Administered by Southern Benefit Administrators, Incorporated

Mailing Address:
P.O. Box 1449
Goodlettsville, TN 37070-1449

Telephone: (615) 859-0131
Toll Free: (800) 831-4914
Fax: (615) 859-0818

Street Address:
2001 Caldwell Drive
Goodlettsville, TN 37072-3589

June, 2022

SUMMARY OF MATERIAL MODIFICATIONS

The Board of Trustees of the UBC HealthCare Trust Fund ("Fund") has adopted the following changes to your Summary Plan Description ("SPD"). Please keep this document with your SPD and your Summary of Benefits and Coverage ("SBC").

Notice of Change in Administrative Manager/Fund Office

Effective July 1, 2022, Southern Benefit Administrators, Incorporated ("Southern Benefit") is replacing HealthSmart Benefit Solutions, Inc. ("HealthSmart") as the Fund's Administrative Manager/Fund Office, and all references to HealthSmart in your SPD are deleted and replaced with references to Southern Benefit.

Also, effective July 1, 2022, the new address of the Fund Office and Administrative Manager is as follows:

Southern Benefit Administrators, Incorporated
P.O. Box 1449
Goodlettsville, Tennessee 37070-1449
Phone: (615) 859-0131
Toll Free: (800) 831-4914

If you have any questions on and after July 1, 2022, please contact the Fund Office at the above numbers. Southern Benefit's hours of operation are from 8:30 a.m. to 5:00 p.m. Central Time, Monday through Friday. Prior to July 1, 2022, you may contact HealthSmart at 1-800-360-6581.

The notice below is required by the U.S. Department of Labor:

The UBC HealthCare Trust Fund believes this plan or coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

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

UBC HEALTHCARE TRUST FUND

SUMMARY PLAN DESCRIPTION

Grandfathered

Effective as of February 1, 2022

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IMPORTANT INFORMATION CONCERNING UTILIZATION REVIEW

Utilization review is a program that reviews the setting, necessity and quality of health care. The Plan provides utilization review through an arrangement with HealthLink Medical Management ("HealthLink"). HealthLink utilization review staff can be reached at (877) 284-0102. This number is also located on the back of your Plan identification card.

You or your provider must contact HealthLink to obtain authorization for the following:

- Inpatient Admissions
- Outpatient Stays (if they include overnight observation or that roll from one calendar day to the next)
- Emergency or Urgent Hospital Admissions (within 48 hours)
- Pregnancy (within first trimester)
- Sleep apnea surgery (authorization not required for initial office visit, diagnostics, and testing to diagnose condition)

Utilization review is performed to determine the medical necessity of the above services for the care and treatment of your Illness or Injury. Authorization by HealthLink does not guarantee that all charges you incur are covered under the Plan. It simply means that HealthLink has determined that the services are appropriate for your Illness or Injury. Charges submitted to the Fund for payment are subject to all other terms, conditions and limitations of the Plan.

As part of the utilization review process, HealthLink will also review proposed medical treatment for alternate methods of medical care or treatment not otherwise listed as covered charges.

PENALTY FOR FAILURE TO OBTAIN AUTHORIZATION: If you (or your Dependent) fail to obtain authorization from HealthLink as required under the Certification/Pre-Certification Section below, a $200.00 penalty will apply. However, the $200.00 penalty does not apply to admissions that are in the Plan's Preferred Provider Organization ("PPO") network; the penalty only applies to non-PPO network admissions. If you (or your Dependent spouse) fail to notify HealthLink of your pregnancy within the first trimester (three months), a $100.00 penalty will apply. These penalties are in addition to any deductible or other cost-sharing imposed under the Plan. In addition, the Fund will only pay benefits for authorized days of inpatient admission. Therefore, if you fail to obtain authorization from HealthLink as required, no benefits will be paid for inpatient days not authorized.

FACTS ABOUT THE PLAN

Name
UBC HealthCare Trust Fund (the "Fund").

Plan Sponsor
The Plan is sponsored by the Board of Trustees of the UBC HealthCare Trust Fund. The Board of Trustees is a joint board made up of representatives of employers that contribute to the Fund and representatives of the United Brotherhood of Carpenters and Joiners of America, or any of its affiliated regional councils or local unions.

Sources of Contribution
Contributions are made to the Fund from employers pursuant to the terms of their collective bargaining agreements with the United Brotherhood of Carpenters and Joiners of America, or any of its affiliated regional councils or local unions, or pursuant to the terms of their Participation Agreements with the Fund. In addition, the Fund receives self-payments from certain eligible employees and their Dependent(s).

Funding Medium
All assets are held in trust by the Board of Trustees. Benefits are paid from the accumulated assets of the Trust. Insurance premiums are also paid by the Fund to insurance companies for certain benefits. The Summary Annual Report (available from the Fund Office) gives details of the Plan's funding of benefits. The Fund's assets are held in an account at First Horizon Bank in Memphis, Tennessee.

Type of Plan
The Plan is a welfare plan designed to provide healthcare benefits, such as hospitalization, medical, surgical, drug, dental, optical, accident & sickness, and loss of time.

Name of Plan Administrator
Board of Trustees of the UBC HealthCare Trust Fund.

Any communication with the Board of Trustees should be addressed as follows:

Board of Trustees
UBC HealthCare Trust Fund
c/o HealthSmart Benefit Solutions, Inc.
602 Virginia Street, East
P.O. Box 3043
Charleston, WV 25331-3043

Type of Administration
Although the Trustees are legally designated as the "Plan Administrator", they have delegated the performance of their day-to-day administrative duties to a professional Administrative Manager, HealthSmart.

The Administrative Manager maintains Participant eligibility records, employer contribution records, processes claims, informs Participants of Plan changes, and performs other routine administrative functions in accordance with Trustee decisions.

Agent for Service of Legal Process

Every effort will be made by the Trustees of this Plan to resolve any disagreements with Participants promptly and equitably. It is recognized, however, that on some occasions, Participants may feel that it is necessary for them to take legal action. The following entity has been designated by the Board of Trustees as their Agent for service of legal process.

HealthSmart Benefit Solutions, Inc.
P.O. Box 3043
(602 Virginia Street, East)
Charleston, WV 25331-3043 (25301)

Legal papers may also be served on the Board of Trustees collectively or individually.

Plan Identification Numbers

When filing various reports with the Department of Labor and Internal Revenue Service, certain numbers are used to properly identify the UBC HealthCare Trust Fund including:

Employer Identification Number (EIN), assigned by the
Internal Revenue Service 23-7331128
Plan Number 501

Fiscal Year

The accounting records of this Plan are kept on the basis of a fiscal year which ends on January 31 of each year.

TRUSTEES OF THE UBC HEALTHCARE TRUST FUND

Steve Herring, Chairman
United Brotherhood of Carpenters and Joiners of America
P.O. Box 429
Fayette, AL 35555

Larry Wyatt
United Brotherhood of Carpenters and Joiners of America
720 Sugar Street
Chilhowie, VA 24319

Tony Hadley
United Brotherhood of Carpenters and Joiners of America
1267 SCR 79
Mize, MS 39116

Sam Spencer, Secretary
Georgia Pacific Corporation
5642 Georgia Street
Orange Beach, AL 36561

John Skedgell,
Georgia Pacific Corporation
133 Peachtree Street, 14th Floor
Atlanta, GA 30303

Paul S. Schmitt
Roseburg Forest Products
3660 Gateway Street
Springfield, OR 97477

Correspondence from the Fund Office

From time to time you may be contacted by the Fund's Administrative Manager ("the Fund Office"), to provide additional information necessary to completely and thoroughly determine the benefits payable on your claims. You (or your Dependent) should respond to such requests as quickly as possible since failure to do so will only result in additional delay in the handling of your claim and possibly even the denial of benefits.

The Fund Office will contact you directly by mail and specify the nature of the information it needs. A standard form will be used for this purpose, and the appropriate section will be checked and, if need be, written instructions will be stated clearly on the form. This form is not a denial of your claim - it is simply a request for additional information. In the event your claim is denied, you will receive a written narrative statement explaining the reason for the denial including a reference to the applicable Plan provisions upon which that decision is based. You will have the opportunity to appeal the denial of your claims as described in Section XII, B of this SPD.

Right of Recovery

If the Fund pays allowable covered expenses in excess of the maximum amount permitted by the Plan, the Fund has the right to recover such payments, to the extent of such excess, from any persons to whom or with respect to whom such payments were made, including any insurance companies, or any other organizations.

Benefits that are payable under this Plan will be paid to you, whether the claim is made on behalf of yourself or one of your Dependents, unless you direct that benefits due to you or your Dependent be paid to another person or entity. You may only direct that benefits that are payable to you or your Dependent be paid to a Physician, hospital, dentist, optician, optometrist or any other legally qualified medical practitioner practicing within the scope of his or her license, in consideration for medical or hospital services rendered or to be rendered, or supplies furnished or to be furnished.

Prohibition of Assignment of Benefits

No benefit under the Plan or right under the Employee Rights Income Security Act of 1974, as amended ("ERISA") may be assigned or transferred to another party by a Participant, Dependent or beneficiary. The Fund will not recognize any attempted assignment. Nothing in this SPD, or the Fund's Trust Agreement shall be construed to make the Fund, the Trustees, any union, or any participating employer liable to any third-party to whom a Participant, Dependent or beneficiary may be liable for medical care, treatment, or services. The Fund may make direct payments to a medical provider. A direct payment by the Fund to a medical provider does not make the provider an assignee, and in no way confers upon the provider any rights that a participant has under the Plan or ERISA.

About This Document

With respect to all uninsured benefits described herein, this document is both the Plan Document and Summary Plan Description (SPD) for the UBC HealthCare Trust Fund, for purposes of ERISA. The terms contained herein constitute the terms of the Plan. It is effective February 1, 2022 and replaces all previously issued Plan documents and amendments. The terms contained

herein constitute the terms of the Plan. With respect to all fully insured benefits described herein, the terms of the Fund's formal agreement or policy with the applicable insurer and, to the extent not inconsistent with such agreement or policy, this SPD, constitute the terms of the Plan. This SPD and Plan Document is effective February 1, 2022 and replaces all previously issued Plan documents and amendments. The Fund is also required under federal law to provide you with other documents, including a Summary of Benefits and Coverage ("SBC"). In the event of an inconsistency between the SBC and this SPD and Plan Document, this SPD and Plan Document will govern.

The Plan is subject to administrative modification and interpretation by the Board of Trustees, and is also subject to the rules, regulations and procedures of the Plan in effect at the time of your claim. The Board of Trustees has the right to interpret the terms of the Plan and will interpret and apply the terms of the Plan in situations not expressly addressed in this document.

The Board of Trustees has the right and discretionary authority to change, modify or terminate this Plan at any time. The Schedule of Benefits attached to the end of this Plan Document and SPD describes the benefits and limitations applicable to your coverage. The Plan benefits described in this document and the Schedule of Benefits, however, may be revised from time to time. Therefore, you should verify coverage with the Fund Office before incurring medical expenses so you can be sure the expenses are covered under the Plan. Please remember that no one other than Fund Office personnel can verify your coverage. You should not rely upon any statements regarding coverage or benefits available under the Plan made by your employer or union agent.

It is your obligation to keep the Fund Office informed of any change in your address or changes in the number of your Dependents. You could lose benefits if you fail to do so. The importance of a current, correct address on file in the Fund Office cannot be overstated. It is the only way the Fund Office can keep in touch with you regarding Plan changes and other developments affecting your benefits under the Plan.

CERTIFICATION/PRE-CERTIFICATION

1. Inpatient Admissions:

You or your provider must notify HealthLink Medical Management of any Hospital stay or other inpatient admission that is not an Emergency Hospital Admission or an Urgent Hospital Admission before admission to a Hospital or other facility as an inpatient. HealthLink Medical Management will review your Physician's recommendation to determine whether an inpatient admission is necessary or if the procedure or other treatment can be safely performed on an outpatient basis. Inpatient admissions include outpatient confinements that include overnight observation or that rollover from one calendar day to the next calendar day. If your treatment is not authorized, a retrospective review will be made to determine medical necessity.

2. Emergency or Urgent Hospital Admission:

For an Emergency or Urgent Hospital Admission, you or your provider must notify HealthLink Medical Management within 48 hours after admission, to the extent permissible under applicable law. For admissions on a holiday, or after 8:00 p.m. on a Friday or during a weekend, you must notify HealthLink Medical Management of the admission by the second business day following your admission. No prior authorization requirement will apply to Emergency Services.

"Emergency Hospital Admission" means an admission for Hospital confinement for Emergency Services.

"Urgent Hospital Admission" means admission for treatment of an Injury or Illness, which is less severe than an Emergency Hospital Admission, but requires care within a reasonably short time. This includes pregnancy-related events and childbirth for stays of more than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section.

3. Pregnancy

You must notify HealthLink Medical Management of your pregnancy within the first trimester (three months) of your pregnancy or as soon as the pregnancy is confirmed, whichever is earlier. You will be charged a $100 penalty for failure to notify the Fund of your pregnancy in accordance with this rule.

You may reach HealthLink at (877) 284-0102.

CONTINUED STAY REVIEW

After admission to the Hospital, other inpatient facility, or Independent Freestanding Emergency Department, HealthLink Medical Management will continue to evaluate your progress. If, after consulting with your doctor, HealthLink Medical Management determines that continued confinement is no longer medically necessary, HealthLink Medical Management will advise you and your doctor. The Fund will only pay benefits for authorized days of Hospital confinement or other inpatient confinement and no benefits will be paid for Hospital or other inpatient days not authorized, to the extent permissible under applicable law.

DEFINITIONS

It will help you to understand the benefits the Plan provides for you and your Dependents if you first become familiar with the following terms:

Allowable Charge means the fee, as determined by the Fund, that is the lowest of: (1) the health care provider's actual charge; (2) the usual charge by the health care provider for the same or similar service or supply; (3) the maximum amount that the Fund has determined it will pay for the service or supply; or (4) the amount that is reasonable and customary for the locality in which incurred. Notwithstanding the above, for in-network PPO claims, the Allowable Charge is the allowed amount determined by the PPO.

