medicare deductible and Medicare copay up to 20%

Physician's Care Inpatient/Outpatient
Services and Supplies ..... $100 of the Medicare deductible and Medicare copay up to 20%

Outpatient Mental/Nervous..... Medicare copay up to 50%

Outpatient Physical Therapy..... $100 of the Medicare deductible and Medicare copay up to 20%

SPECIAL COVERAGE

Care Outside United States ..... Up to 80% of eligible expenses (UCR), emergency only, $25,000 lifetime maximum

Inpatient Private-Duty Nurse .....Up to 80% of eligible expenses (UCR), maximum of $1,000.00 payable per calendar year

DENTAL CARE

Benefit - the maximum annual (calendar year) benefit per person is $200.
- this benefit is NOT subject to the deductible or Co-insurance.

Lifetime Maximum for Medicare Supplement Coverage $150,000 per Individual, includes all benefits paid under the Medicare Supplement Coverage

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MEDICARE PART D – RX DRUG BENEFIT

Under the Medicare program persons eligible for Medicare can enroll in a prescription drug card plan with Medicare. Prescription drugs **are not covered** under the Medicare Supplement coverage of this Plan.

You SHOULD enroll in the Medicare Part D – Rx Drug Benefit or some other prescription drug program at the same time you enroll in Medicare Part A and Part B. Annual enrollment in Medicare Part D programs is November 15 – December 31. The Ohio Bricklayers Health & Welfare Plan **will not** pay any of the cost associated with your prescriptions.

For more information and help: www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227)

OTHER COVERED EXPENSES

The Medical Plan provides benefits for Usual Customary Reasonable (UCR) charges. UCR amounts are determined by comparing actual provider charges with the usual charges for those services and supplies. Coverage is based on eligibility, the Schedule of Benefits and other sections of the Plan.

1. hospital semi-private, ward, average semi-private charges, intensive care unit, cardiac care unit, and burns unit;
2. qualified miscellaneous hospital charges
3. emergency outpatient expenses for:
   a) emergency medical treatment due to accidental bodily injury;
   b) outpatient surgery;
   c) a sickness.
4. preadmission testing;
5. second surgical opinion – up to two opinions by different physicians paid at one hundred (100%) percent of Usual Customary and Reasonable charges;
6. charges for medical and surgical services provided for a mastectomy, including the following:
   a) Reconstruction of the breast on which the mastectomy was performed;
   b) Surgery and reconstruction of the other breast to produce a symmetrical appearance;
   c) Prostheses and treatment of physical complication including lymphedema of all stages of mastectomy;
   d) Surgical Bras are covered following mastectomy, (Surgical Bras are limited to two (2) per eighteen (18) months period);
   e) Prosthesis are covered following mastectomy, prosthesis is limited to two (2) per breast per five (5) year period;
7. in-hospital medical visitation and/or consultation;
8. laboratory tests and x-ray services;
9. charges made by a Hospital for inpatient treatment. Room and board charges may not exceed the Hospital's semi-private accommodation. If the Hospital does not have semi-private accommodations, the covered charge will not exceed the average rate for such accommodation charged by Hospitals located in the surrounding geographical area;
10. charges made by such Hospital for outpatient treatment;
11. charges for diagnosis, treatment, and surgery by a Physician;
12. charges for anesthesia and its administration, use of radium and radioactive isotopes;
13. charges for services of a radiologist, cardiologist or pathologist who is a physician, provided no other benefit is payable for the charges;
14. charges made by a qualified physiotherapist or a registered graduate nurse (RN.) for private duty nursing service rendered solely for you or your Dependent, except for services provided by a person who ordinarily resides in your household or is a member of your family by blood, marriage or legal adoption;
15. charges for local professional ambulance service and, if the injuries or sickness requires special and unique Hospital treatment, transportation within the United States or Canada to the nearest Hospital equipped to furnish treatment not available in a local Hospital by professional ambulance, railroad or commercial airline on a regularly scheduled flight;
16. charges for professional services of a qualified physical therapist for administration of physical therapy in accordance with a legally qualified Physician's specific instructions as to type and duration;
17. charges for professional services of a qualified speech therapist for the administration of speech therapy for the treatment of a speech defect which is the direct result of Injury or Sickness in accordance with a legally qualified Physician's specific instructions as to type and duration;

18 charges for the removal of impacted wisdom teeth;

19. charges for the following additional services and supplies: drugs and medicines requiring a Physician's written prescription; diagnostic x-ray and laboratory service; oxygen and the rental equipment for its administration; blood or blood plasma and its administration; radium, x-ray therapy;
20. charges for casts, splints, braces, trusses and crutches; rental (up to the purchase price) of hospital type bed, wheelchair or iron lung or other durable mechanical equipment, except for rental charges which are in excess of the purchase price of the rented equipment;
21. charges for artificial limbs and eyes to replace natural limbs and natural eyes resulting from non-occupational accidental injury or illness even if the person was not eligible for Plan benefits when the accidental injury or illness occurred. (If the treatment is due to an accidental injury the treatment must be started within six (6) months after the earliest date on which the treatment based on the medical condition of the person could be started);
22. the Plan provides coverage under the medical benefits portion for charges for dental treatment provided by a dentist or dental surgeon in connection with a non-occupational accidental injury to sound natural teeth (teeth that are free of defect or decay), including any necessary dental x-rays and initial replacement of teeth, provided the treatment is received within six (6) months after the accident. Treatment of such injuries is covered even if the person was not eligible for Plan benefits when the accidental injury occurred;
23. organ transplants, any applicable services and supplies and any of the following services and supplies, provided for and in connection with an organ transplant which is medically necessary and which is not experimental or investigative:
    a) Acquisition, preparation, transportation, and storage of a human organ;
    b) Transportation for the patient to and from the site of the transplant procedure;
    c) Expenses incurred by a donor, even if the donor is not covered under the Plan. Benefits for such expenses will be paid as though incurred by the covered person who is the recipient.
24. pregnancies, eligibility and benefits are based on date of delivery and not as of the date of conception.

ALCOHOLISM AND DRUG DEPENDENCY TREATMENT

Both outpatient and inpatient treatment of alcoholism or drug dependency at a Hospital or qualified Alcoholism/ Drug Dependency Facility are covered. However, the care must be provided by a certified counselor and/or other professionals at an accredited facility.

MENTAL AND NERVOUS CARE

Both outpatient and inpatient treatment of mental and nervous disorders at a Hospital or qualified facility are covered. However, the care must be provided by a licensed psychologist and/or other professionals under a program approved by the State Division of Mental Health.

MANIPULATION SERVICES

Charges made for manipulation services are only covered under the major medical section of this Plan per the Schedule of Benefits. Initial x-rays and diagnosis will be covered at the Coinsurance percentage after the applicable deductible.

AIM IMAGING PROGRAM

The AIM Safe Choices in Imaging Program alerts physicians via the portal regarding patients who have undergone multiple imaging exams that may be associated with high levels of exposure to harmful ionizing radiation. AIM offers peer-to-peer consultations to physicians to help them adopt best practices in imaging so that they can successfully manage radiation risk to their patient population.

The program is seamless for participants and providers:

- A physician calls to obtain an order for a computerized tomography or magnetic resonance imagining service for a member.
- The physician is given information about the area's most cost-effective, quality facilities so they can make informed decisions for their patients.
- If the physician does not refer the member to one of these locations, a health outreach specialist calls the member to let them know about more affordable options.
- Members have the choice to follow their physician's first referral, or choose to schedule an appointment at a more cost-effective location.

If participants chose the lower-cost option, their savings could be significant depending on the members' specific health coverage and the cost sharing.

Participants can view cost and quality information on their own through the Estimate Your Cost tool at anthem.com. By accessing the online tool, members can see and compare cost information for imaging and other outpatient and inpatient services.

AIM SLEEP STUDIES

The use of sleep labs for conducting overnight tests used to diagnose obstructive sleep apnea (OSA) may be over-utilized when compared to home testing, and at a significant cost to the health care system. AIM's sleep management program is designed to align the diagnosis and treatment of sleep apnea against clinical guidelines, enhance participant access to high value providers, and ensure treatment compliance for the dispensing of supplies.

LIVEHEALTH ONLINE

The use of sleep labs for conducting overnight tests used to diagnose obstructive sleep apnea (OSA) may be over-utilized when compared to home testing, and at a significant cost to the health care system. AIM's sleep management program is designed to align the diagnosis and treatment of sleep apnea against clinical guidelines, enhance participant access to high value providers, and ensure treatment compliance for the dispensing of supplies.

The cost of his new program is $10 per visit.

CONDITIONCARE

Through the ConditionCare Program, participants get personalized, one-on-one support straight from a nurse to help them better manage chronic conditions. They also get information and tools to help them avoid unnecessary emergency room visits, hospital stays, and time away from the job.

ConditionCare helps participants manage:

- Asthma
- Diabetes

- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease
- Heart Failure

CLINICAL TRIALS

The Plan pays benefits for certain clinical trials. To be considered a covered service, a clinical trial must be a phase I, II, III, or IV clinical trial. It must also be a:

- Federally funded or approved trial;
- Trial conducted under an FDA investigational new drug application; or
- Drug trial that is exempt from requirement of an FDA investigational new drug application.

The Plan pays benefits for your clinical trial, provided you are diagnosed with cancer or another life-threatening condition, and you:

- Submit proof that your health care professional (who must be an in-network provider) is referring you to the clinical trial and that the clinical trial is considered appropriate for your care; or
- Provide medical and scientific information to the Fund Office that demonstrates that the clinical trial is appropriate for you.

If your clinical trial is approved, the Plan pays benefits for the reasonable routine covered services furnished in connection with your participation in the clinical trial. These services must already be considered covered services under the Plan. For example, if you require temporary hospitalization or monitoring in connection with the trial and there is an expense for the services, the Plan considers the services as covered services and pays benefits for the eligible expenses. Routine costs do not include:

- Investigational items, devices, or services;
- Items and/or services provided for the sole purpose of data collection and analysis needs;
- Services that are inconsistent with widely accepted and established standards of care for a particular diagnosis; or
- Any other items that the Fund Office determines are not eligible routine expenses.

The Plan reserves the right to use reasonable medical management techniques to interpret and apply coverage provisions related to clinical trials. The Plan does not discriminate against you on the basis of your involvement in an approved clinical trial.

LIMITATIONS AND EXCLUSIONS

No payment will be made by the Plan for any of the following items (this list is not intended to be exclusive as the Board of Trustees retains the right to make all coverage determinations under the Plan):

a. any services not recommended or approved by your Physician;

b. charges which you are not required to pay;

c. for treatment of bodily injuries arising from or in the course of any employment;

d. charges due to injury or accident or illness or disease which are payable or should have been payable under any applicable workers' compensation act or occupational disease law or similar law:

   1) This exclusion also applies to owner whether or not the individual is eligible for workers' compensation and/or industrial commission coverage

   2) This exclusion also applies to any person if they choose to opt out of the workers' compensation and/or industrial commission coverage

   3) This exclusion also applies to any person for failure to make the required payments for the workers' compensation and/or industrial commission coverage

   4) This exclusion also applies if lump sum settlements are reached with the workers' compensation and/or industrial commission coverage;

e. for medical examinations not necessary for treatment of injury or illness;

f. for services rendered or supplies obtained on or after the date the coverage with respect to the Employee is terminated excepted as provided under "Extended Benefits";

g. for services furnished by or payable under any plan or law of any Government, Federal or State, Dominion or Provincial or any political subdivision thereof, or furnished during confinement in a hospital or institution owned or operated by the United States Government or any agency thereof, or which are or could have been the subject of any worker's compensation or industrial commission claim, except that the Plan, to the extent required by law, will reimburse a Veterans Administration (VA) Hospital for care of a covered person's non-service related disability if the Plan would normally cover such care if the VA were not involved, unless this exclusion is pre-empted by the exclusions below:

   1) This workers' compensation and industrial commission exclusion also applies to owners whether or not the individual is eligible for workers' compensation and industrial commission coverage, or whether said Participant has chosen to opt out of the worker's compensation and industrial commission coverage as a sole proprietor or partner or for failure to pay worker's compensation and industrial commission premiums on himself.

h. any professional fee other than the Physician's or surgeon's fees for performing the operation or for the administration of the anesthesia during the operation;

i. eye refractions (i.e. lasik), examinations, or the fitting or cost of glasses or contact lenses, any type of eye surgery or vision care products or services;

j. therapeutic x-rays;

k. any visits made by the surgeon on or after the date of any operation for which surgical expenses are payable;

l. a consultation by a Physician who is not a "legally qualified physician," - a legally qualified physician is one who is Board Certified in the field of the proposed surgery or a specialist in the field of medicine concerned with the condition involved;

m. more than two consultations in connection with a proposed surgery;

n. x-rays and tests not related to the proposed surgery; for examination not made in person by the Physician rendering the opinion;

o. services with regard to a second surgical opinion, if:
   1) the same consulting Physician also performs the surgery; or
   2) the Physician has a financial interest in the outcome of his opinion; or
   3) if a written report is not sent to the Fund by the examining Physician; or
   4) for more than two (2) consultations in connection with the proposed surgery;

p. for consultation for cosmetic surgery or cosmetic surgery or any related services to cosmetic surgery before or after the cosmetic surgery, or any services resulting from the cosmetic surgery whether or not Medically Necessary unless required because:

   1) The Plan will cover cosmetic surgery for repair of disfigurement resulting from non-occupational accidental injury or illness <u>even if the person was not eligible for Plan benefits when the accidental injury or illness occurred.</u> If the treatment is due to an accidental injury the treatment must be started within six (6) months after the earliest date on which the treatment based on the medical condition of the person could be started; or

   2) congenital disease or anomaly which results in a functional defect;

   3) incidental to or following surgery resulting from trauma, infection, or other disease of the involved part;

NOTE: In no case will payment be made for services related to cosmetic surgery where there were complications and additional health care/services are needed.

q. an elective abortion except:
   1) where the life of the mother is endangered if the fetus is carried to term; or
   2) from complications of an abortion;

r. foot care in connection with corns, calluses, toenails, or subcutaneous tissue, except when prescribed by a doctor who is treating the person for metabolic disease, such as diabetes mellitus, or a peripheral-vascular disease such as arteriosclerosis;

s. charges for services, supplies, and treatment which were not prescribed by a legally qualified physician;

t. hearing aids or the fitting of hearing aids;

u. transportation other than as described in other sections of this booklet;

v. injury or illness resulting from war or armed aggression;

w. drugs obtained without a prescription;

x. drugs and insulin dispensed while confined in a Hospital, inpatient mental health or substance abuse facility, nursing home or similar facilities which operate on its premises a dispensing pharmacy;

y. experimental drugs even though a charge is made to you;

z. the administration of any drug or insulin;

aa. any prescription refill dispensed after one (1) year from the order of a Physician;

bb. support garments and other devices or appliances, regardless of their intended use, except as follows:

1) Orthotics for feet are covered if prescribed by a qualified physician with a Plan payment limit of two thousand ($2,000) dollars per person per lifetime.

2) Surgical Bras are covered following mastectomy. Surgical Bras are limited to two (2) per eighteen (18) months period.

3) Breast Prosthesis are covered following mastectomy. Breast Prosthesis are limited to two (2) per breast per five (5) year period.

cc. (intentionally skipped);

dd. drugs which may be properly received without charge under local, state, or federal programs;

ee. any expenses paid for or furnished by any government agency for expenses related to service related injury or illness;

ff. any care, service, or supplies provided primarily as rest cure or maintenance, custodial care, or educational training. Expenses incurred for accommodations (including room and board and other institutional services) and nursing services for a person because of age or other mental or physical conditions primarily to assist the person in daily activities will be considered custodial care;

The fact that the person is then receiving medical service that is merely maintenance care that cannot reasonably be expected to substantially improve a medical condition will not prevent this limitation from applying.

gg. any care, service, or supplies incurred as the result of an intentionally self-inflicted injury or sickness, of any kind is not covered by the Plan. Except where the source of the injury results from an act of domestic violence or from an underlying medical condition;

hh. routine care and other treatments or procedures which are not Medically Necessary;

ii. treatment, medical procedures, facility, equipment, drugs, drug devices, or supplies generally regarded as experimental or unproven or investigative in nature and is limited to research by recognized medical professionals or appropriate governmental agencies, such as, but not limited to, Medicare, the U.S. Food and Drug Administration, the Public Health Services Office of Health Technology Assessment, or the National Institutes of Health;

Experimental Procedure means any medical procedure, equipment, treatment or course of treatment, or drugs or medicines that is meant to investigate and is limited to research. This term also means techniques that are restricted to use at those centers that are capable of carrying out disciplined clinical efforts and scientific studies. "Experimental Procedure" also includes procedures which are not proven in any objective manner to have therapeutic value or benefit. Any procedure or treatment whose effectiveness is medically questionable is also deemed experimental.

This includes techniques that are restricted to use at those centers that are capable of carrying out disciplined clinical efforts and scientific studies.

This exclusion does not preclude the Plan from paying benefits for approved clinical trials.

jj. for routine immunizations, well baby/child check-ups and other similar services rendered for routine maintenance care (except the preventive benefits listed in the Schedule of Benefits);

kk. for any bodily or sickness which arises from or is sustained in the course of any occupation or employment for compensation, profit or gain;

ll. services or supplies provided in connection with smoking cessation, including but not limited to therapy, counseling, or medications (prescription or non-prescription);

mm. treatment of obesity except as required by law;

nn. voluntary sterilization is covered for member and spouse only, however, reversal or attempted reversal of any sterilization procedures are not covered;

oo. voluntary sterilization procedures for dependent children;

pp. artificial insemination or any related procedures, whether experimental or not, including but not limited to invitro or vivo fertilization, egg implantation, etc., or hormone therapy or any other direct attempt to induce or facilitate conception, or for treatment, therapy, or counseling for infertility. However, the Plan does cover the initial diagnostic evaluation to determine the cause of infertility;

qq. home health care services, unless a part of an alternative method of treatment recommended as part of the cost management program;

rr. charges for or in connection with dental treatment except for removal of tumors and except for dental work made necessary by accidental injury to natural teeth. The Plan provides coverage under the medical benefits portion for dental treatment provided by a dentist or dental surgeon in connection with a non-occupational injury /accident natural teeth (teeth are free of defect or decay), including any necessary dental x-rays and initial replacement of teeth, provided the treatment is received within six (6) months after the accident. Treatment of such injuries is covered <u>even if the person was not eligible for Plan benefits when the accidental injury occurred</u> or for the extraction of impacted wisdom teeth. Accidental injury does not include tooth breakage while chewing. Dental work must be completed within six (6) months from the date of injury;

ss. for medical observation and diagnostic studies undertaken as a matter of routine physical examination or health checkup except as set for in the Schedule of Benefits;

tt. charges for private duty nursing services;

uu. charges in connection with confinement of a child prior to the date the child attains fifteen (15) days of age and while the mother is confined in the same hospital;

vv. charges for services or supplies purchased outside the United States or Canada, unless the Employee is a resident of the United States or Canada and the charges are incurred while traveling for pleasure;

ww. any care, service, or supplies incurred for injuries or sickness, inflicted or received during the commission of or attempt to commit an illegal act are not covered by the Plan. Except where the source of the injury results from an act of domestic violence or from an underlying medical condition. For proposes of this section, the commission of or attempt to commit an illegal act shall not include acts involving traffic violations;

xx. for treatment of mental/nervous, alcoholism or drug dependency expenses in excess of any limitations previously described in this Plan description;

yy. charges for weekend admission for non-emergency unless pre-certified;

zz. charges for any drug testing directly or indirectly associated with any collectively bargained agreement between the Union and the Employers. The Fund does not cover any drug test associated with or required by any collectively bargained agreement;

aaa. charges for an injury, illness or disease incurred or aggravated during performance of service in the uniformed services and/or armed forces of the United States or in the uniformed services and/or armed forces of any country. Service in the uniformed services shall include, but shall not be limited to, the performance of duty on a voluntary or involuntary basis in: the U.S. Armed Forces or their respective units; the U.S. Army National Guard and Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service and any other category of persons designated by the President in time of war or emergency;

bbb. charges for a surgical procedure will not be payable if the results became medically invalid due to postponement or the surgical procedure for any reason other than those charge for x-rays and testing;

ccc. charges for more than one (1) hospital visit on any one (1) day;

ddd. charges related to an injury, sickness or illness caused by or claimed to be caused by an Accountable Person or claims (past, present and future) related to an injury, sickness or illness for which a settlement, judgment or any payment is received unless the Plan agrees to pay such claims pursuant to a written subrogation and reimbursement agreement;

eee. charges incurred by a covered person acting as a surrogate mother are not covered under the Plan. This includes but is not limited to any and all charges incurred by the surrogate mother for prenatal care and delivery of the child and any charges incurred by the child born to the surrogate mother unless and until the Plan is otherwise required to provide coverage for the child because the child is

a Dependent as defined by the Plan. For the purpose of this Plan, a "surrogate mother" is defined as a person who becomes pregnant through artificial or assisted methods for the purpose of carrying the fetus to term for a third party. All expenses paid by the Plan in such cases may be recovered from the Participant, the Participant's spouse and/or the third party or any related parties. Care, services or treatments required as a result of complications from a surrogate pregnancy by the Participant or Participant's spouse will not be covered under the Plan.

HEALTH REIMBURSEMENT ACCOUNT

If you have accumulated more than an amount equal to two (2) months' worth of the monthly rate for your coverage class in your Dollar Bank, the excess will become part of the Health Reimbursement Account (HRA) that you can use the excess to be reimbursed for your individual and/or family deductibles and coinsurances as well as other medical services which are not covered by the Plan and which are allowed per IRS tax code. This includes expenses for your spouse and dependents even if they are not eligible in this Plan and for whom you are legally obligated to pay.

ELIGIBILITY

You must have in excess of two (2) months' worth of the monthly rate for your coverage class in your eligibility account at the time you submit your claim for payment and payment is made from the Fund. You must apply for this benefit by submitting a Request for Reimbursement claim form and a paid receipt for medical service/ items not covered by the Plan. Claim forms can be requested from the Administration Office.