Ancillary Services means, with respect to an in-network Health Care Facility, (1) items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner; (2) items and services provided by assistant surgeons, hospitalists, and intensivists; (3) diagnostic services, including radiology and laboratory services; and (4) items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

Continuing Care Patient means an individual who is: (1) receiving a course of treatment for a Serious and Complex Condition; (2) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; (4) determined to be terminally ill and receiving treatment for the illness; or (5) undergoing a course of institutional or inpatient care from the provider or facility.

Convalescent Care Facility means a licensed institution, other than a Hospital, that operates pursuant to applicable state and federal law and provides all of the following:

1. Inpatient skilled nursing care and treatment to convalescing patients;
2. Full-time supervision by at least one Physician or registered nurse;
3. A Physician available to furnish medical care in emergencies;
4. 24-hour nursing service by licensed professional nurses in a facility for 5 or more patients;
5. Complete medical records for each patient; and
6. Utilization review plan for all patients.

A Convalescent Care Facility does not include a home or facility used primarily for:

1. The care of the aged;
2. Custodial Care; or
3. Educational care.

Durable Medical Equipment means medical equipment designed for repeated use that meets all of the following criteria:

1. Is necessary for treatment of an Illness or Injury or to improve or prevent further deterioration of your condition;

2. Is generally not useful in the absence of an Illness or Injury; and

3. Is appropriate for use in the home.

Emergency Medical Condition means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Emergency Services means any of the following, with respect to an Emergency Medical Condition:

1. An appropriate medical screening examination that is within the capability of the emergency department of a Hospital or Independent Freestanding Emergency Department, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition;

2. Such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished); and

3. Services provided by an out-of-network provider or facility after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay related to the emergency visit, until:

    - The provider or facility determines the patient is able to travel using nonmedical transportation or nonemergency medical transportation;

    - The patient is supplied with a written Notice, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, of the estimated charges for treatment and any advance limitations that the Plan may put on such treatment, of the names of any in-network providers at the facility who are able to treat the patient, and that the patient may elect to be referred to one of the in-network providers listed; and

    - The patient gives informed Consent to continued treatment by the nonparticipating provider, acknowledging that she or he understands

that continued treatment by the out-of-network provider may result in greater cost to the patient.

Fund means the UBC HealthCare Trust Fund.

Health Care Facility. For non-Emergency Services, a: (1) Hospital; (2) Hospital outpatient department; (3) critical access Hospital; or (4) ambulatory surgical center.

Hospital means an institution that meets each of the following criteria:

1. Is primarily engaged in providing diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment, and care of Injured or sick persons by or under the supervision of a Physician on an inpatient basis;

2. Contains a laboratory, X-ray equipment, surgical facilities and an operating room, unless it is a hospital for mentally ill patients;

3. Operates under the supervision of staff Physicians and provides 24-hour-a-day nursing service by registered graduate nurses;

4. Has a staff of one or more licensed Physicians available at all times;

5. Is not primarily a place of rest, a place for the aged, a place for substance abusers or alcoholics (except for a facility licensed for the treatment of alcohol and drug abuse for which benefits are specifically provided as described in Section VIII, B), a nursing home, a hotel or the like, an institution that is supported in whole or in part by federal government funds, or an institution that is engaged in the schooling of its patients; and

6. Hospital shall also mean, where appropriate, an ambulatory surgical center.

For alcohol or other substance abuse treatment, a Hospital means a facility or institution that provides a program for the treatment of alcohol or other substance abuse pursuant to a written treatment plan approved and monitored by a Physician. Such facility must also be a licensed Hospital accredited by the Joint Commission on the Accreditation of Hospitals, or the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities and operated pursuant to law.

Illness means a bodily disorder, disease, physical illness, substance abuse disorder, mental health disorder, or functional nervous disorder that requires treatment by a Physician. Concurrent illnesses will be considered one Illness unless the concurrent illnesses are totally unrelated. All disorders existing simultaneously that are due to the same or related causes shall be considered one Illness. For an Employee or Dependent spouse only, Illness also includes pregnancy, childbirth or any related condition.

Independent Freestanding Emergency Department means any facility that is geographically separate and distinct from a Hospital under applicable state law and provides, and is licensed under state law to provide, Emergency Services.

Injury means bodily injury(ies) caused by an accident occurring while coverage under the Plan is in effect and resulting independently of all other causes of loss covered by the Plan. The term "Injury" does not include an injury that occurs as a result of your employment or occupation for compensation or profit.

Intensive Care ("ICU") Accommodation or Cardiac Care Accommodation ("CCU") means an accommodation that is specifically designed and permanently equipped with special equipment or supplies immediately available on a standby basis and that is segregated from the rest of the Hospital's facilities and staffed to provide extensive care for critically ill or injured patients requiring constant audiovisual observation as prescribed by the attending Physician. Such Unit shall provide room and board and nursing care by nurses whose duties are primarily confined to care of patients in the Intensive Care Accommodation or Cardiac Care Accommodation for which an additional charge is made.

Necessary means that the service received is required to identify or treat the Illness or Injury that a Physician has diagnosed or reasonably suspects. The service must be consistent with the diagnosis and treatment of the condition, be in accordance with local standards of good medical practice, be required for reasons other than the convenience of the person or the Physician, and be performed in the least costly setting required by the condition. The fact that a service is ordered, recommended, approved or prescribed by a Physician does not necessarily mean that such service is Necessary or a covered expense even though it is not specifically limited as exclusion.

No Surprises Act means the No Surprises Act enacted under the federal Consolidated Appropriations Act of 2021, as amended, and its implementing regulations.

No Surprises Services means the following services, to the extent covered under the Plan: (1) out-of-network Emergency Services; (2) out-of-network air ambulance services; (3) non-emergency Ancillary Services (such as anesthesiology, pathology, radiology, neonatology and diagnostic services and other services defined as ancillary under the No Surprises Act) when performed by out-of-network providers at in-network Health Care Facilities; and (4) other out-of-network non-Emergency Services performed by an out-of-network provider at in-network Health Care Facilities with respect to which the provider does not comply with federal Notice and Consent requirements.

Notice and **Consent** means, **w**ith respect to out-of-network services provided at an in-network Health Care Facility, (1) that at least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), you are provided with a written notice, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, the names of any in-network providers at the facility who are able to treat you, and that you may elect to be referred to one of the in-network providers listed; and (2) you give informed consent to continued treatment by the out-of-network provider, acknowledging that you understand that continued treatment by the out-of-network provider may result in greater cost to you.

Physician or Surgeon means any person who is licensed and authorized to practice medicine or surgery and to prescribe and administer drugs in the locale in which the service is rendered. In addition, any other licensed practitioner may satisfy the definition of Physician or Surgeon if the

practitioner is operating within the scope of his license and is performing services that would otherwise be payable by the Fund if performed by a Physician or Surgeon. Licensed osteopaths, chiropractors, ophthalmologist, optometrist, dentists, doctors of dental surgery, psychiatrist, or psychologists and licensed or certified nurse midwives with respect to maternity cases, are included in the definition of a Physician.

Plan means the plan of benefits of the Fund, as described in this Plan Document and Summary Plan Description for the Fund, as amended from time to time.

Psychologist means a clinical psychologist who has been trained in aspects of the assessment and treatment of the mentally ill and mentally handicapped and has attained a doctorate level of education; however, such persons are not necessarily licensed medical doctors and therefore cannot prescribe drugs in conjunction with mental health treatment.

Room and Board means the Hospital's charge for:

1. Room and linen service; and
2. Dietary service including meals, special diets and nourishments.

Serious and Complex Condition means (1) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent disability; or (2) in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.

Total Disability or Totally Disabled means a condition that:

1. Prevents the Employee from engaging in his regular or customary occupation and from performing work of any kind for compensation or profit; or

2. Prevents a Dependent from engaging in substantially all of the normal activities of a person of like age and sex in good health.

The Trustees reserve the right to require you (or your Dependent) to be examined by a Physician selected by the Trustees to determine whether you are or continue to be disabled. In addition, the Trustees reserve the right to discontinue benefits under this Plan if you are no longer Totally Disabled.

I. TYPE OF COVERAGE AVAILABLE

A. SINGLE COVERAGE

You can obtain Single Coverage if you have no Dependents or you do not want to obtain coverage for your Dependents.

B. FAMILY COVERAGE

If you have Dependents or if you acquire Dependents after you have already been provided Single Coverage, you can apply for Family Coverage under the Plan, as explained in Section II, E.

II. ELIGIBILITY REQUIREMENTS

A. WHEN ARE EMPLOYEES ELIGIBLE

You are eligible for coverage under this Plan as an "Employee" if you are a regular full-time employee of an employer that contributions to the Fund on your behalf as required by an applicable collective bargaining agreement between the employer and the United Brotherhood of Carpenters and Joiners of America, or any of its affiliated regional councils or local unions, or as defined in a Participation Agreement between the Fund and your employer.

Your coverage with the Fund becomes effective on the first day of the next month following the month in which you complete the probationary period required by the collective bargaining agreement or Participation Agreement that requires your employer to contribute to the Fund on your behalf. Notwithstanding any provision of the collective bargaining agreement or Participation Agreement to the contrary, this probationary period will not be longer than 60 days. Once you are eligible for coverage, you are considered a Participant in the Fund.

B. COVERAGE FOR YOUR DEPENDENTS

Eligible Dependents include your lawful spouse and your child(ren) under 26 years of age.

The term "spouse" includes a same-sex spouse to whom you are lawfully married in the jurisdiction in which the marriage took place, regardless of whether the marriage is recognized in your state of residence.

The term "child(ren)" includes:

- Your natural child(ren),
- Your step child(ren),
- Your adopted child(ren) or child(ren) placed with you for adoption,
- Your foster child(ren), and
- Children for whom you are appointed as legal guardian.

An eligible Dependent also includes someone who is provided coverage under the Plan pursuant to a Qualified Medical Child Support Order ("QMCSO"). A copy of the Fund's QMCSO procedures can be obtained without charge from the Fund Office.

In addition, the Plan provides coverage for your disabled child so long as your coverage remains in force and the child's incapacity continues. To be eligible for coverage, the disabled child must be:

- Unmarried,
- Incapable of self-sustaining employment by reason of mental retardation or physical handicap on the date coverage would otherwise end,
- Incapacitated prior to the date the coverage of the child or individual for whom you are appointed as legal guardian would otherwise end, and
- Chiefly dependent upon you for support and maintenance.

You must provide proof of your child's incapacity (or incapacity of the individual for whom you are appointed as legal guardian) to the Fund within 31 days of the date the Dependent coverage would otherwise terminate, and thereafter as required by the Fund.

An Eligible Dependent does not include any spouse who is eligible for coverage as an Employee. If both husband and wife are covered under the Plan as Employees, either, but not both, may elect to cover eligible children as described above.

An Eligible Dependent also includes your Domestic Partner, to the extent he or she meets the requirements for Domestic Partner Coverage set forth in Section II, I below.

C. CHANGE IN AMOUNT OF COVERAGE

If your benefits are increased under the Plan because of a change in job classification or an increase in the amount of benefits payable under the Plan such increase will be effective on the first day of the month that is on or after the effective date of such change.

However, if you are not actively at work when an increase in the amount of coverage would otherwise take effect, the increase in the amount of coverage will take effect on the first day of the month next following the date you are actively at work. If you are not actively at work due to Illness or Injury, you will be treated as being actively at work for purposes of eligibility for all medical benefits (with the exception of Loss of Time Benefits and Life Insurance Benefits). Of course, you must continue to meet the Plan's eligibility requirements in order to be eligible for any increase. In the event your benefits are decreased, the decrease will be effective for all Employees on the date of the Plan change regardless of whether you are actively at work on the date of the change.

D. IF YOU ARE COVERED BY AN HMO

As explained in Section X, the Fund does not provide coverage for medical services obtained through a Health Maintenance Organization ("HMO"). Therefore, if you or your Dependent is covered by an HMO maintained by your employer when you join the Fund, coverage under the Fund will only be available for services received from providers outside of your HMO network.

If you are covered by this Plan and then join an HMO maintained by your employer, then starting on the first day you become a member of the HMO, coverage under the Fund will only be available for services received from providers outside of the HMO network. Please see Section X for further information.

E. ADDING DEPENDENTS TO YOUR EXISTING COVERAGE

Your Dependent will become eligible for benefits on the later of the following dates:

1. The date you become eligible for benefits; or

2. Except as provided in Paragraph 3 below, if you have Single Coverage, coverage for a newly acquired Dependent shall be effective the first day of the month following the date you first acquire the Dependent, provided that you enroll the Dependent within 30 days of acquiring the new Dependent; or

3. If you have Single Coverage and acquire a new Dependent through birth, adoption, or placement for adoption, coverage for the newly acquired Dependent will be effective as of the date of birth, adoption, or placement for adoption provided that you enroll the Dependent within 30 days of acquiring the new Dependent; or

4. If you have Family Coverage and acquire a new Dependent, the Dependent shall be eligible for benefits from the date you first acquire the Dependent provided that you notify the Fund Office within 30 days of the acquisition of the new Dependent on forms provided by the Fund Office.

5. Notwithstanding anything herein to the contrary, if you have Family Coverage, then your newborn children will be covered at birth regardless of whether you notify the Fund Office within 30 days of the birth of the child.

6. If you fail to enroll Dependents within 30 days, you may enroll the Dependent at any time and, except as provided in Paragraph 5 above, coverage for the Dependent will be effective as of the first of the month following completion of all enrollment procedures on behalf of the Dependent.

7. For a Dependent who is a Domestic Partner, eligibility will be determined in accordance with Section II, I below.

Dependents Previously Covered As Employees. If two spouses are covered by the Fund as Employees and one terminates employment, he or she may be added as a Dependent to the other spouse's coverage within thirty (30) days of such termination of employment. Dependents previously covered under the Plan as an Employee for hospital, surgical and medical expenses incurred during a period that began while the covered person was covered as an Employee shall not exceed the benefit that would have been payable during the period had the Dependent remained an Employee.

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 30 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents in this Plan. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you are declining enrollment for either yourself or your Dependents (including your spouse) because you are eligible for financial assistance under Medicaid or the State Children's Health Insurance Program ("CHIP") and you or your Dependents later lose such eligibility, you may be able to enroll yourself or your Dependents in this Plan. However, you must request enrollment within 60 days of the date that CHIP or Medicaid assistance terminates for you or your Dependents.

In addition, you may be able to enroll yourself and your Dependents (including your spouse) in this Plan if you or your Dependents become eligible to participate in a health insurance premium assistance program under Medicaid or CHIP. Again, you must request enrollment within 60 days of the date you or your Dependents become eligible for premium assistance through Medicaid or CHIP, in order to be covered under this Plan.

To request special enrollment or obtain more information about your special enrollment rights, contact the Administrative Manager at HealthSmart Benefit Solutions, Inc., 602 Virginia Street East, P.O. Box 3043, Charleston, WV 25331, Tel. 1-800-360-6581.

If you or your Dependents are declining enrollment because you or your Dependents have other health coverage, you must provide a written statement to the Fund stating the reason you are declining enrollment. If you or your Dependents do not provide such a written statement, then you and your Dependents will not be entitled to the special enrollment rights described above.

F. COVERAGE DURING LEAVE UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993

The Family and Medical Leave Act of 1993 ("FMLA") requires employers with 50 or more employees to provide eligible employees with up to 12 weeks per year of unpaid leave in the case of the birth, adoption or foster care of an employee's child or for the employee to care for their own sickness, or to care for a seriously ill child, spouse or parent, or, for a qualifying exigency that arises in connection with the active military services of a child, spouse, or parent. The FMLA requires that employers with 50 or more employees provide eligible employees with up to 26 weeks per year of unpaid leave to care for a child, spouse, parent, or nearest blood relative who is a service member and is undergoing medical treatment, recuperation or therapy, or is on a temporary disability retired list, as a result of a serious injury or illness sustained in the line of duty that renders the service member unfit to perform his or her duties.

In compliance with the provisions of the FMLA, your employer is required to maintain your preexisting coverage under the plan during your period of leave under the FMLA just as if you were actively employed. Your coverage under the FMLA will cease once the Fund Office is notified or otherwise determines that you have terminated employment, exhausted your 12 or 26 weeks FMLA leave entitlement, or you inform the Fund Office of your intent not to return from leave. Your coverage will also cease if your employer fails to make contributions required to maintain coverage on your behalf.

Once the Fund Office is notified or otherwise determines that you are not returning to employment following a period of FMLA leave, you may elect continued coverage under the COBRA continuation of coverage rules described in Section III, D. The qualifying event entitling you to COBRA continuation coverage is the last day of your FMLA leave.

G. COVERAGE DURING LEAVE UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") requires that the Fund provide the right to elect continued health coverage for up to 24 months to Participants who are absent from employment due to military service, including Reserve and National Guard Duty under federal authority, as described below.

Coverage Under USERRA

A Participant who is absent from employment by reason of service in the uniformed services can elect to continue coverage for the Participant and his or her eligible Dependents under the provisions of USERRA. The right to elect USERRA coverage does not apply to Dependents who enter military service. Further, USERRA rights do not apply to service in a state national guard under authority of state law.

The period of coverage begins on the date on which the Participant's absence begins and ends on the earlier of:

1. The end of the 24-month period beginning on the date on which the absence begins; or

2. The day after the date on which the Participant is required to, but fails to apply under USERRA for or return to a position of employment covered under the Fund. (For example, for periods of service over 180 days, generally the Participant must reapply for employment within 90 days of discharge.)

This right to temporarily continue group health coverage does not include any life insurance benefits, accidental death and dismemberment benefits, accident and sickness benefits or other similar non-health benefits provided under the Fund. In addition to the right to continued coverage under USERRA, Participants or Dependents also may have rights to elect continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Please refer to Section III, D of this SPD for more information.

If the Participant met the Plan's eligibility requirements at the time he or she entered the uniformed services, the Participant will not be subject to any additional exclusions or a waiting period for coverage under the Fund upon return from uniformed service, as required under USERRA.

Notice and Election of USERRA Coverage

The Participant must notify his or her employer or the Fund Office of the absence from employment due to military service unless giving notice is precluded by military necessity or unless under all the relevant circumstances, notice is impossible or unreasonable. If the Participant wishes to elect USERRA coverage, he or she also must notify the Fund Office within 60 days of the last day of employment unless the Participant is excused from giving advance notice of service under the provisions of USERRA. While an employee may notify an employer of service orally, the Fund requires that Participants elect USERRA coverage in writing. The Fund will provide you with the necessary forms.

Paying for USERRA Coverage

The Participant may be required to pay all or a portion of the cost of these benefits. If the period of military service is less than 31 days, there is no charge for this coverage beyond the normal deductible or co-payments that would be paid if the Participant were employed. If the military service extends more than 31 days, the Participant must pay 102% of the cost of the coverage unless the employer pays for the coverage under its leave policy. The cost will be determined in the same manner as the costs for COBRA continuation coverage. Participants should contact the Fund Office for the current cost.

USERRA coverage requires timely monthly payments. The payment due date is the first day of the month in which USERRA coverage begins. For example, payments for the month of November must be paid on or before November 1st. The payment due for the initial period of USERRA coverage must include payment for the period of time dating back to the date that coverage would have terminated if the Participant had not elected USERRA coverage. There is an initial grace period of 45 days to pay the first premium due starting with the date USERRA coverage was elected. After that, there is a grace period of 30 days to pay any subsequent amounts due. If the Participant timely elects and pays for USERRA coverage, coverage will be provided retroactive to the date of the Participant's departure for military service. If payment is not received by the end of the applicable grace period, USERRA coverage will terminate as of the end of the last period for which payment was received. If the Participant fails to pay the full payment by each due date (or within the 30-day grace period), the Participant will lose all USERRA coverage and such continuation coverage cannot be reinstated.

Once a timely election of USERRA coverage has been made, it is the responsibility of the Participant to make timely payment of all required payments. The Fund will <u>not</u> send notice that a payment is due or that it is late, or that USERRA coverage is about to be terminated due to the untimely payment of a required payment.

H. RE-ENROLLMENT TO CHANGE PLAN OPTIONS

You must re-enroll during the annual open enrollment period to change the coverage provided to you or your eligible Dependent(s).

The annual open enrollment period will be in November of each year. During the open enrollment period you can change your coverage status (i.e., Single Coverage, Family Coverage, etc.) and add or drop eligible Dependents.

Coverage changes will become effective on January 1 provided you complete a new enrollment form and submit it to your employer during the annual enrollment period. Your employer must forward that information to the Fund Office prior to January 1.

I. DOMESTIC PARTNER COVERAGE

Dependent coverage under the Plan is extended to Domestic Partners. This coverage does not include COBRA continuation coverage, described in Section III, D, and does not include any Life and Accidental Death and Dismemberment coverage described in Section IX. Your Domestic Partner may be of the same or opposite sex as you.

For purposes of coverage under the Plan, an individual is considered your Domestic Partner if you are both mentally competent and 18 years of age or older and you have been living together for at least 12 months, are not married to anyone else and are not related by blood in a manner that would bar marriage under the law, are financially interdependent, have not been registered as members of another Domestic Partnership within the last 12 months, and are registered as Domestic Partners in the state of your residence if such registration is available to you. If the relationship between you and your Domestic Partner is recognized as a marriage in your state of residence, your Domestic Partner may be covered under the Plan as your lawful spouse.

In order to establish eligibility for your Domestic Partner, you and your domestic partner must provide evidence of such relationship that is satisfactory to the Board of Trustees. The Fund Office can provide you with the necessary enrollment forms that must be completed to obtain coverage for your Domestic Partner.

Coverage for your Domestic Partner will terminate on the earliest of the following dates:

(1) The date the Plan terminates; or
(2) The date you are no longer eligible for benefits; or
(3) The date a change in the Plan terminates the Domestic Partner's coverage; or
(4) The date the relationship between you and your Domestic Partner no longer satisfies the requirements for eligibility for Domestic Partner coverage.

Contact the Fund Office for more information regarding Domestic Partner coverage.

Under certain circumstances, coverage for a Domestic Partner may be considered taxable income to you. We encourage you to consult with your tax advisor to determine if you can take advantage of dependent status for your Domestic Partner and the tax implications of this coverage.

III. TERMINATION OF BENEFITS FOR EMPLOYEES AND DEPENDENTS

A. TERMINATION OF YOUR EMPLOYEE COVERAGE

Employee coverage will terminate on the earliest of the following dates:

1. The last day of the calendar month in which you are no longer eligible for coverage pursuant to the terms of your employer's collective bargaining agreement or Participation Agreement with the Fund;
2. The day the Plan is terminated;
3. The last day of the second month following the month in which your employer fails or refuses to make the required contribution to the Fund on your behalf on the date such contribution is due;
4. The last day of the month following your failure or refusal to contribute towards the cost of coverage on the date such contribution is due (if required);
5. The date of your death;
6. The last day of the month in which you are absent from employment by reason of service in the uniformed services and coverage ceases except as provided under the Uniform Services Employment and Reemployment Rights Act of 1994 and described in Section II, G.
7. The date the Plan is amended to terminate coverage for a class of Employees in which you are included; or
8. The day preceding your membership in an HMO sponsored by your employer.

If your loss of eligibility occurs due to your termination of employment or a reduction in your hours or employment, you may be entitled to continue your coverage under COBRA as described in Section III, D. If your loss of eligibility occurs due to a lay-off or while you are disabled, you may be entitled to continue your coverage under the Disability Extension or Employer Lay-off provisions described in Section III, C.

B. TERMINATION OF DEPENDENT COVERAGE

Coverage for your Dependents will terminate on the earliest of the following dates:

1. The date you are no longer eligible for benefits; or
2. The date the Dependent ceases to qualify as a Dependent under the Plan; or
3. The date a change in the Plan terminates coverage for Dependents; or
4. The date of the Dependent's death; or
5. The date the Plan terminates.

C. EXTENDED BENEFITS AFTER TERMINATION

Disability Extension
If your coverage terminates while you are totally disabled, benefits will be extended and covered expenses related to your disability will be paid for provided the covered expenses were incurred while you were admitted to a Hospital during a period of Total Disability. This extension will be provided until treatment of your Injury or Illness in a Hospital has terminated. However, in no case will the Fund pay benefits for expenses incurred following the earlier of your recovery from Total Disability or one (1) month from the date your coverage was terminated.

In order to be eligible for this Disability Extension, you must have an Injury or Illness that completely prevents you from performing the duties of your regular job and which prohibits you from performing any work of any kind for compensation or profit. In order to prove that you are totally disabled, the Fund may require that you be examined by a Physician selected by the Fund to determine whether you are disabled.

Employee Lay-off
During a lay-off, coverage will continue until the earlier of the end of the month during which you are laid off or until the date of your recall to work.

Any period of continued coverage under the Disability Extension of Employee Lay-off provisions above will be considered continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA") and will be offset against any applicable period of COBRA coverage described in Section III, D. You will be permitted to continue Family Coverage for Dependents during any period listed above by arranging to make direct premium payments to the Fund pursuant to the COBRA provisions.

D. CONTINUATION OF COVERAGE UNDER THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") requires that the Plan offer eligible Participants and their eligible Dependent(s) the opportunity to pay for a temporary extension of health coverage at group rates in instances where coverage under the Plan would otherwise end, in accordance with the provisions of federal law.

You may have other options available to you if you lose coverage under the Plan. 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 doesn't accept late enrollees.

Participant's Rights
Eligible Participants who lose eligibility for any of the following reasons, referred to as "Qualifying Events" can continue coverage:

1. Termination of employment (except for gross misconduct); or
2. Deduction in hours of employment.

Spousal Rights
The Dependent spouse of an eligible Participant will have the right to continue coverage for himself or herself, if he or she loses coverage under the Plan for any of the following reasons, referred to as "Qualifying Events":

1. The death of the Participant;
2. Termination of the Participant's employment (except for gross misconduct) or reduction in the Participant's hours of employment;
3. Divorce or legal separation from the Participant; or
4. Eligibility of the Participant for Medicare.

Dependent Children's Rights
The Dependent child of a Participant will have the right to continue coverage for himself or herself, if he or she loses coverage under the Plan for any of the following reasons, referred to as "Qualifying Events":

1. The death of the Participant;
2. Termination of the Participant's employment (except for gross misconduct) or reduction in the Participant's hours of employment;
3. Divorce or legal separation of the Participant;
4. Eligibility of the Participant for Medicare; or
5. The Dependent child ceases to satisfy the Fund's eligibility rules.

Coverage may be continued for any eligible Dependent(s) properly enrolled on the day before the event resulting in the loss of eligibility (listed above). Each eligible Dependent has an independent right to elect or reject COBRA continuation coverage. An election on behalf of a minor Dependent child can be made by the child's parent or legal guardian.

Domestic Partners
Notwithstanding anything in this Section to the contrary, Domestic Partners are not eligible for COBRA continuation coverage.

Newborn or Adopted Children
If you or your Dependent spouse give birth to a child, or if a child is placed for adoption with you, you may elect COBRA continuation coverage for that child provided you first complete a Fund enrollment card and file it with the Fund Office. Coverage for the newborn or adopted child will continue until such time as coverage for Dependent children who were properly enrolled in the Fund on the day before the event resulting in the loss of eligibility would otherwise end.

Notification Requirements
The participating employer must notify the Fund, in writing, within 30 days of your death, termination of your employment or reduction in working hours, your entitlement to Medicare, or the participating employer's initiation of bankruptcy proceedings.

You or your eligible Dependent(s) must inform the Fund, in writing, within 60 days of a divorce or legal separation, or a Dependent child's loss of Dependent status under the Fund. If you or your eligible Dependent is determined to have been disabled at any time during the first 60 days of

continuation coverage, you or your Dependent must notify the Fund Office within 60 days of the date that the Social Security Administration determines that you or your eligible Dependent(s) are disabled and within 30 days of any final determination that you or your eligible Dependent(s) are no longer disabled.

If you or your eligible Dependent(s) fails to notify the Fund within 60 days of the date that coverage would otherwise cease, the right to elect COBRA continuation coverage will be forfeited.

The Fund will notify you or your eligible Dependent(s) within 14 days of receipt of notification of any of these events of the right to continue coverage. You or your eligible Dependent(s) must elect COBRA continuation coverage within 60 days of the date that coverage would otherwise end or, if later, within 60 days of the date that the Fund sent the notice of the right to elect COBRA continuation coverage. This election must be made in writing and returned to the Fund within the 60 day election period. Failure to notify the Fund on time will result in forfeiture of COBRA rights.