COVERED EXPENSES

The following types of expenses are considered covered expenses by the Trustees and Section 213(d) or the Internal Revenue Code:

- Payments for health coverage and health insurance, including regular self-payments, COBRA continuation coverage self-payments and retiree self-payments.
- Comprehensive Major Medical Expense Benefit deductibles and your out-of-pocket copayments, to the extent allowable under the Affordable Care Act.
- Medical expenses not covered by or in excess of the benefits provided under the Comprehensive
- Major Medical Expense Benefit.
- Vision expenses.
- Dental expenses. Pre-Service reimbursement available in the following circumstances:
    - The service must meet all the current requirements of the Plan for Medical Reimbursement; for example, the service must be allowed per IRS code which does not include cosmetic type services; and
    - Your dentist provides a schedule of the planned treatment program listing the total charges and the amount required prior to the start of the treatment; and
    - If the pre-reimbursement is approved, payment will be made from your Dollar Bank account and paid directly to your dentist for the planned treatment program provided by your dentist; and
    - If the planned treatment is cancelled or not completed, any excess payment must be returned by the dentist directly to the Ohio Bricklayers' Health & Welfare Plan and will be credited back to your Dollar Bank balance.
- Acupuncture.
- Guide dogs for blind or deaf people.
- Smoking cessation programs.

- Hearing examinations and hearing aids.
- Special telephone and television equipment for hearing-impaired persons.
- Surgery or laser treatment to correct vision.
- Weight-loss programs, but not food or dietary supplements.
- Transportation expenses primarily for and essential to medical care as permitted by Internal Revenue Code §213(d)(1)(B).
- Prescription drugs and certain over-the-counter drugs and products that are determined to be qualified medical expenses by the Internal Revenue Service and determined by the Trustees to be a Covered Medical Expense. Note that, under the Patient Protection and Affordable Care Act, funds under this MRP may only be used to reimburse prescribed drugs, insulin, over-the-counter ("OTC") drugs that are obtained with a prescription from a physician and OTC items that are not medicines or drugs. A "prescription" means a written or electronic order for medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.
- Qualified "Special Schooling for the Mentally Impaired or Physically Disabled," provided that the schooling is medically necessary and the school qualifies under the IRS regulations as such a special school.

OTHER RULES FOR COVERED EXPENSES

If the expenses exceed three hundred dollars ($300.00) you can specifically authorize payment to be made directly to a provider from your HRAbalance.

You can have your HRA automatically deducted for any Co-Insurance and Deductible amounts which you may owe to health care providers. This automatic deduction will be paid directly to health care providers. Please contact the Plan Administrator if you wish to have your HRA automatically deducted for co-insurance and deductible purposes.

REIMBURSEMENT TIME LIMITATIONS

You can submit your claim for reimbursement at any time as long as it is not more than twenty-four (24) months following the date such expenses were incurred.

EXPENSES THAT ARE NOT COVERED

The following types of expenses are not considered covered expenses and will not be reimbursable to you:

- Cosmetic surgery and treatments.
- Health club memberships or expenses.
- Elder care.
- Household help.

- Maternity clothes.

- Cosmetics, toiletries and sundry products, including but not limited to acne treatments, dietary supplements, fiber supplements, herbs, lip balm, shampoos and soaps, suntan lotion, weight loss drugs and vitamins, or any other product that is not determined to be a qualifying medical expense by the IRS, or that the Trustees have determined not to be a MRP covered expense.

- Premiums for long-term care insurance.

- Expenses for which you can be reimbursed by some other source.

- Sales tax, shipping and handling or related expenses for prescription drugs, durable medical equipment, etc.

COMPLIANCE WITH FEDERAL LAW

This HRA is intended to be "integrated" with the Ohio Bricklayers Health and Welfare Fund, which currently meets "minimum value" standards as defined in the regulations issued pursuant to the Patient Protection and Affordable Care Act. In the event that the Ohio Bricklayers Health and Welfare Fund is certified by the Plan Administrator or Plan actuary as failing to provide "minimum value" as such term is defined under the Patient Protect and Affordable Care Act, reimbursement of Medical Care expenses from the HRA shall be limited to reimbursements of co-payments, co-insurance, deductibles and premiums under non-HRA coverage, as well as medical care expenses that are not considered essential health benefits. A Participant, Eligible Retiree, Spouse or Dependent seeking reimbursement for expenses from a health plan other than the Ohio Bricklayers Health and Welfare Fund shall be required to submit proof sufficient to the Plan Administrator that the health plan related to which the individual is seeking reimbursement from the HRA provides minimum value as required under PPACA.

An individual who is eligible to participate in the HRA may elect to permanently opt-out of participation. By permanently opting out of participation in the HRA, the Participant forfeits all amounts accumulated in his Dollar Bank/HRA and waives all future contributions to his Dollar Bank/HRA for the eligibility period in which the opt-out is made.

WEEKLY DISABILITY INCOME BENEFITS

You will be entitled to loss of time benefits if, while covered under this Plan, you were disabled and unable to work because of an accident or illness. This benefit is only for non-work related accident or illness. This benefit is not available to any Dependents.

WEEKLY DISABILITY INCOME BENEFIT

If you are eligible to receive a Weekly Disability Income Benefit in accordance with the provisions and conditions under the Plan, you will receive a benefit in the amount of $250.00 weekly, less applicable withholdings.

Benefits begin on the first day of disability if due to an accident and on the eighth (8th) day if due to sickness. Your maximum period of benefit is twenty (20) weeks for any one period of disability.

Successive periods of disability will be considered one period of disability unless the subsequent period of disability:

a. results from causes entirely unrelated to the causes of the previous disability;
   or
b. begins after you have returned to active full-time work of at least forty (40) hours per week for at least two consecutive weeks.

A return to work for at least one (1) full day is required if you have successive disabilities due to different or unrelated causes.

You do not have to be confined to your home to collect benefits. However, you must be under the care of a Physician. Likewise, no disability will be considered as started more than three (3) days before you first see a Physician.

Also, see section “Continuation During Temporary Disability” for information regarding eligibility credits.

PROOF OF DISABILITY

A certificate indicating that you are unable to work, signed by a doctor who is an M.D. or D.O., is required before benefits will be paid. The Plan will not accept certification from a chiropractor. You can contact the Benefit Office for the proper form. A disability will not be considered to have begun until the first day that you are actually examined or treated by a doctor.

The Plan requires the following information supporting any disability claim, to be supplied at your expense:

1. The date of the disability;

2. The cause of the disability;

3. The prognosis of the disability;

4. Proof that you are receiving appropriate and regular care for the condition from a licensed doctor (excluding a chiropractor), who is someone other than you or a member of your immediate family and whose specialty or expertise is the most appropriate for the disabling condition(s);

5. A description of the extent of the disability, including restrictions and limitations which are preventing you from performing your regular occupation; and

6. The name and address of any hospital or medical facility where you have been treated for the disability.

CONTINUING PROOF OF DISABILITY

You may be asked to provide proof that you continue to be disabled and are receiving appropriate and regular care from a doctor. Requests for continuing proof of disability will be made only as often as the Board of Trustees deems reasonably necessary and must be satisfied at your expense within 30 days of the Board's request. If you fail to comply with a request for continuing proof of disability, your benefits may be delayed, suspended or terminated.

The Board may also require you to be examined as often as reasonably necessary while the weekly income disability claim continues. Such an examination will be done at the Board's expense by a board-certified doctor of the Board's selection. Further, the Board may examine any and all hospital or medical records relating to the injury or sickness underlying your short-term disability claim.

Overpayments: If you receive weekly disability income benefits when ineligible for such benefits, you must immediately notify the Benefit Office and return any overpayments. The Board may choose the method of recovery for any overpayments.

FRAUD

Any person who knowingly and with intent to defraud provides false information or omits relevant facts when filing a claim may be subject to criminal and civil penalties. These penalties include, but are not limited to, fines, denial or termination of benefits, recovery of any amounts paid, civil damages and/or criminal prosecution.

TAXATION OF WEEKLY BENEFITS

You must include your weekly Disability Income Benefits in your gross income and pay federal income tax on them. If you have a question about this, or about exclusions in the law, you should check with a competent tax advisor or counsel.

Weekly Income Benefits are also subject to Social Security taxes (FICA). You pay half of the tax and the Plan pays half. In accordance with federal law, the Plan will withhold your share of the FICA tax from each weekly benefit paid to you and will send it to the government.

DISABILITY CLAIMS PROCEDURE

The Plan Administrator will make a decision on the claim and notify you of the decision within forty-five (45) days. This period may be extended by the Plan for up to thirty (30) days, provided the Plan Administrator both determines that an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial forty-five (45) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If, prior to the end of the first thirty (30) day extension period, the Plan Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for an additional thirty (30) days.

Calculation of Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing.

Adverse Determination. An adverse determination includes a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. It also includes any rescission of disability coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except if it is the result of a failure to timely pay required premiums or contributions.

Content of Notice. The Plan Administrator shall provide a Claimant with written or electronic notification of any adverse benefit determination. The notification shall set forth, in a manner calculated to be understood by the Claimant and in a culturally and linguistically appropriate manner:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review;
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist;
- A statement that the Claimant is entitled to receive upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Claimant's benefit determination;
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    - The views presented by health professionals treating the Claimant and vocational professionals who evaluated the Claimant;
    - The views of medical or vocational experts whose advice was obtained on behalf of the plan, without regard to whether the advice was relied upon in making the benefit determination; and
    - A disability determination by the Social Security Administration

Appeals Procedure

1. The Claimant shall have 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination.

2. The Claimant shall have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.

3. The Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits.

4. The review on appeal shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

5. On appeal the Claimant shall be provided with any new or additional evidence or rationale considered or relied upon in connection with the claim automatically and free of charge; such evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the decision will be made. The Claimant shall be provided with a review that does not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor the subordinate of such individual. In deciding an adverse benefit determination that is based in whole or in part on medical judgment including determinations regarding whether a treatment or drug is experimental, investigational, or not medically necessary, the Plan will consult a health care professional who has the appropriate training and experience in the medical field involved in the judgment and the medical or vocational expert will be identified. The healthcare professional engaged for consultation will not be an individual who was consulted in making the adverse benefit determination that is the subject of the appeal, nor their subordinate. The Plan Administrator will identify any medical or vocational experts whose advice was obtained on behalf of the plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

6. The Trustees shall make a benefit determination no later than the date of the meeting of the Trustees that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within thirty (30) days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second (2nd) meeting following the Plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third (3rd) meeting of the Trustees following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Plan Administrator shall provide the Claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Plan Administrator shall notify the Claimant of the benefit determination as soon as possible, but not later than five (5) days after the benefit determination is made.

7. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the reasonable procedures of a Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended due to a Claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

8. The Plan Administrator shall provide the Claimant with a written or electronic notification of the Plan's benefit determination on review. The notification shall set forth, in a manner reasonably calculated to be understood by the Claimant and in a culturally and linguistically appropriate manner:

   - The specific reason or reasons for the adverse determination;
   - Reference to the specific Plan provision on which the benefit determination is based;

- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits;
- A statement of the Claimant's right to bring an action under Section 502(a) of ERISA and a statement of the applicable contractual limitation period that applies to the Claimant's right to bring such as action, including the calendar date on which the contractual limitations period expires for the claim; and
- The following statement: "You and your plan may have other voluntary alternative dispute resolutions 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 your State insurance regulatory agency.";
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and
- A statement that the Claimant is entitled to receive upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Claimant's benefit determination.
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    - The views presented by health professionals treating the Claimant and vocational professionals who evaluated the Claimant;
    - The views of medical or vocational experts whose advice was obtained on behalf of the plan, without regard to whether the advice was relied upon in making the benefit determination; and/or
    - A disability determination by the Social Security Administration.

Statute of Limitations. No action at law or equity shall be brought by any Participant or Beneficiary after the expiration of three (3) years from the date the Board provides written notice of a decision on appeal of an adverse benefit determination. Failure to bring an action within this three (3) year period shall forever bar such action.

Restriction on Venue. A participant or Beneficiary shall only bring an action in connection with the Plan in the federal courts of Ohio.

De Minimis Violations. If the Plan fails to strictly adhere to all the requirements of the claims and appeals section of the Plan with respect to the claim, the Claimant is deemed to have exhausted the administrative remedies available under the Plan, except for de minimis violations explained below. As such, the claimant is entitled to pursue any remedies under Section 502(a) of ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If a Claimant choses to pursue remedies under Section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

The administrative remedies available under the Plan with respect to claims for disability benefits will not be deemed exhausted based on de minimis violations that do not cause and are not likely to cause, prejudice or harm to the Claimant so long as the Plan demonstrates that the violation was for good cause or due to matters

beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan. The claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects the Claimant's request for immediate review under this section on the basis that the Plan met the standards for the exception under this paragraph, the claim shall be considered re-filed on appeal upon the Plan's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Plan shall provide the claimant with notice of the resubmission.

External Appeals Procedures

You have the right to request an "external review" of your adverse benefit determination. The timeline for an external review is as follows:

Request for External Review: External review must be requested within four (4) months after receipt of notice of adverse benefit determination.

Preliminary Review: Must be completed within five (5) business days after receipt of request. The Plan will determine: (1) if the claimant is or was covered under the plan; (2) if the adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the plan; (3) if the claimant has exhausted the internal appeal process; and (4) of the claimant has provided all the information and forms required to process an external review. The Plan must issue notification in writing to the claimant within one business day after completion of the preliminary review. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and the current contact information, including the phone number, for the Employee Benefits Security Administration. If the request is not complete, such notification must describe the information or materials needed to make the request complete. The Plan must allow the claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Referral to Independent Review Organization (IRO): The Plan must contract with at least three (3) IROs. Within five (5) business days after assignment to an IRO, the Plan must provide all documents and information considered in denying the appeal to the IRO. The IRO must provide written notice of its decision within 45 days of assignment.

Implementation of Reversal: Upon receipt of notice of a final external review decision reversing an adverse benefit determination, the Plan must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits for claim).

LIFE INSURANCE BENEFITS

GROUP LIFE INSURANCE

Death and dismemberment benefits are provided by an insurance policy issued to the Fund. You should refer to the Schedule of Benefits for the amounts of coverage. These benefits are only available for active employees and retirees. **Dependents are not eligible for these benefits.**

You are not eligible for the Life or Accidental Death and Dismemberment (AD&D) benefits for any period during which your Plan coverage is being continued under COBRA coverage.

CONTINUATION OF LIFE INSURANCE DURING PERMANENT AND TOTAL DISABILITY

If you become Permanently and Totally Disabled and unable to work, your Life Insurance may be continued at no cost to you. The following conditions must be met: the disability must begin before your sixtieth (60th) birthday; you must become totally disabled while eligible for benefits in this Plan; the total disability must have existed for a period of at least nine (9) months; and you must submit acceptable medical evidence to the insurance company that your total disability is permanent. **The first notice and proof of your Total Disability must be given to the insurance company within twelve (12) months of the date your coverage terminates in this Plan; but in no event more than 24 months from the date your Total Disability began.** Proof of Total Disability must be furnished each year afterwards.

The decision on this continuation benefit is made solely by the insurance company underwriting such coverage. The Health and Welfare Fund is not involved in this decision-making process.

If you receive approval from the insurance company, your life insurance will be continued by the insurance company for as long as you are Totally Disabled. When your Total Disability ends, your life insurance will no longer be continued.

This waiver of premium rule allows someone to drop coverage in this Health & Welfare Plan but keep their life coverage with the insurance company.

Whether or not you are eligible for this waiver of premium option, your monthly premium amount for health coverage in this Health & Welfare Plan is not affected.

If you are eligible in the Health & Welfare Plan for health benefit, and you have been approved and are eligible for the Waiver of Premium benefit, you are NOT eligible for the life benefit listed in the Schedule of Benefit. Your life benefit would be for the amount which was approved under the Waiver of Premium benefit.

CONVERSION PRIVILEGE UPON TERMINATION OF COVERAGE

If your life insurance terminates because your eligibility for benefits under this Plan terminates, or because the group life insurance policy terminates and is not replaced by another policy, you can convert your life insurance to an individual policy.

You must pay the insurance premiums; no medical examination or proof of good health is required; and you can convert to any type of individual life insurance policy customarily issued by the insurance company except term insurance.

The decisions on this continuation of life benefit are made solely by the insurance company underwriting the coverage. This Plan is not involved in the decision-making process but will offer assistance to you when making application.

Your written application and first premium payment must be made within thirty-one (31) days after termination of your eligibility for life insurance or termination of the group insurance policy. If you die within the thirty-one (31) day period allowed for conversions, your life insurance will be paid even if you have not applied for conversion.

LIFE AND AD&D BENEFIT CLAIMS

Decision Timeline

You will be notified of the decision within 30 days after receipt of the claim. However, this period may be extended by an additional 15 days, if the Fund Administrator determines that the extension is necessary due to matters beyond the control of the Plan. The Fund Administrator will notify you of the extension before the end of the initial 30-day period, the circumstances requiring the extension, and the date by which the Fund Administrator expects to make a decision. If the extension is required because you did not submit the necessary information to decide the claim, the notice of extension will specifically describe the necessary information, and you will be afforded at least 45 days to provide the information.

Content of Notice

The Fund Administrator will provide a claimant with written or electronic notification of any denial. Any electronic notification shall comply with the standards imposed by law. The notification shall set forth, in a manner calculated to be understood by the claimant:

1. The specific reason or reasons for the denial;
2. Reference to the specific Plan provisions on which the denial is based;
3. A description of any necessary additional information to consider the claim and an explanation of why the information is necessary;
4. A description of the Plan's review procedures, applicable time limits, a statement of your right to bring a civil action under Section 502(a) of ERISA following a denial on appeal, and the applicable contractual limitations period for filing such a claim;
5. The notice shall also include the following if applicable:
    a. If an internal rule, guideline, or protocol was relied upon in making the denial, the specific rule, guideline or protocol; or a statement that such a rule, guideline, or protocol was relied upon in making the denial and that a copy will be provided free of charge upon request; or
    b. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to the medical circumstances, or a statement that such explanation will be provided free of charge upon request.

LIFE AND AD&D BENEFIT APPEALS

The following are the procedures to be followed by the Plan in reviewing an appeal of a claim denial:

- You must file your appeal within 180 days following receipt of the first initial denial.
- You will have the opportunity to submit written comments, documents, records, and other information related to the claim.
- The Plan must allow you to review the claim file and present evidence and testimony as part of the review process

- You will be provided, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to the claim.
- The review on appeal will not afford deference to the initial denial and will be conducted by the Board of Trustees or a designated committee thereof.
- The Board of Trustees will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
- In deciding an appeal of any denial that is based in whole or in part on a medical judgment, including denials with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate, the Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; this health care professional shall not be the individual who was consulted in connection with the original denial, nor the subordinate of any such individual.
- The Plan will provide to the claimant the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit denial;
- You will be provided with any new or additional evidence or rationale considered, relied upon, or generated in connection with the claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the benefit determination will be decided on appeal. You will be given a reasonable opportunity to respond prior to the date of the appeal determination. If new or additional evidence is received so late that it would be impossible to provide you with a reasonable opportunity to respond, the period for providing a notice of final internal adverse benefit determination is tolled until you have a reasonable opportunity to respond.

Decision Timeline

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that period of time is extended as permitted due to a claimant's failure to submit the information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

The Trustees shall make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, you will be notified in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. You will be notified of the decision within 5 days after the determination is made.

Content of Notice

The Fund Administrator will provide you with written or electronic notification of any denial. Any electronic notification shall comply with the standards imposed by law. The notification will set forth, in a manner calculated to be understood:

1. The specific reason or reasons for the denial;

2. Reference to the specific Plan provisions on which the denial is based;
3. 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 the claim;
4. A statement of your right to bring a civil action under Section 502(a) of ERISA following a denial on appeal, and description of the applicable time limits to file such an action, including the applicable calendar date on which the contractual limitations period expires;
5. If an internal rule, guideline, or protocol was relied upon in making the denial, the specific rule, guideline or protocol; or a statement that such a rule, guideline, or protocol was relied upon in making the denial and that a copy will be provided free of charge upon request;
6. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to the medical circumstances, or a statement that such explanation will be provided free of charge upon request.
7. 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 your State insurance regulatory agency."

CONTINUATION OF MEDICAL BENEFITS (COBRA)

CONTINUATION OF BENEFITS

Federal law requires most employers sponsoring group health plans to offer Members and their families the opportunity to elect a temporary extension of health coverage (called "Continuation Coverage" or "COBRA Coverage") in certain instances where coverage under the group health plan would otherwise end. You do not have to show that you are insurable to elect continuation coverage. However, you will have to pay all of the costs of your continuation coverage.

This section is intended to summarize your rights and obligations under the law. The Plan offers no greater COBRA rights than what the COBRA statue requires, and this section shall be construed accordingly.

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 that plan generally does not accept late enrollees.

ELIGIBILITY FOR COBRA

A qualified beneficiary under COBRA law means an employee, employee's spouse or dependent child covered by the Plan on the day before a qualifying event. A qualified beneficiary under COBRA law also includes a child born to the employee during the coverage period or a child placed for adoption with the employee during the coverage period.

Employee Qualifying Events: An employee covered by the Plan shall become a qualified beneficiary on the date his or her eligibility for benefits from the Plan terminates due to the occurrence of any of the following qualifying events:

- Termination of the employee's employment or reduction in the hours of employee's employment (for reasons other than gross misconduct, as defined by your employer);
- The employee has becomes entitled to Medicare benefits; or
- The employee begins work for a non-contributing employer.

Spouse/Dependent Child Qualifying Events: A spouse or a dependent child covered by the employee's Plan has the right to elect continuation coverage if the group coverage is lost due to one of the following qualifying events:

- The death of the employee;
- Termination of the employee's employment or reduction of the employee's hours of employment with the employer (for reasons other than gross misconduct, as defined by your employer);
- The loss of eligible dependent status as defined in this Plan (i.e., a dependent spouse's divorce or legal separation from the employee); or
- The employee becomes entitled to Medicare benefits.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in loss of coverage under the Plan.

BENEFITS AVAILABLE

All benefits are available under COBRA coverage except disability benefits.