Length Of Coverage
Coverage may continue under COBRA as follows:

1. Coverage for you and your Dependent(s) may be continued for up to eighteen (18) months, if coverage is terminated due to your:
   a. Termination of employment, other than for gross misconduct; or
   b. A reduction in work hours

The eighteen (18) month period of continuation coverage may be extended an additional eleven (11) months for you and your eligible Dependent(s) if, within 60 days of the date of the event described in (a)(1) or (a)(2) above, you are determined to be disabled by the Social Security Administration. The self-pay premium for this 11-month extension will be increased by about 50%. Proof of disability must be provided to the Fund within sixty (60) days of the date the Social Security Administration makes the determination and within the initial 18-month period of Continuation Coverage. If the Social Security Administration determines during the initial eighteen (18) month period that you are no longer disabled, the eleven (11) month extension does not apply. If the Social Security Administration determines after the initial eighteen (18) month period that you are no longer disabled, the period of Continuation Coverage ends with the first month that begins more than thirty (30) days after the date of the Social Security Administration's determination, so long as the period of Continuation Coverage does not exceed twenty nine (29) months.

2. Coverage for your eligible Dependent(s) may be continued for up to a maximum of thirty-six (36) months, if coverage terminated due to:
   a. Your death;
   b. Your divorce or legal separation; or
   c. With respect to your Dependent child, his or her ceasing to satisfy the Fund's rules for Dependent status.

3. If you become entitled to Medicare, and within 18 months of becoming entitled to Medicare, you become entitled to COBRA because of the termination of employment (other than for gross misconduct) or a reduction

in work hours, coverage for your Dependent(s) may be continued for up to thirty-six (36) months from the date the you became entitled to Medicare.

Remember to obtain an extension of COBRA Continuation Coverage as described above, you must notify the Fund Office that you may be eligible for an extension of coverage.

Termination Of Coverage
Continuation Coverage will terminate on the first of the following dates:

1. The date a required premium is due and is not timely paid;
2. The date you or your eligible Dependent(s) become covered by another group health plan other than TRICARE (as an employee or otherwise) which does not contain any pre-existing condition exclusion or limitation affecting you or your eligible Dependent(s);
3. The date you become entitled to Medicare benefits;
4. In the event of divorce, the date you remarry and are eligible for coverage under your spouse's plan;
5. The date the Fund no longer provides group health plan coverage for similarly situated Participants or Dependents;
6. The date your participating employer ceases to maintain any group health plan for its employees through this Fund;
7. The date your eligible Dependent(s) become eligible for Medicare. (This does not apply in situations where the Qualifying Event is your employer's bankruptcy proceeding under the United States Bankruptcy Code);
8. In situations where the Qualifying Event is the participating employer's bankruptcy proceeding under the United States Bankruptcy Code, then for a retired Participant, the date of the retired Participant's death, or for the surviving eligible Dependent(s), the date that is 36 months after the date of the retired Participant's death;
9. The date the applicable period of Continuation Coverage is exhausted; or
10. In situations where coverage was being extended for eleven (11) months, the first month that begins more than thirty (30) days after the date of the Social Security Administration's determination that you or your eligible Dependent(s) are no longer disabled so long as the period of Continuation Coverage does not exceed twenty-nine (29) months.

If your former participating employer alters the level of benefits provided through the Fund to similarly situated active Employees, your coverage will also change.

You or your eligible Dependent(s) must notify the Fund Office immediately if you become covered by any other plan of group health benefits through your employment or your spouse's employment. You must repay the Fund for any claims paid in error as a result of your failure to notify the Fund Office of any other health coverage.

Type of Coverage You May Elect
You or your Dependent(s) can continue coverage for either 1) medical and drug benefits or 2) for medical, drug, optical, and dental benefits. However, you may only elect to continue benefits that are already in place at the time of the event resulting in the loss of eligibility. The cost that you must pay to continue benefits is determined annually and will be contained in the notice of right to elect continuation of coverage sent to you by the Fund Office.

Payment Of Premiums
The initial payment must be made by you either at the time you elect continuation coverage or within 45 days of the election. **Ongoing payments must be made by the 30th of the month for which coverage is to be continued**. For example, if you desire coverage for October, the Fund Office must receive your payment no later than October 30th. **You will not be billed; it is your responsibility to remit payments to the Fund Office. Late payments can result in termination of coverage.** You are responsible for the payment of any required premium.

Important! If you elect COBRA coverage at the end of the 60 day election period, timely retroactive payments must be made back to the date of your loss of eligibility in order for you to be eligible for COBRA coverage.

Claims incurred following the date of the event resulting in the loss of eligibility, but before you or your Dependent(s) have elected continuation coverage, will be held until a coverage election has been made and premiums have been paid in full. If you or your eligible Dependent(s) do not make a timely election and pay the premiums, no coverage will be provided. Coverage under this Plan will remain in effect only while the monthly premiums are timely and fully paid.

Other Coverage Options Besides COBRA Coverage

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

IV. COMPREHENSIVE MEDICAL EXPENSE BENEFIT

A. COMPREHENSIVE MEDICAL BENEFITS PAYABLE

The Plan provides comprehensive medical benefits for the care of an Injury or Illness while you or your Dependent are covered under the Plan. Comprehensive medical benefits are subject to the deductible as described below and any other cost-sharing and specific calendar year and lifetime maximums as provided in this SPD and the attached Schedule of Benefits. These benefits are also subject to the pre-certification and continued stay review requirements as described at the beginning of this SPD.

The Plan's comprehensive medical benefits coverage provides broad and extensive coverage to help you pay the cost of medical care. It is particularly effective in providing the coverage you need in connection with the expensive treatment required for care of serious illnesses.

B. DEDUCTIBLE

The deductible is the amount of covered expenses that you and your Dependent(s) will incur before benefits are payable by the Fund. The amount of your deductible (including accident deductibles) is shown on the attached Schedule of Benefits.

Except as provided under the deductible for Family Coverage as described below, each Dependent in your family must satisfy the applicable individual deductible during each calendar year.

Deductible Limit for Family Coverage – The applicable individual deductible applies separately to you and each Dependent. However, if you have elected Family Coverage, the Family Coverage deductible does not apply separately to you and each Dependent in your family. Instead, once you and your Dependents collectively satisfy the Family Coverage deductible as shown in your Schedule of Benefits, covered expenses incurred by you or any Dependents in your family during the remainder of the calendar year will not be subject to a deductible, even if you or any of your Dependents have not yet satisfied the applicable individual deductible. You and each Dependent in your family can help meet the Family Coverage deductible amount, but no more than each person's individual deductible amount may be applied by that person toward the satisfaction of the Family Coverage deductible. For example, if your individual deductible is $800 and the Family Coverage deductible is $2,400, then the maximum amount that you and each of your Dependents may individually contribute toward the satisfaction of the Family Coverage deductible is $800 (the amount of the individual deductible).

Any covered expenses incurred during the last three months of a calendar year that are applied toward the deductible (whether or not the deductible is fully satisfied) will also be applied toward the deductible for the following calendar year.

C. PREFERRED PROVIDER ORGANIZATIONS

Where feasible, the Plan has made arrangements with Preferred Provider Organizations ("PPO") to make available a group of preferred providers to supply health care services to you and your covered Dependents. For a complete listing of participating providers for your area, please contact the Fund Office. The Fund Office will provide you with a PPO identification card that must be presented to the provider at each visit to assure that the provider is aware that you are covered by the PPO network.

By using the services of a preferred provider, your out-of-pocket expenses will generally be less. For example, a lower co-insurance applies to any inpatient charges rendered by a participating PPO Hospital.

In order for charges relating to an Illness or Injury to be payable at the PPO co-insurance level, it is your responsibility to verify that the provider is participating in the PPO network at the time services are rendered. The provider directory listing those providers that are in-network because they participate in the PPO network is updated at least every ninety (90) days and is available through the Fund's website. If you receive services from a provider that you thought was in-network, based on inaccurate information in a current provider directory, then the services provided by that out-of-network provider will be covered as if the provider was in-network.

If certain covered providers, including ambulance service providers, home health care agencies, or hospice care agencies, are not available through the PPO network, those expenses will be paid at the PPO level. If a Participant uses a PPO network facility for inpatient or outpatient surgery, but the PPO network facility uses a non-network provider for anesthesia, the interpretation of laboratory tests and X-rays, No Surprises Services, and other Medically Necessary services, the Plan will pay benefits at the PPO level.

If PPO network providers are not accessible in certain limited cases, the Plan will pay benefits for providers not in the PPO network at the PPO level. These limited cases shall include when services are rendered to a Dependent enrolled and regularly attending classes as a full-time student at an accredited college or when services are rendered to Participants and their Dependent(s) on an emergency basis while traveling outside of the geographic location of the PPO network. All eligible services are subject to any applicable deductible, out-of-pocket maximum and are covered only to the extent the charges do not exceed Allowable Charges, to the extent permissible under applicable federal law.

In addition, notwithstanding any provision in this SPD and Plan Document to the contrary, out-of-network No Surprises Services are covered at the same co-payment and co-insurance rates applicable to in-network services, up to the lesser of the median of the in-network rates payable for the same or similar service in the same geographic region, which may also be referred to as the "Qualifying Payment Amount" ("QPA"), or the amount billed by the provider. You will not be responsible for any other amount relating to No Surprises Services, even if the provider does not accept the Allowable Charge.

If a PPO provider leaves the PPO network, a Continuing Care Patient who is receiving care with that provider will be notified, and may elect to continue to receive such care at the same PPO network co-payment and co-insurance rate for up to 90 days after the provider leaves the PPO network.

D. COVERED EXPENSES

Covered expenses incurred for the following services and supplies that are certified by the attending Physician as Necessary for treatment will be paid to the extent that the charges do not exceed Allowable Charges:

1. Hospital Care - Room and board charges and miscellaneous charges incurred during a Hospital confinement, and outpatient charges if outpatient treatment is provided as an alternative to a Hospital confinement. Covered expenses do not include Hospital charges that exceed the Hospital's average daily charge for a semi-private room. Covered expenses for Intensive Care Accommodation or Cardiac Care Accommodation cases are payable at twice the semi-private room rate. If a Hospital has private rooms only, then the average semi-private room rate will be deemed to be 93% of the private room rate.

2. Physician Care - Treatment by a Physician, whether in or out of a Hospital, for an Injury or Illness, including diagnosis, X-ray and laboratory services, in-Hospital visits or Physician's office visits.

3. Surgical Care - Physician charges incurred in connection with a surgical procedure, including anesthetist's charges. If two or more operations are performed during one period in the operating room, the amount payable shall not exceed the Allowable Charge for the principal operation performed plus 50% of the Allowable Charge for each of the other operations performed. However, if two or more operations are performed through the same incision, or in the same bodily orifice, or in the same operative field, then payment shall be made only for the operation for which the largest amount is payable. Only one Hospital treatment per day will be covered unless there is more than one diagnosis being treated.

4. Nursing Services - Charges of a registered graduate nurse ("R.N."), or a practical nurse who is licensed or registered as a practical nurse ("L.P.N."), provided the nurse is not related to you either by blood or marriage, by lineal descent or by any communal relationship.

   Also private duty nursing services of an R.N. or L.P.N. or treatment by a licensed physical therapist for inpatient or outpatient services. Skilled nursing care provided in a Convalescent Care Facility will be paid for only up to one hundred (100) days per calendar year.

5. Ambulance service to a Hospital that results in a Hospital confinement or transfer between Hospitals, if Necessary, if it is for local travel. Covered ambulance service includes only Hospital-provided service or ambulance service by an entity that customarily provides such service in the ordinary course of its business. Under applicable law, the cost-sharing requirement applicable to out-of-network air ambulance services will be no greater than the cost-sharing requirement that would apply if the services had been furnished by an in-network provider. In general, you cannot be balance billed for these air ambulance services.

6. Anesthetics, oxygen, other gases and their administration, including services of a Certified Registered Nurse Anesthetist ("C.R.N.A"). However, benefits for the expenses of non-surgical anesthesia treatment, including epidural, caudal, or any other anesthesia injection not associated with a surgical procedure or operation will be limited to not more than five treatments per year or an annual maximum of $1,500, in those cases where recommendations by a Physician have not been followed.

7. X-ray and laboratory tests.

8. Radium, radioactive isotope or similar therapy.

9. Blood, blood plasma, blood components and their administration, cost and processing.

10. Rental of durable medical equipment such as a hospital bed, wheelchair, or iron lung for the initial equipment only, provided that the rental price shall not exceed the purchase price.

11. For medical supplies if rendered by or prescribed by a Physician including but not limited to: braces, casts, splints, trusses, crutches, dressing, sutures, colostomy bags, and catheters.

12. For lenses (contact or frames) for each eye immediately following and because of cataract surgery, an accidental injury, or therapeutic treatment limited to initial charges only.

13. Surgical hose, stump socks and mastectomy bras limited to 2 per year.

14. For electrocardiograms ("EKG"), electroencephalograms ("EEG"), pneumoencephalogram, basal metabolism test, or similar well established diagnostic tests generally approved by Physicians throughout the United States.

15. Services for voluntary sterilization such as tubal ligations and vasectomies, but only for male and female Participants and Dependent spouses of Participants.

16. Services performed by an ambulatory surgical center or minor emergency medical clinic.

17. Services for the detection and correction by manual or mechanical means, for the structural imbalance, distortion or subluxation in the human body or for the removal of interference, where such interference is the result of or related to the distortion, misalignment or subluxation of or in the vertebral column. Such care that exceeds the maximum for the Physician's office visit fees and treatment fees and is determined to be maintenance, palliative, or excessive care will not be considered a covered expense.

18. Expenses for allergy testing.

19. Expenses for diagnosing and correcting hearing impairments, including hearing therapy are covered; however, the costs of hearing aids are not covered.

20. Expenses for treatment of kidney disorders by hemodialysis or peritoneal dialysis.

21. Dental treatment for repair to or replacement of injury or damage to sound natural teeth (including their replacement) that were harmed as a result of an accident that occurred while you were eligible for benefits under the Plan and as long as the treatment occurs within one year of the accident. Please note that breaking or chipping a tooth while eating will not be covered as

an “accident” under this provision. Removal of tumors or cysts or extraction of impacted teeth will also be covered to the extent not reimbursed as indicated in Section VII.