PROCEDURE FOR OBTAINING COBRA COVERAGE

1. **Notification Requirements.** The Plan provides that coverage terminates for a spouse or a child when they lose dependent status. Under the law, the employee or qualified beneficiary has the responsibility to notify the Plan Administrator **in writing** within 60 days whenever any of the following qualifying events occur:

   a. Divorce from the employee;
   b. Legal separation from the employee; or
   c. Loss of status as an eligible dependent;
   d. Eligibility for Medicare coverage.

   The notification shall take place immediately after any of the qualifying events occur. No specific form must be used, but oral notification to a Trustee or the Plan Administrator is not sufficient. If a qualifying event listed above is not reported to the Plan Administrator within sixty (60) days after it occurs, COBRA coverage shall NOT be provided. Such notice should be sent or delivered to:

   BeneSys
   P.O. Box 99550
   Troy, MI 48099

   It is the responsibility of contributing employers to notify the Benefit Office within forty-five (45) days of an employee's death, termination of employment, commencement of a proceeding in bankruptcy with respect to the employer or a reduction in hours which causes a loss of medical benefits under the Plan. However, you or another family member should also notify the Plan Administrator if any of these qualifying events occurs in order to assure timely notification of eligibility for, and processing of, your choice to receive COBRA Coverage.

2. **Election Notices and Forms.** When the Plan Administrator determines that a qualifying event has occurred, the Plan Administrator shall send an election notice to the qualified beneficiary. The election notice shall inform the qualified beneficiary what coverage may be continued, the cost of said coverage and what the qualified beneficiary must do in order to obtain the COBRA coverage. The election notice shall also contain an application form for the COBRA coverage that must be completed and returned, along with the proper payment, to the Plan Administrator within the time period set forth therein.

   The election notice shall be sent to the qualified beneficiary's last known address on file in the Plan Administrator. In the case of multiple qualified beneficiaries of the same family, a single election notice shall be sent to all qualified beneficiaries at that address. It shall be the responsibility of each qualified beneficiary to read the election notice and take the required action(s). The parent or guardian of a qualified beneficiary who is a minor child may read the election notice for said child and take action on said child's behalf.

3. Election of COBRA Coverage.

a. A covered employee or the spouse of the covered employee may elect continuation coverage for all covered dependents, even if the covered employee or spouse of the covered employee or all covered dependents are covered under another group health plan (as an employee or otherwise) prior to the election. The covered employee, spouse and dependent child each have an independent right to elect continuation coverage.

b. A spouse or dependent child may elect continuation coverage even if the covered employee does not elect it, as each qualified beneficiary shall be entitled to individually elect the COBRA coverage.

c. If the qualified beneficiary, or a parent or guardian acting on behalf of a minor qualified beneficiary, elects COBRA coverage, he shall make sure that a completed and signed application form is returned to the Plan Administrator within sixty (60) days of the date on the election notice. Each qualified beneficiary who elects COBRA coverage must be named on the application form or a separate application form must be submitted for any person not named therein.

d. If, for any reason, the Plan Administrator/Benefit Office does not receive the completed application for any qualified beneficiary within the sixty (60) day period, that qualified beneficiary's eligibility for COBRA shall expire and his health care benefits shall terminate as of the date he first became a qualified beneficiary. The Plan shall not be liable and shall be held harmless in the event that a parent or guardian, acting on behalf of a qualified beneficiary who is a minor child, fails to inform the minor qualified beneficiary of his right to elect COBRA coverage and/or fails to elect COBRA coverage for said minor qualified beneficiary within the sixty (60) day period.

4. When Coverage Begins. Coverage will not be provided during the election period. However, if the individual makes a timely election, coverage will be provided from the date that coverage would otherwise have been lost. If coverage is waived before the end of the 60-day election period and the waiver revoked before the end of the 60-day election period, coverage will be effective on the date the election of coverage is sent to the Plan Administrator.

5. COBRA Coverage Self-Payment Rules.

a. The monthly self-payment rate for COBRA coverage shall be determined periodically by the Board of Trustees and shall be based upon the cost of the coverage provided by the Plan. The monthly self-payment rate and frequency of payment shall be stated on the election notice at the time it is sent to the qualified beneficiary. The self-payment rate may change due to changes in the benefits offered by the Plan and to reflect any changes in the cost of the coverage.

b. The monthly premium payment to the Plan for continuing coverage must be submitted directly to the Plan. This monthly premium may include the employee's share and any portion previously paid by the employer's contributions. The monthly premium must be a reasonable estimate of the cost of providing coverage under the Plan for similarly situated non-COBRA beneficiaries. The premium for COBRA continuation coverage may include a 2% administration charge. However, for qualified beneficiaries who are receiving up to 11 months additional coverage (beyond the first 18 months) due to disability extension (and not a second qualifying event), the premium for COBRA continuation coverage may be up to 150% of the applicable premium for the additional months. Qualified beneficiaries who do not take the additional 11 months of special coverage will pay up to 102% of the premium cost.

c. The first self-payment shall be due on the first day of the calendar month next following the date on which the qualifying event occurs. The first self-payment shall cover the qualified beneficiary from the date of the qualifying event through the last day of the next following calendar month and shall be in an amount prorated to reflect the actual number of days of coverage during the period.

d. The entire amount shown on the bill must be received within forty-five (45) days of the due date as stated on the bill. Until the bill is paid in full, COBRA coverage shall not be effective and no medical expenses incurred after the qualifying event shall be paid. Subsequent self-payments shall be due on the first day of each calendar month in an amount equal to the monthly self-payment rate, except that the last self-payment due shall be prorated to reflect the actual number of days of coverage up to the date COBRA coverage terminates.

e. It shall be the absolute responsibility of each qualified beneficiary or the person acting on behalf of a qualified beneficiary to ensure that the Plan Administrator receives correct payment on a timely basis. The Plan shall not be liable and shall be held harmless by the qualified beneficiary in the event that a parent or guardian, acting on behalf of a qualified beneficiary who is a minor, causes the qualified beneficiary to lose COBRA coverage through a failure to submit correct payment in a timely fashion.

MAXIMUM COVERAGE PERIOD

Coverage may continue up to:

- 18 months for an employee and/or dependent whose group coverage ended due to termination of the employee's employment or reduction in hours of employment;

- 36 months for a spouse whose coverage ended due to the death of the employee or retiree, divorce, or the employee becoming entitled to Medicare at the time of the initial qualifying event;

- 36 months for a dependent child whose coverage ended due to the legal separation or divorce of the employee parent, the employee becoming entitled to Medicare at the time of the initial qualifying event, the death of the employee, or the child ceasing to be a dependent under the Plan;

- For the retiree, until the date of death of the retiree who is on continuation due to loss of coverage within one year before or one year after the Plan filed Chapter 11 bankruptcy.

DISABILITY

An 11-month extension of coverage may be available if any qualified beneficiaries are determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The qualified beneficiary must provide notice of such determination prior to the end of the initial 18-month continuation period to be entitled to the additional 11 months of coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If a qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination.

SECOND QUALIFYING EVENT

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying event may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after the second qualifying event occurs if you want to extend your continuation coverage.

TERMINATION OF COBRA COVERAGE

COBRA coverage shall terminate on the first date that any of the following events occur:

- The date on which a qualified beneficiary completes the maximum period of COBRA coverage for which he is eligible;
- The date on which the Fund no longer provides group health coverage to any of its participants;
- The date on which a self-payment for COBRA coverage is not made in a timely manner;
- The date, after the qualifying event, on which a qualified beneficiary first becomes covered under another group health plan (as an employee or otherwise);
- The individual on continuation becomes entitled to Medicare benefits;
- If there is a final determination under Title II or XVI of the Social Security Act that an individual is no longer disabled; however, continuation coverage will not end until the month that begins more than 30 days after the determination;
- The occurrence of any event (e.g. submission of a fraudulent claim) permitting termination of coverage for cause under the Plan; or
- The date the Plan terminates.

OTHER COVERAGE OPTIONS

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid or other group health plan options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn about many of these options at www.healthcare.gov.

OTHER INFORMATION

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

the Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.healthcare.gov.

If you or your qualified beneficiaries have any questions about COBRA, please contact the Plan Administrator at the address listed below. Also, please contact the Fund Office if you wish to receive the most recent copy of the Plan's Summary Plan Description, which contains important information about the Plan benefits, eligibility, exclusions and limitations.

It is important for the covered person or qualified beneficiary to keep the Plan Administrator informed of any changes in marital status, dependent status or changes in address:

BeneSys
P.O. Box 99550
Troy, MI 48099

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

CONTINUATION OF BENEFITS

Federal law requires that health plans must offer to continue coverage for employees who are absent due to service in the uniformed services and/or their dependents. Coverage may continue for up to 60 months after the date the employee is first absent due to uniformed service. Health coverage means hospital, surgical, medical, dental or vision coverage provided under the Plan. Health coverage is subject to change as a result of plan modification. In the event of a conflict between this provision and USERRA, the provisions of USERRA shall apply. A member's USERRA rights terminate if his uniformed service ends in an undesirable conduct category of discharge.

ELIGIBILITY

An employee is eligible for continuation under USERRA if absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, the commissioned corps of the Public Health Service, or any other category of persons designated by the President of the United States of America in a time of war or national emergency. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and for the purpose of an examination to determine fitness for duty.

An employee's dependents who have coverage under the Plan immediately prior to the date of the employee's covered absence are eligible to elect continuation under USERRA.

COVERAGE DURING LEAVE

If you go on active duty in the military, you must notify the Fund Office in writing before you enter active duty to preserve your rights under the Plan. Your rights under the Plan will then continue as long as the following requirements are met:

1. Your time on active duty does not exceed five (5) years: and

2. You are released from active duty under honorable conditions; and

3. You apply for work in covered employment under the Plan and notify the Fund Office within ninety (90) days of being released from active duty.

If you meet the above requirements, the following rules will apply:

1. You will be treated as if you never left the Plan; and

2. Any balance in your Dollar Bank will be held until you return to covered employment under the Plan. At that time the Dollar Bank balance can be used to maintain your eligibility, and

3. Pre-existing condition rules will not be applied to you or your eligible dependents when you return to the Plan; and

4. You and your eligible dependents will be eligible for continuation coverage on a self-pay basis for twenty-four (24) months at the time you begin active duty. Your Dollar Bank balance can be used for the monthly payment if you agree. Please note that continuation of coverage through this

provision is in lieu of COBRA coverage. You will have to choose between continued coverage through this provision and COBRA coverage (see pages dealing with COBRA coverage).

DURATION OF COVERAGE

Elected continuation coverage under USERRA will end at midnight on the earliest of:

- The day the Plan is terminated;
- The day the premium is due and unpaid;
- The day the employee again becomes covered under the Plan;
- The day health coverage has been continued for the period of time of 60 months, beginning the first day of absence from employment due to service in the uniformed services; or
- The day after the employee fails to apply for or return to employment as required by USERRA, after completion of a period of service.

Under federal law, the period of coverage available under USERRA shall run concurrently with the COBRA period available to an employee and/or eligible dependents.

OTHER INFORMATION

The employee should contact the Benefit Office with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the Benefit Office of any changes in marital status, or a change of address.