22. Emergency Services and treatment of a condition less severe than an Emergency Medical Condition but that would require care in a reasonably short period of time.

23. Outpatient surgery and all related charges, if the surgery is performed in a Physician's office, or as an outpatient in a Hospital or ambulatory surgical facility.

24. Pregnancy-related charges for a Participant or Dependent spouse of a Participant, excluding charges for an elective abortion.

25. Initial prosthetic devices and orthopedic appliances that are required because of Illness or Injury, but not the replacement of these devices (other than orthotics) unless outgrown by a child. Covered expenses include pacemakers, cervical collars, braces, breast prostheses to include special bras; orthotics; corrective shoes needed due to or following a surgical procedure, or when custom made to fit, or a brace when medically Necessary. The Plan does not cover the expenses to replace a device or appliance due to a loss, theft, or damage.

26. Charges incurred through the use of an alternative birthing center for medical care and treatment received in connection with a birth up to and including the forty-eight (48) hour period following delivery.

27. Charges for Certified Nurse-Midwives and licensed midwives for services not furnished by a Physician.

28. Charges by a home health care agency, if home health care services are recommended by a Physician, and are in accordance with the Physician’s recommended home health care plan. Such expenses will not be covered for services for more than one hundred (100) days in a calendar year. Covered expenses under this section include:

    a. Part-time or intermittent nursing care by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse if the services of a registered nurse are not available;

    b. Part-time or intermittent certified nursing assistants consisting primarily of patient care of a medical or therapeutic nature, by other than a registered or licensed practical nurse;

c. Physical therapy, occupational, speech or respiratory therapy provided through the home health care agency by a qualified therapist;

d. Nutrition counseling provided by or under the supervision of a registered dietician; and

e. Physician and laboratory services, medical supplies, drugs and medications prescribed by a Physician by or on behalf of a Hospital to the extent such items would have been covered if you were confined in a Hospital or in a skilled nursing facility.

29. Room and Board and related services for an eligible stay in a Convalescent Care Facility but only up to a total of one hundred (100) days in each calendar year. A stay in a Convalescent Care Facility is covered only if the following requirements are met:

a. The stay begins within seven (7) days after a Hospital confinement of at least five (5) days;

b. The stay is due to the same or related causes as the Hospital confinement; and

c. Hospital confinement would otherwise be needed.

30. Charges made by a hospice care facility or hospice care agency for hospice care as provided in the Schedule of Benefits.

31. Hospital outpatient care for an Illness.

32. Charges for inpatient and outpatient treatment of mental health or nervous disorders and substance abuse treatment.

33. Surgeon's charges for outpatient surgical expenses incurred in an ambulatory surgical center or on an outpatient basis.

34. Pre-admission X-ray and laboratory expenses provided that an inpatient Hospital confinement starts within 10 days of the tests.

35. Specialized services rendered by a licensed medical, speech or clinical therapist operating within the scope of his license to restore impaired function incurred while eligible for benefits under the Plan. Covered expenses include physical therapy, physiotherapy, X-ray radiation therapy, chemotherapy, diagnostic X-ray and laboratory expenses, speech therapy, clinical, counseling or school psychologist therapy.

36. Reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to achieve symmetry in appearance and necessary prosthesis or physical complication at any stage of mastectomy, including lymphedemas. These procedures shall be performed in a manner determined in consultation with the patient and the patient's attending Physician. Said coverage is subject to all deductibles, co-insurance, and other Plan provisions not inconsistent with ERISA.

37. Expenses for emergency bee sting kits.

38. Expenses for emergency diabetic kits.

39. Expenses for diagnostic testing for sleep disorders, including sleep apnea, and given medical necessity, further treatment or medical supplies (including C-Pap apparatus). A sleep study is required to determine medical necessity of treatment and equipment.

40. Expenses related to vision benefits, up to $400.00 annually (except that the annual limit will not apply to pediatric vision care).

41. Expenses for diabetic shoes and supplies up to an annual maximum of $350.00.

In addition to the covered expenses paid under the Plan's comprehensive medical benefit provisions described above in this Section IV, the Plan also provides the following special benefits:

Annual Physical Exam Benefits
The Plan provides coverage for your annual physical exam if you have been covered for twelve (12) consecutive months under the Plan prior to the performance of the exam. Your annual physical exam will be covered at the Allowable Charge, subject to the applicable copayment and coinsurance requirements shown on your Schedule of Benefits.

Dependent children, ages 1-18, will be eligible for an annual physical exam covered at the Allowable Charge, subject to the applicable copayment and coinsurance requirements shown on your Schedule of Benefits, and will not be subject to any deductible requirement.

Unless the Physician performing the exam determines that specific tests are not required, then to qualify as an exam, a Physician's exam shall include the following: complete history, physical exam, differential, Sequential Multiple Analysis ("SMAC"), Prostate-specific antigen ("PSA"), Complete Blood Count with Differential ("CBD"), Urinalysis and rectal exam. If a Participant is older than 30, the exam shall also include an electrocardiogram ("EKG") and Chest X-ray unless the Physician determines that these tests are not required.

An exam may qualify as a covered expense even if the exam does not contain all of the minimum procedures if the Physician determines that specified procedures are not appropriate for the patient's age or condition.

NOTE: Neither your co-payment for an annual physical exam or any excess you are required to pay over the maximum amount covered will apply toward any deductible or other co-payment requirements.

Colorectal Cancer Screening Benefit
One routine screening for colorectal cancer (fecal occult blood testing, sigmoidoscopy, or colonoscopy) per year will be covered under the Plan beginning at age 50 and continuing until age 75, payable at the amount shown in the Schedule of Benefits. This benefit is not subject to the deductible shown in the Schedule of Benefits and any co-payment or expenses that are not covered will not apply toward any deductible or co-payment maximum.

Routine Pap Smear Benefits
One routine pap smear per year will be covered under the Plan at 100% of the Allowable Charge.

Routine Diagnostic Mammogram Benefits
Routine diagnostic mammograms will be covered up to the amount shown in the Schedule of Benefits.

Breast Reconstruction Benefit
In connection with a mastectomy that is covered under the Plan, the Plan will provide benefits for 1) reconstruction of the breast on which the mastectomy was performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prosthesis and physical complications at all stages of the mastectomy, including lymphedemas. These benefits are subject to the Plan's annual deductibles and co-payment provisions.

Well Baby and Routine Nursery Care
If you have Family Coverage, the Plan covers well baby and routine nursery care while confined in a Hospital, not to exceed 48 hours following a normal vaginal delivery, or 96 hours following a cesarean section (subject to the provisions of the "Maternity Benefit Notice" below). This coverage includes Physician charges for circumcision and other charges for well newborns incurred during the Hospital confinement. **The payment of benefits pursuant to Well Baby and Routine Nursery Care coverage are subject to any co-payment or co-insurance shown on the Schedule of Benefits.**

NOTE: The Plan will not pay any charges in excess of 48 hours following a normal vaginal delivery, or 96 hours following a cesarean section and such charges will not apply to any deductible or co-payment amounts (subject to the provisions of the "Maternity Benefit Notice" below). In addition, the Plan will pay a percentage of the Allowable Charge incurred for the first five (5) Physician visits during the first year following a newborn's birth, as shown in the Schedule of Benefits. This benefit is not subject to the deductible shown in the Schedule of Benefits and any co-insurance or expenses that are not covered are not included in the calculation of out of pocket expenses. Eligible expenses for these five (5) visits include routine examinations, immunizations, vaccinations and inoculations for childhood diseases. The Physician's first visit in the Hospital after the newborn's birth is considered a Physician visit for purposes of this Section. Expenses incurred by the newborn child during the first 31 days will be covered according to the provisions of the Plan, even if you do not have Dependent coverage. To continue your Dependent child's coverage after the first 31 days, you must complete an Enrollment/Change form to enroll your

child for coverage. If you do not enroll your newborn child within 31 days of birth, the child may not be added to your coverage as a Dependent until the next open enrollment period.

Maternity Benefit Notice
In accordance with federal law, the Fund, as a group health plan, generally does not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods.

Substance Abuse Drug Benefit
Medications used to treat substance abuse will be covered by the Plan subject to the Plan's prescription drug benefit provisions, which are discussed in further detail in Section VI.

LiveHealth Online
With LiveHealth Online, doctors are available to you online seven days a week, 24 hours a day, 365 days a year. LiveHealth Online lets you talk face-to-face with a doctor through your mobile device or a computer with a webcam. You do not need an appointment and a typical LiveHealth Online session lasts about 10 minutes.

When you need to see a doctor, simply go to livehealthonline.com or access the LiveHealth Online mobile app, available for download on the Apple App Store or Google Play. Select the state that you are located in and answer a few questions. All costs of LiveHealth Online are covered by the Fund and there is no cost to you to use this service. There is no co-payment or any other cost to participants for this service.

You can use LiveHealth Online for common medical situations like colds, sore throats, the flu, fevers, rashes, infections and allergies. The online doctor can diagnose, treat and, if state regulations allow, prescribe medications. However, LiveHealth Online should not be used for emergency care. If you experience a medical emergency, call 911 immediately.

For more information, go to livehealthonline.com or contact Anthem at 1-855-603-7985 or customersupport@livehealthonline.com.

F. CERTIFICATE OF CREDITABLE COVERAGE

In certain circumstances, federal law requires that the Plan provide you and your Dependent(s) with evidence of your coverage under the Plan for use as proof of prior coverage when beginning coverage under another health plan. Accordingly, to the extent required by federal law, the Fund will provide a Certificate of Creditable Coverage to Covered Persons within a reasonable time after the occurrence of any of the following events:

1. At the time the Covered Person would lose coverage under the Fund in the absence of COBRA continuation coverage;
2. Loss of coverage under the Fund;
3. Loss of COBRA continuation coverage; and

4. Upon written request, within the first 2 years of the loss of coverage under the Fund.

V. VISION CARE BENEFITS

The Plan provides vision care benefits; however, there are limits as to the frequency of services covered. In addition, eye exams, lenses and frames are covered as shown on the Schedule of Benefits.

The Plan will pay for covered services and supplies provided by a Practitioner. The amount covered is determined based on a percent of the prevailing fee for the incurred expense, up to a maximum amount of $400.00 per calendar year (except that the maximum amount will not apply to pediatric vision care).

A "Practitioner" for purposes of the Plan's vision care benefits means a licensed Physician, ophthalmologist, optometrist, or optician. The Practitioner cannot be you, your spouse, or the children, brothers, sisters, or parents of you or your spouse.

The following expenses are covered expenses under this benefit:

Class I Expenses - Vision Screening, including a check of vision functions and a check of ability and condition of vision.

Class II Expenses - Vision Analysis.
If vision screening indicates the need for additional services then the following Vision Analysis services are covered expenses:

1. Case history;
2. Measurement and recording of visual acuity;
3. Examination of fund, media, crystalline lens, optic disc, and pupil reflex;
4. Corneal curvature measurements;
5. Retinoscopy;
6. Fusion determination, far and near;
7. Subjective determination, far and near;
8. Stereopsis determination, far and near;
9. Color discrimination;
10. Amplitude of accommodation;
11. Analysis of findings;
12. Determination of prescription; and
13. Measurement and recording of visual acuity with new prescription.

Class III Expense - Purchase of Lenses and Frames.
If vision analysis indicates the need for lenses or frames, then the following services are covered expenses:

1. Professional advice on frame selection;
2. Facial measurements and preparation of specifications for a laboratory;

3. Frames with prescription lenses, or a change of lenses, including cost for verifying and fitting frames and lenses;
4. Contact lenses required because a vision defect cannot be treated except by their use, including disposable contact lenses. Disposable contact lenses are not subject to the annual maximum of one pair, but are subject to the maximum annual dollar limitation in the Schedule of Benefits;
5. Contact lenses not so required, but only up to the amount that would be paid for frames and lenses for the vision defect;
6. Re-evaluation and progress report within four weeks after a new prescription; and
7. Subsequent servicing.

Class IV Expense - Surgical Correction of Vision.
Surgical Correction of Vision shall include Lasik surgery ("surgery") as a covered expense with the following limitations:

1. The surgery shall only be available if provided for in the Schedule of Benefits; and
2. The percentage of the total cost of the surgery specified in the Schedule of Benefits shall be considered a covered expense after the deductible for the calendar year has been satisfied, unless the Schedule of Benefits provides that it is not subject to the deductible.

Vision Benefit Exclusions
The Plan does not pay vision care benefits for the following:

1. Medical or surgical treatment of an eye injury or eye disease;
2. Sunglasses (plain), safety lenses or goggles;
3. Orthoptics, vision training, or aniseikonia;
4. Services or supplies not required to examine or correct a vision defect;
5. Charges for which the person does not have to pay;
6. Eye exams or lenses in excess of the amount shown on the Schedule of Benefits; and
7. Frames in excess of the amount shown on the Schedule of Benefits.