COORDINATION OF BENEFITS

The Medical Plan has a coordination of benefits (COB) provision that ensures that you do not receive duplicate benefits when you have coverage under more than one plan. It applies if you are covered by another employer's plan or government health plan in addition to this Plan and any automobile insurance, including but not limited to med-pay provision, uninsured motorists provision, etc., or any claim which may arise under these provisions.

Benefits are coordinated when both you and your spouse (and/or your Dependent children) are covered by this Plan as well as by another plan (usually your spouse's plan). Coordination allows benefits to be paid by two or more plans, up to but not to exceed one hundred (100%) percent of the allowable expenses on the claim.

GENERAL INFORMATION

1. Benefits are coordinated on all Employee and Dependent claims; C.O.B. applies only to the medical benefits provided under this Plan.

2. You must file claims for any benefits that you are entitled to from any source. If you don't file claims with other sources, this Plan will calculate benefits as though you have done so.

3. Benefits are coordinated with other group plans, including group Blue Cross and Blue Shield, blanket insurance plans, employer sponsored plans, plans sponsored by the federal government or by any state or local government or any tax-supported plan provided by or through any governmental action. Benefits are also coordinated with Medicare.

4. Benefits are paid under C.O.B. for "allowable expenses", which are expenses which are eligible to be considered for reimbursement.

5. If the other plan has procedures which must be followed or providers which must be used in order to get maximum reimbursement, benefits will be coordinated as if those procedures had been followed or the providers used even if they were not. For example, if the other plan assesses a penalty for noncompliance with a utilization review program, expenses represented by that penalty, in dollars or other reduction in benefits, will not be allowable expenses under C.O.B.

6. A plan that is required to pay its benefits before another plan pays its benefits is the "primary" plan; the plan that pays its benefits after the other plan has paid its benefits is the "secondary" plan. When this Plan is the secondary plan, the amount payable by this Plan after the other plan has paid is reduced so that the total reimbursement does not exceed one hundred (100%) percent of the allowable expenses on the claim.

When anyone in your family who is covered under another group health plan has a claim, be sure that you and the affected Dependent file claims with all plans and provide all required information about other coverage on all forms.

ORDER OF BENEFIT DETERMINATION

When a person who has a claim is covered under one or more other plans, the plans will determine their benefits as follows:

1. If the other plan does not have C.O.B. rules, that plan will pay its benefits first and this Plan will pay second.

2. When the other plan does have C.O.B. rules, the plan covering the person for whom the claim is filed as an Employee or as a Retiree will pay first and the plan covering the person other than as an Employee or as a Retiree will pay second.

3. If you and your spouse are both covered as Employees under this Plan, the Plan will coordinate benefits, first as an Employee and then as a Dependent, if dependency status exists.

4. C.O.B when a person has COBRA Coverage – If a covered person is covered under another group health plan and also has COBRA Coverage under this Plan because he has one or more preexisting conditions for which the other plan limits or excludes coverage, this Plan will pay primary benefits only on claims for treatment of the pre-existing condition(s) and the other plan will pay primary benefits on claims for treatment of all other conditions.

5. C.O.B. on claims for Dependent children:
   a. When the parents are not separated or divorced, the plan covering the parent whose birthday comes first in the year will pay first and the plan covering the parent whose birthday comes later in the year will pay second (the year of birth doesn't count). The Plan will pay benefits according to this rule regardless of the C.O.B. rules of the other plan.
   b. When the parents are separated or divorced, benefits are payable according to any existing court decree. If there is not a court decree stating who is responsible for a child's health care, the plan covering the parent with custody (if not remarried) pays first and the plan covering the parent without custody pays second. If the parent with custody has remarried, that parent's plan pays first, the stepparent's plan pays second and the plan covering the parent without custody pays third.
   c. If you and your spouse are both covered as Employees under this Plan, benefits for claims for a Dependent child will be coordinated.

6. If a covered person is covered under one plan as an active Employee and under another plan as a laid-off or retired Employee, the plan which covers him as an active Employee will pay its benefits before the plan which covers him as a laid-off or retired Employee. This same rule will also apply if a covered person is a Dependent of a person covered as both an active Employee or retired Employee.

7. If the above rules still do not clearly show which plan should pay first, the plan that has covered the person (for whom the claim is filed) the longest period of time will pay first, the plan that has covered the person for the next longest period of time will pay second, and so on.

COORDINATION OF BENEFITS WITH MEDICARE

If a person is eligible for Medicare, the Plan will pay benefits, including C.O.B. calculations, as if he is enrolled in Medicare Part "A" and "B" coverage, even if he/she is not actually enrolled in these Parts of Medicare.

REIMBURSEMENT/SUBROGATION

Subrogation and reimbursement allows the Fund to recoup the value of any benefits (medical, disability, etc.) paid on behalf of a person covered by this Plan who is injured or suffers an illness through the act or omission of another person or entity accountable for the injury or illness (hereinafter called "Accountable Person" or "Accountable Persons"). The subrogation and reimbursement process help the overall financial stability of the Fund by ensuring that the Plan is not the only entity paying claims for illness and injuries caused by Accountable Persons.

By accepting benefits from the Fund, every covered person shall be deemed to have conclusively agreed to cooperate with the Fund to enforce its subrogation and reimbursement rights and to hold any recovery in trust for the benefit of the Fund in accordance with the terms of this Plan:

1. The Plan shall be repaid the full amount of the covered expenses it pays from any amount received from an Accountable Person for the bodily injuries or losses that necessitated such covered expenses. Without limitation, "amounts received from a Accountable Person" specifically includes, but is not limited to, liability insurance, workers' compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments, and any other settlements, judgments or insurance proceeds from any source in connection with the illness or accident. The Plan's rights apply to any recovery for any covered person regardless of whether the amounts are characterized or described as medical expenses or as amounts other than for medical expenses.

2. The Plan's right to repayment is, and shall be, prior and superior to the right of any Accountable Person, including the covered person, and the Plan's subrogation and reimbursement rights shall apply on a priority first-dollar basis to any recovery whether by suit, settlement, or otherwise even though the covered person may not have been fully compensated or "made whole" for all physical, psychological and/or financial damages. This provision rejects any "make whole" doctrine which would require a covered person to be "made whole" before the Plan is entitled to assert its subrogation rights.

3. The right to recover amounts from a Accountable Person for the injuries or losses that necessitate covered expenses is jointly owned by the Plan and the covered person. The Plan is subrogated to the covered person's rights to that extent. Regardless of who pursues those rights, the funds recovered shall be used to reimburse the Plan as prescribed above; the Plan has no obligation to pursue the rights for an amount greater than the amount that it has paid, or may pay in the future. The rights to which the Plan is subrogated are, and shall be, prior and superior to the rights of any Accountable Person, including the covered person. Any recovery, regardless of the source, must be held in trust by the covered person for the benefit of the Plan.

4. The covered person will cooperate with the Plan in any effort to recover from a Accountable Person for the bodily injuries and losses that necessitate covered expense payments by the Plan. The covered person will notify the Plan immediately of any claim asserted and any settlement entered into, and will do nothing at any time to prejudice the rights and interests of the Plan. Neither the Plan nor the covered person shall be entitled to costs or attorney fees from the other for the prosecution of the claim.

5. The Plan's rights of reimbursement and subrogation shall not be affected, reduced or eliminated by the make whole doctrine, comparative or contributory fault or the common fund doctrine, or any other federal or state common law defense.

6. The Plan is entitled to recover your debt to the Plan (such as, but not limited to, instances of overpayment) by offsetting future employer contributions.

RIGHT TO COLLECT NEEDED INFORMATION

You must cooperate with the Plan Administrator and when asked, assist the Plan Administrator by:

- Authorizing the release of medical information including the names of all providers from whom you received medical attention;
- Obtaining medical information and/or records from any provider as requested by the Plan Administrator;
- Providing information regarding the circumstances of your sickness or bodily injury;
- Providing information about other insurance coverage and benefits, including information related to any bodily injury or sickness for which another party may be liable to pay compensation or benefits; and
- Providing information, the Plan Administrator requests to administer the Plan.

Failure to provide the necessary information will result in denial of any pending or subsequent claims, pertaining to a bodily injury or sickness for which the information is sought, until the necessary information is satisfactorily provided.

The covered person must sign forms assigning subrogation and reimbursement rights to the Plan. The Plan Administrator may withhold payment of any benefits due under the Plan until it receives the signed forms. Payment of Plan benefits before the signed forms are received does not modify or invalidate the Plan's subrogation and reimbursement rights. By accepting benefits from the Plan, every covered person shall be deemed to have conclusively agreed to cooperate with the Plan to enforce its subrogation and reimbursement rights, and to hold any recovery in trust for benefit of the Plan.

DUTY TO COOPERATE IN GOOD FAITH

You are obliged to cooperate with the Plan Administrator in order to protect the Plan's recovery rights. Cooperation includes promptly notifying the Plan Administrator that you may have a claim, providing the Plan Administrator relevant information, and signing and delivering such documents as the Plan Administrator reasonably request to secure the Plan's recovery rights. You agree to obtain the Plan's consent before releasing any Accountable Person from liability for payment of medical expenses. You agree to provide the Plan Administrator with a copy of any summons, complaint or any other process serviced in any lawsuit in which you seek to recover compensation for your bodily injury or sickness and its treatment.

You will do whatever is necessary to enable the Plan Administrator to enforce the Plan's recovery rights and will do nothing after loss to prejudice the Plan's recovery rights.

You agree that you will not attempt to avoid the Plan's recovery rights by designating all (or any disproportionate part) of any recovery as exclusively for pain and suffering.

Failure of the covered person to provide the Plan Administrator such notice or cooperation, or any action by the covered person resulting in prejudice to the Plan's rights will be a material breach of this Plan and will result in the covered person being personally responsible to make repayment. In such an event, the Plan may deduct from any pending or subsequent claim made under this Plan any amounts the covered person owes the Plan until such time as cooperation is provided and the prejudice ceases.

TRUSTEES' DISCRETION

Even though the subrogation rights of the Fund are specifically and unequivocally due from the first dollar received by the covered person, the Plan reserves the right to exercise judgment as to the facts of each case. In determining each individual case, even though the Fund has the right to recover from the first dollar received, the Trustees may consider and allow for the cost of collection from the Accountable Person, including reasonable attorney's fees incurred by the covered person, in the sole discretion of the Trustees.

GENERAL PROVISIONS

The following provisions are to protect your legal rights and the legal rights of the Plan.

CONTESTABILITY

The Plan has the right to contest the validity of your coverage under the Plan at any time.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

1. Made in error; or

2. Made to you or any party on your behalf where the Plan determines the payment to you or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against you if the Plan has paid you or any other party on your behalf.

RIGHT OF RECOVERY

The Plan reserves the right to recover benefit payments made for an allowable expense under the Plan in the amount that exceeds the maximum amount the Plan is required to pay under these provisions. This right of recovery applies to the Plan against:

1. Any person(s) to, for or with respect to whom, such payments were made; or

2. Any other insurance companies, or organizations that according to these provisions, owe benefits due for the same allowable expense under any other plan.

The Board of Trustees has sole discretion in deciding against whom this right of recovery will be exercised.

WORKERS' COMPENSATION NOT AFFECTED

The Plan is not issued in lieu of, nor does it affect any requirement for coverage by any Workers' Compensation or Occupational Disease act or law.

WORKERS' COMPENSATION

If benefits are paid by the Plan and the Plan determines you received Workers' Compensation for the same incident, the Plan has the right to recover as described under the Reimbursement/Subrogation provision. The Plan will exercise its right to recover against you even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

2. No final determination is made that bodily injury or sickness was sustained in the course of or resulted from your employment;

3. The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by you or the Workers' Compensation carrier;

4. The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by the Plan, you will notify the Plan Administrator of any Workers' Compensation claim you make, and that you agree to reimburse the Plan as described above.

CONSTRUCTION OF PLAN TERMS

The Plan has the sole right to construe and prescribe the meaning, scope and application of each and all of the terms of the Plan, including, without limitation, the benefits provided thereunder, the obligations of the covered person and the recovery rights of the Plan; such construction and prescription by the Plan shall be final and uncontestable.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the covered mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis; and
- Treatment of physical complications of the mastectomy, including lymphedema.

Contact your employer if you would like more information on WHCRA benefits.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008

The Ohio Bricklayers' Health & Welfare Plan (OB H&W Plan) is in compliance with the Genetic Information Nondiscrimination Act of 2008. While genetic information may be required for determination of medical appropriateness by the OB H&W Plan, this genetic information is never used to determine eligibility for benefits. If genetic information is needed to help with the determination of medical appropriateness, only the minimum amount of genetic information will be requested.

However, in some cases, the appropriateness of certain courses of treatment for a patient depends on the patient's genetic makeup. The OB H&W Plan may condition benefit payment for an item or service based on medical appropriateness that depends on an individual's genetic makeup.

Additionally, genetic information is never used to increase or set monthly premium amounts or contributions amounts required for eligibility.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

This Plan will also provide applicable benefits in accordance with the applicable requirements of any "Qualified Medical Child Support Order" (QMCSO) from a domestic relations court, as that term is defined by federal law at the time such order is presented to the Plan Administrator. A copy of the Plan's Qualified Medical Child Support Order Procedures is available upon request.

FRAUD

In the event that any covered person under the Fund is suspected of having fraudulently obtained coverage for him and/or dependents, the Fund at the discretion of its Board of Trustees may offset future benefits, terminate benefits, bring a civil action and/or refer the case for criminal prosecution.

PRIVACY POLICY (HIPAA)

The Plan is required to protect the confidentiality of your Protected Health Information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services ("HHS"). Protected Health Information (PHI) is defined as all individually identifiable health information transmitted or maintained by the Plan that relates to your past, present, or future health, treatment, or payment for health care services.

This Privacy Notice is provided by the Ohio Bricklayers Health and Welfare Plan. This notice describes the Plan's privacy practices, legal duties, and your rights concerning your PHI. The Plan must follow the privacy practices described in this notice while it is in effect. This policy will remain in effect until the Plan publishes and issues a new notice.

The Ohio Bricklayers Health and Welfare Plan ("Plan") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- The Plan's uses and disclosures of PHI;
- Your privacy rights with respect to your PHI;
- The Plan's duties with respect to your PHI;
- Your right to file a complaint with the Plan and to the secretary of the US Department of Health and Human Services; and
- The person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Section 1. Notice of PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it. Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Pursuant to the provisions of the Genetic Non-Discrimination Act (GINA), genetic information will be treated as health information.

- **Uses and disclosures to carry out treatment, payment and health care operations**

Although the Plan and the administrative office do not normally maintain or retain PHI, sometimes it does temporarily use such information. PHI would be maintained and used by the insurance companies/benefit service vendors retained by the Plan. The following categories give details about the times when the Plan could have access to your PHI. Not every use or disclosure in a category will be listed, but all of the uses and disclosures permitted by law fall within the categories.

To Help with Treatment. The Plan itself does not directly provide any health care treatment. However, the Plan may use or share your PHI care information to help health care providers serve or treat you. For example, the Plan may share information about allergies to a hospital emergency department if needed to render appropriate emergency care.

To Obtain Payment of Claims. The Plan may use and share your PHI to make payment possible for covered health care that you receive. This includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations).

For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations. These include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

As Required to Comply with Laws and Government Authorities. The Plan will disclose your PHI when required by federal, state or local law, regulation, or court or government agency order. For example, as permitted or required by law, the Plan must reveal PHI when: required to work with public officials to prevent or manage a serious threat to public health or safety; required for government monitoring of health care, civil rights laws, or other government oversight activities; order to do so by a court or other lawful process relating to a civil lawsuit or criminal matter; and directed by law enforcement officials, coroners, medical examiners, or national security officials in the lawful pursuit of their duties. If ordered by a court or other legal process to provide PHI about you, the Plan will make an effort to tell you about the request.

Use and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release. Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Section 2. Rights of Individuals

Right to Request Restrictions on PHI Uses and Disclosures. You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Such requests should be made to the Privacy Officer:

BeneSys
P.O. Box 99550
Troy, MI 48099

Right to Inspect and Copy PHI. You have the right to inspect and obtain a copy of your PHI for as long as the Plan maintains the PHI.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the Privacy Officer.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend PHI. You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests for amendment of PHI in a designated record set should be made to the Privacy Officer. You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set.

The Right to Receive an Accounting of PHI Disclosures. At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: 1) to carry out treatment, payment or health care operations; 2) to individuals about their own PHI; or 3) prior to the compliance date.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

The Right to Receive a Paper Copy of This Notice Upon Request. To obtain a paper copy of this Notice, contact the Privacy Officer.

A Note about Personal Representatives. You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section 3. The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide each covered person and beneficiary with notice of its legal duties and privacy practices.

The Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan retroactively if needed. If a privacy practice is changed, a revised version of this notice will be provided (to all past and present covered persons and beneficiaries) for whom the Plan still maintains PHI. This notice will be delivered by first class mail to the most recent address on file with the Benefit Office.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Minimum Necessary Standard. When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:
- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to the individual;
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- Uses or disclosures that are required by law; and
- Uses or disclosures that are required for the Plan's compliance with legal regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual and is therefore not considered to be individually identifiable health information.

In addition, the Plan may use or disclose "summary health information" to the Plan sponsor for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA.

Section 4. Breach Notification Rights for Unsecured Protected Health Information

The HITECH Act requires HIPAA-covered entities to provide notification to affected individuals and to HHS following the discovery of a breach of unsecured protected health information. In addition, in some cases of breach involving more than 500 individuals, the Act requires covered entities to provide notification to the

media. Finally, the Act requires the Secretary of HHS to post on an HHS Web site a list of covered entities that experience breaches of unsecured protected health information involving more than 500 individuals.

If your PHI is breached, the Plan will notify you without unreasonable delay and in no case later than 60 calendar days after discovery of the breach. Notice will be provided via first-class mail to your most recently known address; therefore, it is important to keep the Plan information of your current mailing address.

Section 5. Your Right to File a Complaint with the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the Privacy Officer. If you believe that your privacy rights have been violated, you may complain to the Plan in care of the Privacy Officer. Note that this right to file a complaint extends specifically to, but is not limited to, the right to complain about the Plan's implementation of the breach notification process, as detailed in Section 4 above.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, DC 20201.

The Plan will not retaliate against you for filing a complaint.

Section 6. Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Privacy Officer.

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

STATEMENT OF ERISA RIGHTS

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

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. Obtain, upon written request from the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for 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 this summary annual report.

PRUDENT ACTIONS OF PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of employee benefit plans. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

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

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

ASSISTANCE WITH QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the 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 or visiting the U.S. Department of Labor website at http://www.dol.gov/ebsa.

CLAIMS PROCEDURES

SUBMITTING A CLAIM

This section describes what you as a covered person (or your authorized representative) must do to file a claim for Plan benefits.

- A claim must be filed with the Plan Administrator in writing and delivered to the Plan Administrator by mail, postage prepaid or e-mail. However, a submission to obtain pre-authorization may also be filed with the Plan Administrator by telephone.

- Claims must be submitted to the Plan Administrator at the address indicated in the documents describing the Plan or on your identification card. Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address.

- Also, claims submissions must be in a format acceptable to the Plan Administrator and compliant with any applicable legal requirements. Claims that are not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by the Plan.

- Claims submissions must be timely. You must file claims as soon as reasonably possible after they are incurred, and in no event later than 12 months after the date of loss, except if you were legally incapacitated. Plan benefits are only available for claims that are incurred by a covered person during the period that he is covered under the Plan.

- Claims submissions must be complete. They must contain, at a minimum:
  a. The name of the covered person who incurred the covered expense;
  b. The name and address of the health care provider;
  c. The diagnosis of the condition;
  d. The procedure or nature of the treatment;
  e. The date of and place where the procedure or treatment has been or will be provided;
  f. The amount billed and the amount of the covered expense not paid through coverage other than Plan coverage, as appropriate;
  g. Evidence that substantiates the nature, amount, and timeliness of each covered expense in a format that is acceptable according to industry standards and in compliance with applicable law.

Presentation of a prescription to a pharmacy does not constitute a claim. If you are required to pay the cost of a covered prescription drug, however, you may submit a claim based on that amount to the Plan Administrator.

A general request for an interpretation of Plan provisions will not be considered to be a claim. Requests of this type, such as a request for an interpretation of the eligibility provisions of the Plan, should be directed to the Plan Administrator.

Mail medical claims and correspondence to:

BeneSys
P.O. Box 99550
Troy, MI 48099

PROCEDURAL DEFECTS

If a pre-service claim submission is not made in accordance with the Plan's procedural requirements, the Plan Administrator will notify you of the procedural deficiency and how it may be cured no later than five (5) days (or within 24 hours, in the case of an urgent care claim) following the failure. A post-service claim that is not submitted in accordance with these claims procedures will be returned to you.

ASSIGNMENTS AND REPRESENTATIVES

The Plan reserves the right to make payments directly to you. When this occurs, you must pay the provider and the Plan is not obligated to pay additional amounts. You cannot assign your right to receive payment to anyone else nor can you authorize someone else to receive your payments for you, including your provider. We will not honor an assignment of your claim to anyone. A direction to pay a provider is not an assignment of any right under this plan or of any legal or equitable right to initiate any court proceeding. Nothing contained in the written description of the Plan's medical coverage shall be construed to make the Plan liable to any third-party to whom a participant may be liable for medical care, treatment or services.

In addition, you may designate an authorized representative to act on your behalf in pursuing a benefit claim or appeal. The designation must provide written authorization for the disclosure of protected health information with respect to the claim between the Plan, the Plan Administrator and the authorized representative. If the Plan Administrator determines that the document is not sufficient to constitute a designation of an authorized representative, then the Plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

- Any document designating an authorized representative must be submitted to the Plan Administrator in advance, or at the time an authorized representative commences a course of action on behalf of a claimant. At the same time, the authorized representative should also provide notice of commencement of the action on behalf of the claimant to the claimant, which the Plan Administrator may verify with the claimant prior to recognizing the authorized representative status.

- In any event, a health care provider with knowledge of a claimant's medical condition acting in connection with an urgent care claim will be recognized by the Plan as the claimant's authorized representative.