VI. PRESCRIPTION DRUG BENEFIT

The Prescription Drug Benefit is not subject to the Plan deductible or any out of pocket provision in the Plan unless specified in your Schedule of Benefits. Benefits are payable for outpatient prescription drugs obtained with a drug card or through the mail-order program only. The Fund has a contract with a pharmacy benefit manager ("PBM") to provide principal drug benefits to you and your eligible Dependent(s). The Fund Office will provide you with a prescription drug card and a list of participating pharmacies. Prescription Drug Benefits are subject to the co-payments as outlined in the Schedule of Benefits. Please contact the Fund Office for more information if you have not received your prescription drug card. If you use the prescription drug card, you will be charged the co-payment shown on the Schedule of Benefits for covered drugs up to a thirty day drug supply with one prescription refill. You may also use the Fund's mail order

program, subject to the 90-day and other supply limits indicated below. The mail order programs are also provided through a contract with the PBM. If you or your pharmacist have questions about the prescription drug benefit or mail order program, you can contact the PBM directly at the number listed on your Schedule of Benefits or you can contact the Fund Office. For purposes of this benefit, prescription drugs are medicines lawfully obtainable only upon the written prescription of a Physician and include the following covered drugs:

1. Federal Legend Drugs;
2. State Restricted Drugs;
3. Compounded Medication, unless the compounded medication or one or more of its ingredients is specifically excluded from coverage below;
4. Over the counter (OTC) Diabetic Supplies, insulin pump supplies, and Insulin;
5. Needles and Syringes that are prescribed; and
6. OTC Claritin D and OTC Zyrtec/D when the Physician writes a prescription

The following are excluded from coverage unless specifically listed above as a covered drug:

1. Drugs procured without a prescription;
2. Drugs and vitamins prescribed for any dietary purpose;
3. Contraceptives, contraceptive material, or infertility medication unless specifically noted in the Schedule of Benefits and if taken for a non-birth control medical reason prescribed and documented by a Physician;
4. Immunization agents;
5. Appliances, supports, and prosthetic devices such as, but not limited to, canes, crutches, wheelchairs, or any means of conveyance or locomotion prescribed for an ambulatory patient, braces, splints, bandages, heat devices, hypodermics, or syringes or needles other than for insulin;
6. Drugs dispensed by a Hospital for resident bed patients or by a rest home or sanatorium, extended care facility, or skilled nursing facility, Convalescent Care Facility or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals because such drugs are covered under the Plan's comprehensive medical benefit provisions described in Section IV or are otherwise excluded;
7. Any drug or medication which, when taken or used in accordance with the directions of the prescribing Physician, is made available in sufficient quantity to provide more than a thirty (30) day supply without the necessity for a refill, unless the prior written consent of the Fund has been obtained;
8. Drugs obtained prior to the effective date of coverage under the Plan, or subsequent to the termination of coverage;
9. Drugs that can be legally dispensed without a Prescription, such as aspirin, even though prescribed by a Physician;
10. A Prescription that has been refilled in excess of the number of refills specified by the Physician or any refill dispensed after one year from the Physician's original order;

11. Drugs labeled “limited to Experimental or Investigational use" even if a charge is made;
12. All smoking and other tobacco use deterrents, except as provided under the “Smoking Cessation Drug Benefit” described at the end of this Section VI or “Preventive Care Services” described at the end of Section IV;
13. All fluoride products;
14. Anorexiants;
15. Drugs whose sole purpose is to promote or stimulate hair growth;
16. Pre-packaged prescription drugs in excess of a 30-day supply;
17. Tazorac and Retin-A will only be available as a covered drug to individuals through age 24, and will not be covered for anyone 25 and older, and
18. Compounded medications with one or more ingredients that are on the exclusion list maintained by Express Scripts. For information on the ingredients included on the exclusion list, please call Express Scripts at 800-372-5817.

Drug Quantity Management
The Fund maintains a Drug Quantity Management program. Drug Quantity Management means that the Fund will only pay for a set quantity amount at a particular strength for certain prescription drugs. Quantity limits are set in accordance with FDA approved prescribing limitations and standard medical practice. The list of prescription drugs subject to the Drug Quantity Management program will be changed from time to time based on new drugs coming to market and clinical recommendations. For more information regarding drugs that are subject to the Drug Quantity Management program, or to request prior authorization for a particular strength or quantity of drug that is contrary to the limits imposed, you can contact the PBM at the number listed on your Schedule of Benefits.

Dispensing Limits
Retail - Drugs, including Insulin, will be dispensed per prescription or refill in quantities up to a 30-day supply.

Mail Service - Covered persons may purchase Prescriptions through mail order service. The Fund will pay the Allowable Charge actually incurred for Prescriptions filled through the mail order service in excess of the amount of the applicable co-payment as shown in the Schedule of Benefits. Drugs, including Insulin, will be dispensed per prescription or refill in quantities prescribed up to 90-day supply, subject to any limits applicable to certain specialty drugs described below.

Step Therapy
The Fund maintains a Step Therapy program, which requires the use of generic drugs or preferred brand name drugs, rather than a more expensive non-preferred brand name drug, for certain medical conditions unless prior approval is obtained from the Fund for the non-preferred brand name drug. The drug classes included in the Step Therapy program include antidepressants, osteoporosis agents, angiotension II receptor blockers (ARBs), allergic rhinitis intranasals, sleep aid medications, glaucoma medications, proton pump inhibitors (PPIs), statins (HMGs), and triptans. Drugs in these classes that have been designated as non-preferred brand name drugs will not be covered by the Plan unless prior approval is obtained from the PBM. For more information regarding brand name drugs that are affected by the Step Therapy Program, or to request prior

authorization for a non-preferred brand name drug, you can contact the PBM at the number listed on your Schedule of Benefits.

Member Pay the Difference
If a prescription drug is available as both a generic drug and a brand name drug, the co-payment applied for the brand name drug will be the applicable generic drug co-payment outlined in the Schedule of Benefits, plus the difference between the Allowable Charge for the brand name drug and the Allowable Charge for the generic drug, unless prior approval is obtained from the PBM. This means that, if you do not obtain prior approval from the PBM, you will be responsible for paying the cost difference between the brand name drug and the generic equivalent drug, plus the applicable generic drug co-payment. You can contact the PBM at the number listed on your Schedule of Benefits to request prior authorization for a brand name drug.

Specialty Drugs
Pre-Authorization for Specialty Drugs. Certain specialty drugs require pre-authorization from Accredo Specialty Pharmacy ("Accredo") before the Fund will provide coverage. The specialty drugs for which pre-authorization is required include, but are not limited to, oral medications used for the treatment of cancer, hepatitis C, rheumatoid arthritis, multiple sclerosis, cystic fibrosis, and pulmonary arterial hypertension. In addition, pre-authorization is also required for new specialty drugs that have recently been approved by the FDA. Once you receive a prescription for a specialty drug, you should contact Accredo immediately at 1-800-803-2523. Accredo will review your medical history and consult with the prescribing doctor to ensure that the drug being prescribed is appropriate for your medical condition. In some cases, after consulting with your doctor, Accredo may authorize a preferred specialty drug as an alternative to a prescribed non-preferred specialty drug. However, Accredo will never change the prescription without the approval of the prescribing doctor. Once a specialty drug has been pre-authorized, it will be covered by the Fund consistent with the terms of the Plan. If Accredo does not pre-approve the drug, the Fund will not provide coverage. You have the right to appeal a pre-authorization denial consistent with the Fund's claims and appeals procedures.

For more information regarding specialty drugs that require pre-authorization, a list of specialty drugs for which preauthorization is required, or to request pre-authorization for a specialty drug, you can contact Accredo at 1-800-803-2523.

Partial Fill Program for Specialty Drugs
Certain specialty drugs are limited to a two-week supply per prescription or refill. If you have not previously received the specialty drug in the last 180 days, your prescriptions and refills of the specialty drug will be dispensed in two-week supplies for three months. Each two-week supply will be subject to one-half of the applicable co-payment outlined in the Schedule of Benefits. After you receive the specialty drug for three consecutive months, your subsequent prescriptions and refills will be dispensed in the full prescribed quantity of the drug, up to a 30-day supply.

For more information regarding specialty drugs that are included in the partial fill program, you can contact Accredo at 1-800-803-2523.

Tobacco Use Cessation Drug Benefit
Drugs, including patches, that are approved by the Food and Drug Administration for the purpose of tobacco use cessation are covered expenses, including but not limited to Habitrol, Prostep, Nicoderm and Zyban.

Fentanyl Patches
Fentanyl patches are covered expenses, but only up to a maximum of 3 patches per 10 day period or 10 patches per 30 day period. In order to obtain additional Fentanyl patches in excess of the 10-day or 30-day maximum, prior authorization must be obtained from the Fund.

HIV PrEP Drugs
Certain Human Immunodeficiency Virus ("HIV") pre-exposure prophylaxis ("PrEP") drugs that are prescribed for a Participant or Dependent at high risk of acquiring HIV are covered expenses. Covered HIV PrEP drugs are not subject to any co-payment or co-insurance requirements. However, if an HIV PrEP drug is available as both a generic and a name brand version, only the medically appropriate generic version will be covered with no cost sharing.

VII. DENTAL EXPENSE BENEFIT

The Fund provides Dental Expense Benefits to certain Participants and Dependents whose employers make contributions to the Fund for these benefits. The attached Schedule of Benefits will indicate whether or not you are eligible for these benefits.

If you or your Dependent(s) is treated by a licensed Dentist, the Plan will pay a percentage of the covered dental expenses as shown on the Schedule of Benefits. For certain Participants and Dependents, this percentage of coverage increases during the second and third years of your coverage under the Plan, when both an exam and cleaning are performed during the previous year. The attached Schedule of Benefits will indicate whether you may be eligible for this increase. The term "Dentist" means a dentist practicing within the scope of his license or a Physician authorized by his license to perform the particular dental services he has rendered.

The Plan requires that you (and your Dependents if they are eligible for this coverage) visit a Dentist for examination and diagnosis at least once during the year. You must have all services that were recommended by the Dentist as a result of the first visit completed by the end of that year in order to be eligible for the Plan's benefits rate increase in the second and third year as shown on the Schedule of Benefits.

The Fund has made arrangements with Anthem to make available a dental provider network to supply dental services to you and your covered Dependents. You are not required to use an Anthem dental provider. However, if you use the services of a Dentist that is within Anthem's dental provider network, your out-of-pocket expenses will generally be less because Anthem dental providers have agreed to a fixed fee schedule. To find a Dentist within the Anthem dental provider network, you may call the Fund Office toll-free at 1-800-360-6581 or visit Anthem's website at www.anthem.com. The Fund Office will provide you with an identification card that should be presented to the Anthem dental network provider at each visit to assure that the provider is aware that you are covered by the network.

A. COVERED DENTAL EXPENSES

Covered dental expenses include the charges of a Dentist for the following dental services and supplies:

1. **Regular Services**
   Routine periodic examinations at six-month intervals, including bitewing X-rays at twelve month intervals;

   Full mouth X-rays in any three year interval unless special need is shown; Dental prophylaxis as prescribed by the Dentist but not more than once every six months;

   Topical fluoride applications as prescribed by the Dentist but not more than once in any twelve month interval.

2. **Regular Restorative Treatments**
   Emergency treatment for relief of pain;

   Regular restorative services: amalgam stainless steel crowns, synthetic porcelain, and plastic restorations

   Oral surgery: extractions and other oral surgery, including pre- and post-operative care

3. **Special Restorative Treatments**
   Gold restorations when the teeth cannot be restored with another filling material and crowns and jackets when the teeth cannot be restored with filling materials. Non-surgical periodontics: procedures necessary for treatment of disease of the gums. (Endodontics: includes pulpal therapy and root canal filling.)

4. **Prosthetics: Removable and Fixed**
   Bridges, partial dentures and complete dentures.

5. **Periodontics**
   Surgical procedures necessary for the treatment of diseases of the gums and bone supporting the teeth.

The Plan may require a complete dental chart showing any extractions, filling, or other work performed prior to the date for which the claim is being made. These include itemized bills of the Dentist or Physician or other sources of services, supplies, and treatment; X-rays, laboratory, or Hospital reports, casts, molds, or study models, or other similar evidence of the condition or treatments of the tooth or mouth.

B. LIMITATIONS ON COVERED DENTAL EXPENSES

Covered dental expenses do not include, and no benefits will be payable for:

1. Treatment by other than a licensed Dentist or Physician except charges for cleaning of teeth performed by a licensed dental hygienist under the supervision and direction of a Dentist.
2. Dental services furnished without charge or paid by a government unit, employer, benefit association, union or similar group.
3. Charges for dentures and bridgework when these charges are incurred for the replacement of teeth, all of which were extracted while the person was not covered under the Plan.
4. Charges for replacement of a lost or stolen prosthetic device.
5. Charges for crowns, bridgework, dentures incurred within six months after the person becomes covered if coverage was elected more than 30 days after he becomes eligible.
6. Charges for orthodontic treatment and for prosthetic devices (including bridges and crowns) and the fitting of prosthetic devices that were ordered while covered under the Plan but not installed or delivered until more than thirty days after termination of coverage.
7. The portion of any charge that exceeds the Allowable Charge for, or the fair and reasonable value of, the service, supply, or treatment for which the charge is made.
8. Expenses in connection with any orthodontic procedure or treatment except as shown on the Schedule of Benefits.
9. Repair and replacement of dentures or bridgework is covered at 50% up to a maximum of $500 for every 2 year period.
10. Any expenses which would be excluded under any limitation or exclusion in the Plan's comprehensive medical expense benefit provisions described in Section IV.
11. Any dental expenses for which benefits are payable under the surgical provision of the Plan's comprehensive medical expense benefit provisions described in Section IV.
12. Temporomandibular Joint Disorder ("TMJ") except to the extent provided on the Schedule of Benefits.
13. Expenses in connection with dental implants and any related services.

No extension of benefits or conversion privilege including the disability extension or lay-off extension benefit other than COBRA continuation coverage that may be part of this Plan shall be construed to apply to dental benefits.

C. SUPPLEMENTAL DENTAL BENEFIT

If you are eligible for Dental Expenses Benefits, the Plan provides an additional Supplemental Dental Benefit and Supplemental Diagnostic and Preventive Dental Benefit. Under the Supplemental Dental Benefit, the percentage payable for covered dental benefits will be increased

by 10% over the percentage applicable in the Dental Benefits section, as shown on the Schedule of Benefits. Under the Supplemental Diagnostic and Preventive Dental Benefit, the percentage payable for Regular Services and other diagnostic and preventive covered dental benefits will be increased by an additional 10% over the Supplemental Dental Benefit and the percentage applicable in the Dental Benefits section, as shown on the Schedule of Benefits. The Schedule of Benefits shows the total percentage paid by the Plan, including any applicable Supplemental Dental Benefit or Supplemental Diagnostic and Preventive Dental Benefit.

The Supplemental Dental Benefit and Supplemental Diagnostic and Preventive Dental Benefit do not apply to the repair and replacement of dentures or bridgework.

VIII. LIMITATIONS AND GENERAL EXCLUSIONS

A. GENERAL EXCLUSIONS

The following exclusions apply to all benefits payable under the Plan and are in addition to any exclusions already set forth in other sections of this Summary Plan Description. Unless specifically covered under Section IV, V, VI, or VII, benefits will not be payable for any of the following, to the extent the exclusion is permissible under applicable federal law:

1. Any charges that are incurred as a result of or in connection with any activity pertaining to any act of employment for profit, gain, compensation.

2. Any expenses incurred as a result of a disease, Illness, sickness or condition for which benefits are payable under any Workers' Compensation Act, any Occupational Diseases Act or any other similar such benefit program.