Covered persons should carefully consider whether to designate an authorized representative. An authorized representative may make decisions independent of the covered person, such as whether and how to appeal a claim denial.

TYPES OF CLAIMS

There are two basic types of claims under the Plan: health care and disability (weekly income disability benefits) claims. The disability claims procedure is described in the section titled "Weekly Disability Income Benefits." Health care claims, which include major medical and prescription drug claims, are further divided into four types of claims:

- **Post-Service:** A claim for health care benefits that you have already received the service.

- **Pre-Service:** A claim for care or treatment where you are required to get preauthorization.

- **Urgent Care:** A claim for care or treatment that would:

    - Seriously jeopardize your life or health if normal pre-service standards were applied; or

- Subject you to severe pain that cannot be adequately managed without the care or treatment for which preauthorization is sought, in the opinion of a doctor with knowledge of your condition.

- **Concurrent:** A claim that is reconsidered after it is initially approved and the reconsideration results in reduced benefits or termination of the benefits.

The claims procedures for benefits are different for each type of claim, as described in the following sections.

CLAIMS DECISIONS

After submission of a claim by a claimant, the Plan Administrator will notify the claimant within a reasonable time, as follows:

PRE-SERVICE CLAIMS

Pre-service requests for benefits are those requests that required notification or approval prior to receiving medical care. If you have a pre-service request for benefits, and it was submitted properly with all needed information, you will receive written notice of the decision from the Plan Administrator within 15 days of receipt of the request. However, this period may be extended by an additional 15 days, if the Plan Administrator determines that the extension is necessary due to matters beyond the control of the Plan. The Plan Administrator will notify you of the extension before the end of the initial 15-day period, the circumstances requiring the extension, and the date by which the Plan Administrator expects to make a decision.

If you filed a pre-service request for benefits improperly, the Plan Administrator will notify you of the improper filing and how to correct it within 5 days after the pre-service request for benefits was received.

If additional information is needed to process the pre-service request, the Plan Administrator will notify you of the information needed within 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Plan Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for benefits will be denied.

URGENT CARE CLAIMS

Urgent requests are those that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, could cause severe pain.

The Plan Administrator will make the determination whether a claim is an urgent care claim on the basis of information furnished by or on behalf of you. In making this determination, the Plan Administrator will exercise its judgment, with deference to the judgment of a physician with knowledge of your condition. Accordingly, the Plan Administrator may require you to clarify the medical urgency and circumstances that support the urgent care claim for expedited decision-making.

In these situations:

- The Plan Administrator will notify you of a favorable or adverse determination as soon as possible, taking into account the medical exigencies particular to your situation, but not later than 72 hours after receipt of the urgent care claim by the Plan Administrator.

- If you filed an urgent request for benefits improperly, the Plan Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, the Plan Administrator will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

- You will be notified of a determination no later than 48 hours after:

    - The Plan Administrator's receipt of the requested information; or
    - The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

CONCURRENT CARE DECISIONS

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for benefits as defined above, the Plan Administrator will decide your request within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Plan Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for benefits and decided according to the timeframes described above.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

POST-SERVICE CLAIMS

Post-service claims are those claims that are filed for payment of benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from the Plan Administrator within 30 days of receipt of the claim, as long as all needed information was provided within the claim. The Plan Administrator will notify you within this 30-day period if additional information is needed to process the claim and may request the one-time 15-day extension and will pend your claim until all information is received. Once you are notified of the extension or missing information, you then have at least 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Plan Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

TIME FOR DECISIONS

The periods of time for claims decisions presented above begin when a claim is received by the Plan, in accordance with these claims procedures.

When an employee's child is subject to a medical child support order, the Plan Administrator will make reimbursement of eligible expenses paid by you, the child, the child's non-employee custodial parent, or legal guardian, to that child or the child's custodial parent, or legal guardian, or as provided in the medical child support order.

Payment of benefits under this Plan will be made in accordance with an assignment of rights for you and your dependents as required under state Medicaid law.

Benefits payable on behalf of you or your covered dependent after death will be paid, at the Plan's option, to any family member(s) or your estate.

The Plan Administrator will rely upon an affidavit to determine benefit payment, unless it receives written notice of valid claim before payment is made. The affidavit will release the Plan from further liability.

Any payment made by the Plan Administrator in good faith will fully discharge it to the extent of such payment.

Payments due under the Plan will be paid upon receipt of written proof of loss.

INITIAL DENIAL NOTICES

Notice of a claim denial (including a partial denial) will be provided to you by mail, postage prepaid, or by e-mail, as appropriate, within the time frames noted above.

However, notices of adverse decisions involving urgent care claims may be provided to you orally within the time frames noted above for expedited urgent care claim decisions. If oral notice is given, written notification will be provided to you no later than 3 days after the oral notification. The notice will provide a description of the Plan's expedited review procedures applicable to such claims.

A claims denial notice will state the specific reason or reasons for the adverse determination, the specific Plan provisions on which the determination is based, a description of the Plan's appeal procedures and associated timeline, and a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review. A copy of the Plan provision relied upon will be provided to a claimant free of charge upon request. The notice will also include a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

If the adverse determination is based on medical necessity, experimental, investigational or for research purposes, or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

APPEALS OF ADVERSE DETERMINATIONS

An "adverse determination" means a denial, reduction, termination or failure to provide or make payment, in whole or in part, of a benefit for a filed claim. "Adverse determination" shall also include any rescission of coverage, regardless of whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.

INTERNAL APPEALS PROCEDURES UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

You must appeal an adverse determination within 180 days after receiving written notice of the denial (or partial denial). With the exception of urgent care claims and concurrent care decisions, the Plan uses a two-level appeals process for all adverse determinations. The Plan Administrator will make the determination on the first level of appeal. If you are dissatisfied with the decision on this first level of appeal, or if the Plan Administrator fails to make a decision within the time frame indicated below, you may appeal to the Plan Administrator. Urgent care claims and concurrent care decisions are subject to only a single level internal appeal process, with the Plan Administrator making the determination.

A first level appeal must be made by a claimant by means of written application, in person, or by mail (postage prepaid), addressed to The Plan Administrator at the address indicated on your Identification Card.

A second level appeal must be made by a *claimant* by means of written application, in person, or by mail (postage prepaid), addressed to:

Board of Trustees

Appeals of denied claims will be conducted promptly, will not defer to the initial determination, and will not be made by the person who made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the *claimant* relating to the claim.

A *claimant* may review relevant documents and may submit issues and comments in writing. A *claimant* on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse determination being appealed, as permitted under applicable law.

If the claims denial being appealed is based in whole, or in part, upon a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or for research purposes, or not medically necessary or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

For internal appeals, the following additional standards apply:

- Note that an "adverse determination" includes rescissions of coverage, pre- and post-service claim determinations, exclusions, limitations, and eligibility determinations.
- Claimants must be provided, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim;
- Notices must be provided in a culturally and linguistically appropriate manner;
- All claims and appeals must be handled in a way that is designed to ensure the decision-maker's impartiality; and
- Notices to claimants must provide additional content such as identifying information on the claim, denial codes, description of available appeals processes and contact information for health insurance consumer assistance.

Time Periods for Decisions on Appeal—First Level

Appeals of claims denials will be decided and notice of the decision provided as follows:

Urgent Care Claims	As soon as possible, but not later than 72 hours after the Plan Administrator receives the appeal request. (If oral notification is given, written notification will follow in hard copy or electronic format within the next 3 days).
Pre-Service Claims	Within a reasonable period, but not later than 15 days after the Plan Administrator receives the appeal request.
Post-Service Claims	Within a reasonable period but no later than 30 days after the Plan Administrator receives the appeal request.
Concurrent Care Decisions	Within the time periods specified above, depending upon the type of claim involved.

Time Periods for Decisions on Appeal—Second Level

Appeals of claims denials will be decided and notice of the decision provided as follows:

Pre-Service Claims	Within a reasonable period, but not later than 15 days after the Plan Administrator receives the appeal request.
Post-Service Claims	Within a reasonable period but no later than the next quarterly meeting after receipt of the appeal request.

LIMITATIONS PERIOD

No action at law or equity based on an adverse determination under the Plan shall be brought after the expiration of three (3) years from the time of the final appeal denial. Additionally, action may be filed only in the United States District Courts situated in the state of Ohio.

APPEAL DENIAL NOTICES

Notice of a benefit determination on appeal will be provided to you by mail, postage prepaid, or by e-mail, as appropriate, within the time frames noted above.

A notice that a claim appeal has been denied will convey the specific reason or reasons for the adverse determination and the specific Plan provisions on which the determination is based.

The notice will also disclose any internal Plan rule, protocol or similar criterion that was relied on to deny the claim. A copy of the rule, protocol or similar criterion relied upon will be provided to a claimant free of charge upon request.

If the adverse determination is based on medical necessity or experimental, investigational, or for research purposes or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the event of a denial of an appealed claim, you will be entitled to receive, upon request and without charge, reasonable access to and copies of any document, record or other information:

1. Relied on in making the determination.
2. Submitted, considered or generated in the course of making the benefit determination.
3. That demonstrates compliance with the administrative processes and safeguards required with respect to such determinations.
4. That constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment, without regard to whether the statement was relied on.

EXHAUSTION

Upon completion of the internal appeals process under this section, you will have exhausted your administrative remedies under the Plan. If the Plan Administrator fails to complete a claim determination or appeal within the time limits set forth above, you may treat the claim or appeal as having been denied, and you may proceed to the next level in the review process. After exhaustion of the internal appeals process, you may pursue an external review. You may also pursue any other legal remedies available to you which may include bringing a civil action under ERISA § 502(a) for judicial review of the Plan's determinations, and compliance with the

internal claims and appeals process requirements. Additional information may be available from a local U.S. Department of Labor Office.

EXTERNAL APPEALS PROCEDURES

You have the right to request an "external review" of your adverse benefit determination. The timeline for an external review is as follows:

- Request for External Review: Must be allowed if requested within four (4) months after receipt of notice of adverse benefit determination.
- Preliminary Review: Must be completed within five (5) business days after receipt of request and within one business day after completion of preliminary review. The Plan must issue notification in writing to the claimant. Note that for an urgent care issue, the preliminary review must be done immediately and the claimant must be notified of the decision immediately.
- Referral to Independent Review Organization (IRO): The Plan must contract with at least three (3) IROs. Within five (5) business days after assignment to an IRO, the Plan must provide all documents and information considered in denying the appeal to the IRO. (For an urgent care issue, the information must be sent electronically, by fax or other expeditious means). The IRO must provide written notice of its decision within 45 days of assignment. (For urgent care issues, the IRO must provide notice of its decision as soon as possible but in no event more than 72 hours after receipt of the request for expedited external review.)
- Implementation of Reversal: Upon receipt of notice of final external review decision reversing an adverse benefit determination, the Plan must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits for claim).

LEGAL ACTIONS AND LIMITATIONS

No action at law or inequity may be brought with respect to Plan benefits until all remedies under the Plan have been exhausted and then prior to the expiration of the applicable limitations period specified under the Plan. All civil legal actions brought in connection with the Plan must be brought in the federal courts of Ohio.

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