3. Service, supply, treatment, therapy, care or procedure which is not rendered for the treatment and correction of a specific Illness, sickness or condition or accidental bodily Injury or which is not rendered by a covered provider.

4. Charges that exceed the Allowable Charge. However, your only financial responsibility for any No Surprises Service is any applicable deductible, co-insurance and/or co-payment amount, up to the lesser of the median of the in-network rates payable for the same or similar service in the same geographic region, which may also be referred to as the "Qualifying Payment Amount" ("QPA"), or the amount billed by the provider. You will not be responsible for any other amount relating to No Surprises Services, even if the provider does not accept the Allowable Charge.

5. Services that are not Necessary or medical or surgical services that do not require a Hospital setting, can be provided in a Physician's office, the outpatient department of a Hospital, or in a lessor facility without adversely affecting the patient's condition or the quality of medical care rendered, including but not limited to admissions primarily for observation or evaluation and/or diagnostic studies that can be provided safely and adequately on an outpatient basis.

6. Cosmetic surgery except 1) operations necessary to repair disfigurement due to an accident that occurred while covered under this Plan and 2) for treatment of a congenital defect that results in the functional defect of a Dependent child.

7. Charges incurred as a result of military service for any country or organization including service with military forces as a civilian whose duties do not include combat.

8. Treatment of any injury or illness that is occasioned by war, declared or undeclared.

9. Charges incurred outside the United States or Canada unless the Participant or Dependent is a resident of the United States or Canada and the charges are incurred while traveling on business or for pleasure.

10. Any charges incurred for education, training or room and board while confined in an institution that is primarily a school or institution of learning or training including treatment for scholastic improvement, vocational training, speech development, visual coordination and motor coordination, whether inpatient or outpatient

11. Any charges incurred while confined in an institution that is primarily a place of rest, a place for the aged or a nursing home.

12. Any charges incurred for any type of Custodial Care or rest cures. Custodial Care means care that is designed primarily to assist an individual in meeting the activities of daily life. This exclusion applies to all such care regardless of what the care is called by the provider.

13. Charges for any services, treatment, care and/or therapy rendered by any practitioner that is a family member or that employs you or a family member that is a Dependent. Family member shall include any relation by blood or marriage including someone who resides with patient.

14. Expenses, charges, or liabilities incurred as the result of or in the commission of a felony or misdemeanor (except traffic violations), or participation in a riot, or illegal occupation, or while legally intoxicated or for charges incurred while under the influence of alcohol or illegal drugs as evidenced by a blood alcohol level equal to or in excess of the legal amount allowed in the state where the injury occurred, unless such expenses are otherwise covered by the Plan and result from a medical condition (such as alcoholism).

15. Any and all medical or prescription drug expenses for charges incurred as the result of any self-destructive act or self-inflicted injury, sickness, or

illness or condition, including but not limited to any therapy or treatment related thereto whether it is psychological or physiological, or the deliberate ingestion of any drug, chemical, or poisonous substance not taken according to a Physician's instructions, unless such expenses are otherwise covered by the Plan and result from a medical condition (such as depression).

16. Expenses for medical or surgical treatment to reverse the effects of tubal ligations or vasectomies.

17. Maternity benefits and all charges incurred in connection with pregnancy are limited to eligible female Participants and Dependent spouses of eligible male Participants. No benefits are payable for any charges related to pregnancy or resulting childbirth of other Dependents.

18. Any ultrasound, echogram or amniocentesis procedures related to pregnancy unless such procedures are required by a complication of pregnancy or complications for participants who are maternal age of 35 or older. Testing for the purpose of fetal age or sex or solely because of maternal age shall not be considered due to a complication of pregnancy.

19. Benefits for any charges incurred in connection with or associated with abortion procedures or pregnancy-related conditions resulting in abortion unless such procedures are Necessary to protect the life of the mother in the opinion of two qualified Physicians.

20. Any charges incurred for services, treatment, programs or surgical procedures rendered for the purposes of weight loss in connection with any overweight condition of obesity, regardless of its classification even if other health conditions might be helped by a reduction of obesity or weight.

21. Expenses for the usual and ordinary nursery and pediatric care of a newborn child, including but not limited to circumcision except as provided under the Plan's Well Baby and Routine Nursery Care Benefit described in Section IV, E.

22. Any charges incurred that the person is not legally required to pay, or for which no charge would be made in the absence of this coverage.

23. Hearing aids or the fitting of hearing aids in connection with a hearing loss except that this exclusion shall not apply to the diagnosis and correction of hearing impairments, including hearing therapy to the extent of the least expensive service, supply or procedure that will correct the condition.

24. Charges for experimental or investigational procedures or devices, including organ transplant or mechanical organ implantation and genetic testing, except charges for heart transplant, kidney transplant, liver

transplant, corneal transplant, bone marrow transplant, or skin transplant as shown on the Schedule of Benefits.

25. Any services or supplies rendered to any person who requires them by reason of acting as a donor of any non-covered organ or element of his body.

26. Charges for filling out claim forms or for failure to keep a scheduled visit.

27. Charges for Physician visits in excess of one each day if surgery is not required or charges for Physician visits on or after the day of surgery unless more than one diagnosis is being treated.

28. Charges for routine physical examinations, preventive medicines, (except for Senejis when given to infants as an immunization against RSV, and TamiFlu medication, Relenza, and flu vaccinations), vitamins, minerals or other dietary supplements, whether or not prescribed by a Physician, except as provided under the Annual Physical Examination Benefits described in Section IV, D.

29. Charges for acupuncture, hypnosis, biofeedback treatments, chelation therapy, massage therapy or rolfing.

30. Charges for care provided to you or your eligible Dependent(s) to the extent that the cost of the professional care or hospitalization may be recoverable by, or on behalf of, you or your eligible Dependent(s) in any action at law, any judgment, compromise or settlement of any claims against any party, or any other payment you, your Dependent(s), or your or your Dependent(s)'s attorney may receive as a result of the accident, no matter how these amounts are characterized or who pays these amounts, as provided in Section X, C.

31. Charges by a licensed social worker, counselor, pastor, or any mental health provider other than a licensed Physician or Psychologist.

32. Vision loss or any charges in connection with vision care except as provided under the Plan's Vision Care Benefit described in Section V.

33. Services or supplies related to sex transformation or sexual dysfunctions or inadequacies.

34. Charges for fertility studies, artificial insemination or in-vitro fertilization including but not limited to fertility tests, hormone therapy to cause pregnancy, and embryo therapy.

35. Surrogate mothers or related services.

36. Medications or devices that are used to prevent pregnancy.

37. Charges furnished in any institution or facility operated by the United States Government, other than a Veteran's hospital, or by any state government, or by any agency or instrumentality of such government, for which the person has no legal obligation to pay for services rendered or expenses incurred except for care or services furnished by a tax-supported state hospital for treatment of mental or nervous disorders.

38. Charges for Hospital care and services rendered after the patient has been discharged from the Hospital by the attending Physician, or for Hospital care and services when the patient is absent from the Hospital.

39. Charges for benefits that are not payable due to the application of any specified deductible or co-payment provisions contained herein.

40. Charges for travel or accommodations whether or not recommended by a Physician.

41. Equipment or supplies made or used for physical fitness, athletic training or general health upkeep.

42. Charges for usual and normal home medical supplies or first aid items, with exception of emergency bee sting kits and emergency diabetic kits.

43. Benefits will not be paid for Injuries received in an accident involving a car or other motor vehicle that is owned or leased by you or any member of your immediate family or involving any car or other motor vehicle for which there is in effect, or is required to be in effect, any policy of insurance. This exclusion is not applicable to expenses not paid by any policy of no-fault insurance as a result of a state required policy of insurance deductibles or maximums.

44. Any charges incurred more than one year prior to the date the claim is filed and all information necessary to process the claim has been submitted to the Fund.

45. Charges which are not specifically listed as covered expenses.

46. All charges related to breast reconstruction except as provided under the Plan's Breast Reconstruction Benefit described in Section IV, D.

47. Any charges for or related to, or as a result of, sleep studies or sleep disorders except as described in Section IV, D, paragraph 40.

48. Outpatient prescription drugs, except as provided under the Plan's Prescription Drug Benefit described in Section VI.

49. For corrective shoes or orthopedic devices except as specifically covered under Section IV, D. See Section IV, D, Paragraph 42 for benefits for diabetic shoes.

50. Stand-by charges for a Surgeon or pediatrician.

51. Non-medical expenses for training, educational instruction, or educational materials.

52. Charges incurred for services or supplies, which constitute personal comfort or beautification items, television or telephone use, or to control or change the environment or in connection with occupational therapy, or expenses actually incurred by other persons as provided in Schedule of Benefits.

53. Charges incurred as a result of an Injury sustained while participating in a speed or endurance contest, stunt driving, acrobatics, trapeze or high-wire demonstration or contest, hang gliding, bungee cord jumping, sky diving, parasailing, or any high risk, hazardous sport.

54. The purchase or fitting of eyeglasses or contact lenses, except as provided under the Vision Care Benefit as described in Section V and the initial purchase of eyeglasses or contact lenses following cataract surgery.

55. Charges for temporomandibular joint disorder ("TMJ"), except to the extent shown on the Schedule of Benefits.

56. Treatment of the teeth or gums except:
    a. Tumors or cysts and incision or drainage of an abscess or cyst;
    b. Excision of impacted unerupted teeth; and
    c. Treatment of accidental injury to natural teeth (including their replacement) due to an accident occurring while you are eligible for the Plan's comprehensive medical expense benefits described in Section IV if the treatment is completed within one year of the date of the accident (breaking or chipping a tooth eating will not be covered) or for any operation or treatment in connection with the fitting or wearing of dentures;
    d. Excision of a tooth root without the extraction of the entire tooth;
    e. Incision or excision procedures on the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;
    f. Separate charge for anesthesia, but only if Necessary;
    g. Inpatient or outpatient hospital charges incurred for treatment and care of the teeth, gums, or alveolar process to the extent Necessary; or
    h. As otherwise provided on the attached Schedule of Benefits under the Dental Benefits provisions.

Note: Injuries resulting from an act of domestic violence or from a medical condition including mental health conditions are not excluded solely because the source of the Injury was an act of domestic violence or a medical condition.

If the Fund pays benefits and it is later determined that such benefits should not have been paid with respect to any of the exclusions mentioned above, you are required to reimburse the Fund in full and the Fund explicitly reserves the right to recover any and all benefits paid to you or to a provider in error by any and all methods which include, but are not necessarily limited to, offsetting the amounts paid against your and/or any of your Dependents' future benefit payments under the Plan.

B. MENTAL HEALTH, NERVOUS, AND SUBSTANCE ABUSE DISORDER BENEFITS

Inpatient and outpatient treatment for mental health, nervous, and substance abuse disorders is covered subject to the deductible, co-payment, and out-of-pocket limit amounts shown on the Schedule of Benefits.

All inpatient treatment for mental health, nervous, and substance abuse disorders must be pre-certified by HealthLink. Contact HealthLink at (877) 284-0102.

The Fund does not impose on mental health or substance abuse benefits any financial requirements or treatment limits that are more stringent than those that apply to medical/surgical benefits in the same classification, as defined by applicable law and regulations, to the extent required by law. With respect to non-quantitative treatment limitations, the Fund applies criteria (including evidentiary standards, strategies and processes) that are comparable to, and no more stringent than, criteria for such limitations for medical/surgical benefits.

C. CHIROPRACTIC CARE LIMITATION

Benefits for Chiropractic Care will be limited to payment of the following covered expenses:

1. Incurred charges per visit, as shown on the Schedule of Benefits; and
2. One visit per week.

Payment will be at the percentage shown in the Schedule of Benefits, subject to the deductible.

D. PODIATRIST LIMITATION

Benefits for the expenses of treatment by a podiatrist will be limited to the following covered expenses up to the amount shown on the Schedule of Benefits:

1. Podiatrist service.
2. Prescription devices.
3. Initial pair of corrective shoes, as covered under Section IV, D.

E. RADIAL KERATOTOMY/LASIK SURGERY LIMITATION

Benefits for all charges related to radial keratotomy or LASIK surgery will be limited to any lifetime maximum shown in the Schedule of Benefits.

IX. OTHER BENEFITS

A. LIFE INSURANCE BENEFITS FOR EMPLOYEES

1. Basic Life Insurance

The Fund provides life insurance benefits to Participants whose employers have agreed to make contributions to the Fund to provide those benefits. If you are eligible for life insurance benefits, the amount of your life insurance is shown on the Schedule of Benefits. If you die while you are eligible for life insurance benefits, your life insurance is payable to the person whom you have named as your beneficiary.

Life insurance benefits are payable regardless of the cause of your death. The life insurance portion of your coverage is provided through a contract between the Fund and Standard Insurance Company ("Standard"). Standard will provide a separate certificate of life insurance to you that describes the life insurance coverage in detail. Please be sure to keep your life insurance certificate with this booklet. Please refer to the coverage certificate issued by Standard for more information as well as additional conditions and limitations. If you have not received a certificate describing your life insurance benefits, contact the Fund Office for more information.

2. Accidental Death and Dismemberment Benefit

The Fund provides accidental death and dismemberment benefits to Participants whose employers have agreed to make contributions to the Fund to provide these benefits. If you are eligible for accidental death and dismemberment benefits, the principal sum of your accidental death and dismemberment coverage is shown on the Schedule of Benefits. This portion of your coverage provides an additional death benefit and coverage in the event you suffer certain dismemberments or loss of sight due to accidental injuries.

This benefit, like the life insurance benefit, is provided through a contract between the Fund and Standard. Standard will furnish you with a certificate of coverage that completely describes the death and dismemberment coverage. Please keep the certificate with this booklet. Please refer to the coverage certificate issued by Standard for more information as well as additional conditions and limitations. If you have not received a certificate describing your death and dismemberment coverage, contact the Fund Office.

3. Supplemental Life Insurance for Employees

The Fund provides supplemental life insurance for Participants who are eligible for life insurance benefits and who are covered by a collective bargaining agreement that requires contributions to the Fund. Supplemental life insurance is provided through a contract between the Fund and Standard.

The benefit paid under this portion of the coverage is based upon your age at the time of your death. The amounts payable to your beneficiary upon your death are shown on the Schedule of Benefits.

The supplemental life insurance coverage terminates once you attain age 70. Standard will furnish you a certificate of coverage that fully describes the benefits payable under this supplemental life insurance benefit of this part of your Plan. Please keep the certificate with this booklet. Please refer to the coverage certificate issued by Standard for more information as well as additional conditions and limitations. If you have not received a certificate of coverage, contact the Fund Office.

B. DEPENDENT LIFE INSURANCE BENEFIT FOR YOUR SPOUSE AND CHILDREN

The Fund provides life insurance in the event of the death of your Dependent spouse or child(ren). In order to be eligible for this benefit you must have Family Coverage under the Plan and you must pay the required contribution, if any, for this portion of the Plan's life insurance coverage. The benefits payable under this portion of the Plan's life insurance coverage are as shown on the Schedule of Benefits.

Dependent life insurance coverage for your Dependent spouse and child(ren) is provided through a contract between the Fund and Standard. Standard will issue you a coverage certificate that describes the benefits in detail. Please keep the certificate with this booklet. Please refer to the coverage certificate issued by Standard for more information as well as additional conditions and limitations. If you have not received a certificate of coverage, contact the Fund Office.

C. WAIVER OF PREMIUM DURING DISABILITY

If you become Totally Disabled while covered under the Fund's life insurance policy and are under age 60, your life insurance may be continued without payment of premiums while you are Totally Disabled. In order to be eligible for this benefit, you must complete a waiting period and must provide Standard with satisfactory proof of loss within a certain period of time. Please refer to the coverage certificate issued by Standard for more information as well as additional conditions and limitations.

D. LIFE INSURANCE CONVERSION

If your life insurance coverage terminates or is reduced (for example, if you terminate employment) and is not replaced with other life insurance within 31 days, you may be able to convert your life insurance coverage under this Plan to an individual life insurance policy without being required to submit evidence of insurability. To do so, you must submit an application for an individual policy, signed by your employer, to Standard within 31 days after the termination or reduction of your insurance. Contact the Fund Office to get the form needed to request conversion information. The cost of the individual policy will be determined by Standard. Both Employee life insurance and Dependent life insurance may be converted, but the amount of insurance you can convert to an individual policy may be limited. Please refer to the coverage certificate issued

by Standard for more information as well as additional conditions and limitations.

E. LOSS OF TIME BENEFITS

If you are Totally Disabled and unable to work due to an Injury or Illness, the Fund will pay you Loss of Time Benefits at the weekly rate shown in the Schedule of Benefits for the period of your Total Disability, provided your employer makes contributions to the Fund to provide you these Loss of Time Benefits. This benefit is only available to Participants; Dependents are not eligible for Loss of Time Benefits. Total Disability must begin while you are eligible for coverage under the Plan and while you are actively at work. Successive periods of Total Disability due to the same or related causes and not separated by a return to active full time employment for at least 60 consecutive days shall be considered as one period of Total Disability. However, successive periods of Total Disability that arise from a different and unrelated cause must be separated by a return to active work for at least seven days.

Loss of Time Benefits are not provided for any loss caused by:

1. Any period of Total Disability that you are not under the treatment of a Physician or Surgeon or

2. Prior to the first attendance of a Physician.

Benefits begin on the first day of Total Disability for Injury due to an accident or a surgery due to an accident or Illness, and on the eighth day for other Illnesses and are limited to the maximum number of weeks for any one period of disability as shown in the Schedule of Benefits.

Loss of Time Benefits are subject to all exclusions listed under the Limitations and General Exclusions section described in Section VIII.

X. COORDINATION OF BENEFITS

The Plan's coordination of benefits provisions limit the reimbursement from this Plan and any other plan providing benefits to you. If you are covered under the Plan both as an Employee and as another Employee’s Dependent, your coverage as a Dependent will be treated as another plan for purposes of the Plan’s coordination of benefits provisions.

The Plan will not duplicate payments that you may be entitled to under other health plans providing benefits to you. This means that the amount paid under any other plan, plus whatever benefit is provided from this Plan, will not exceed 100% of the Allowable Charges you incur for medical care. However, in no event will the Fund pay more than what would have been payable if there were no other plans or providers involved.

When benefits are coordinated, they are reduced so that the maximum amount that is payable on your behalf from this Plan and any other plan does not exceed 100% of covered expenses.

A. ORDER OF BENEFIT DETERMINATION

When the other plan that provides you with coverage does not have a coordination of benefits provision, it shall be considered the primary payor and will be deemed to pay your claims or the claims of your Dependent(s) first. This Plan will then pay the remaining balance of your unpaid claims second and will coordinate payment with the amount paid by the other plan.

If the Fund Office determines that the other plan that provides you with coverage contains a coordination of benefits provision and you are covered under the other plan, the plan that has been in effect the longest will be considered the primary payor and will always pay first. The other plan will pay second and will coordinate its payment with the first payment.

When your Dependent spouse is covered by another plan as an employee and the other plan has a coordination of benefits provision, the order of benefit payments for claims submitted to this Plan for your spouse will be determined as follows:

1. The plan covering the spouse as an employee will pay first.
2. This Plan, which covers your spouse as a Dependent, will pay second and will coordinate payments with the other plan.

For claims submitted for your Dependent child(ren), the order of benefit payment will be determined as follows:

- The plan covering the Dependent child of the parent whose birth date (month and day) occurs first in the calendar year will be primary. This is called the "birthday rule." The other plan will pay second and will coordinate payments with the primary plan.

In situations of divorce, separation and/or divorce and remarriage, benefits for a Dependent child shall be determined as follows:

- If the parent with custody of the child has not remarried, the plan that covers the child as a Dependent of the parent with custody of the child shall be primary and shall pay first and the plan that covers the child as a Dependent of the parent without custody shall pay second.

- If the parent with custody of the child has remarried, the plan that covers the child as a Dependent of the parent with custody shall be primary and pay first and the plan that covers the child as a Dependent of the step-parent shall pay second, and the plan that covers the child as a Dependent of the parent without custody shall pay last.

Notwithstanding the above, if there is a court decree that establishes financial responsibility for the hospital, medical, surgical, or other health care expenses with respect to the child, the plan that covers the parent financially responsible shall pay first and the plan of the other natural parent shall pay second, and, if applicable, the plan of the spouse of the parent with court-decreed financial responsibility shall pay last.

A plan that covers a person who is neither laid off nor retired is primary and pays first and the plan that covers a person that is laid-off or retired will pay second.

If benefits cannot be determined under the rules described above then the plan that has covered the person who incurs the expenses for the longer period of time shall be primary and shall pay before a plan that has covered such person for a shorter period of time.

Coordination with a Health Maintenance Organization ("HMO"):

If you or your Dependent(s) are also covered under an HMO and you elect to receive treatment through an HMO provider, the Fund will not pay any claim for charges incurred through the HMO provider.

However, if you or your Dependent(s) are covered under an HMO but you choose not to use an HMO provider and instead you receive treatment outside of the HMO setting from a non-HMO provider for which you are expected to pay for the charges incurred, then benefits will be paid in accordance with the provisions concerning the coordination of benefits as described above.

Coordination of Benefits for the Prescription Drug Program:

When other coverage for prescription drugs is available under another plan that is primary, this Plan will pay the co-payment amount up to the Allowable Charge for the prescription, but in no case in excess of the benefit provided through this Plan.

B. COORDINATION WITH MEDICARE

Active Employees Age 65 and Over and Their Dependents

If you work for an employer with fewer than 20 employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year, and the Fund has obtained an exception for your employer from the Health Care Financing Administration, then Medicare shall be primary for you and your eligible Dependent(s).

If your work for an employer with more than 20 employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year, the following rules apply:

- This Plan will be primary for any person age 65 and older who is an active employee or the Dependent spouse of an active employee age 65 and over.

- You or your eligible Dependent(s) may decline coverage under this Plan and elect Medicare as your primary coverage. If you elect Medicare as your primary coverage, the Fund will not pay benefits secondary to Medicare for Medicare covered services. However, you and/or your Dependent(s) will continue to be covered by this Plan as primary until you and/or your Dependent(s) notify the Fund Office in writing of the desire to elect Medicare as primary, or unless coverage under this Plan ceases.

Disabled Employees or Disabled Dependents Under 65

If you are actively employed and you or your eligible Dependent(s) are under age 65 and are entitled to Medicare due to disability, other than for end stage renal disease ("ESRD"), this Plan will pay benefits as the primary payor.

End Stage Renal Disease (ESRD)

If you or your eligible Dependent(s) are entitled to Medicare on the basis of age or disability and then become entitled to Medicare based on ESRD, and this Plan is currently paying benefits as primary, the Plan will remain primary for the first 18 months of your entitlement to Medicare due to ESRD. If the Plan is currently paying benefits secondary to Medicare, the Plan will remain secondary upon your entitlement to Medicare due to ESRD.

C. SUBROGATION OF BENEFITS

Were you or your eligible Dependent(s) injured in a car accident or other accident in which someone else may be responsible? If so, that person (or his/her insurance) may be liable for paying your (or your eligible Dependent's) medical and Loss of Time expenses and these expenses would not be covered under the Fund.

Waiting for a third party to pay for these injuries may be difficult. Since recovery from a third party can take a long time (you may have to go to court), and your creditors will not wait patiently, as a service to you, the Fund will advance your (or your Dependent's) benefits based on the requirement that you reimburse the Fund in full from any recovery you or your eligible Dependent may receive, no matter how it is characterized. This means that you must reimburse the Fund if you obtain any recovery from any source, person or entity. This reimbursement and subrogation program is a service to you and your Dependents. It provides for the early payment of benefits and also saves the Fund money (which saves you money too) by making sure that the responsible party pays the costs incurred as a result of your or your dependent's injuries.

You and/or your Dependent(s) are required to notify the Fund within ten days of any accident or injury for which someone else may be liable. Further, the Fund must be notified within ten days of the initiation of any lawsuit or settlement negotiations relating to the accident and of the

conclusion of any settlement, judgment or payment relating to the accident to protect the Fund's claims.

If you or your Dependent(s) receive any benefit payments from the Fund for any injury or sickness and you or your Dependent(s) recover any amount from any third party or parties in connection with that injury or sickness, you or your Dependent(s) must reimburse the Fund from that recovery the total amount of all benefit payments the Fund made or will make on your or your Dependent(s)'s behalf in connection with such injury or sickness.

Also, if you or your Dependent(s) receive any benefit payments from the Fund for any injury or sickness, the Fund is subrogated to all rights of recovery available to you or your Dependent(s) arising out of any claim, demand, cause of action or right of recovery that has accrued, may accrue or which is asserted in connection with such injury or sickness, to the extent of any and all related benefit payments made or to be made by the Fund on your or your Dependent(s)'s behalf. This means that the Fund has an independent right to bring an action in connection with such injury or sickness in your or your Dependent(s)'s name and also has a right to intervene in any action brought by you or your Dependent(s), including any action against an insurance carrier under any uninsured or underinsured motor vehicle policy.

The Fund's rights of reimbursement and subrogation apply regardless of the terms of the claim, demand, right of recovery, cause of action, judgment, award, settlement, compromise, insurance or order, regardless of whether the third party is found responsible or liable for the injury or sickness, and regardless of whether you and/or your Dependent(s) actually receive the full amount of such judgment, award, settlement compromise, insurance or order. The Fund's rights of reimbursement and subrogation provide the Fund with first priority to any and all recovery in connection with the injury and sickness, whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified. This includes amounts payable under your or your Dependent(s)'s own uninsured motorist insurance, under insured motorist insurance, or any medical pay or no-fault benefits payable. The "make-whole" doctrine does not apply to the Fund's right of reimbursement and subrogation. The Fund's rights of reimbursement and subrogation are for the full amount of all related benefits payments; this amount is not offset by legal costs, attorney's fees or other expenses incurred by you or your Dependent(s) in obtaining recovery.

The Fund has a constructive trust, lien and/or equitable lien by agreement in favor of the Fund on any amount received by you, your Dependent(s) or a representative of you or your Dependent(s) (including an attorney) that is due to the Fund under this Section, and any such amount is deemed to be held in trust by you or your Dependent(s) for the benefit of the Fund until paid to the Fund. You and your Dependent(s) hereby consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund exists with regard to any payment, amount and/or recovery from a third party. In accordance with that constructive trust, lien, and/or equitable lien by agreement, you and your Dependent(s) agree to cooperate with the Fund in reimbursing it for Fund costs and expenses.

Consistent with the Fund's rights set forth in this Section, if you or your Dependent(s) submit claims for or receive any benefit payments from the Fund for an injury or sickness that may give rise to any claim against any third party, you and/or your Dependent(s) will be required to execute a subrogation agreement affirming the Fund's rights of reimbursement and subrogation with respect to such benefit payments and claims. This subrogation agreement also must be executed by your or your Dependent(s)'s attorney, if applicable. However, even if you or your Dependent(s) or a representative of you or your Dependent(s) (including your or your Dependent(s)'s attorney) do not execute the required subrogation agreement and the Fund nevertheless pays benefits to or on behalf of you or your Dependent(s), you or your Dependent(s)'s acceptance of such benefits shall constitute your or your Dependent(s)'s agreement to the Fund's right to subrogation or reimbursement from any recovery by you or your Dependent(s) from a third party that is based on the circumstance from which the expense or benefit paid by the Fund arose, and your or your Dependent(s)'s agreement to a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund on any payment amount or recovery that you or your Dependent(s) recovers from a third party.

Any refusal by you or your Dependent(s) to allow the Fund a right to subrogation or to reimburse the Fund from any recovery your receive, no matter how characterized, up to the full amount paid by the Fund on your or your Dependent(s)'s behalf relating to the applicable injury or sickness, will be considered a breach of the agreement between the Fund and you that the Fund will provide the benefits available under the Plan and you will comply with the rules of the Fund. Further, by accepting benefits from the Fund, you and your Dependent(s) affirmatively waive any defenses you may have in any action by the Fund to recover amounts due under this Section or any other rule of the Plan, including but not limited to a statute of limitations defense or a preemption defense, to the extent permissible under applicable law.

Because benefit payments are not payable unless you sign a subrogation agreement, your or your Dependent(s)'s claim will not be considered filed and will not be paid if the period for filing claims passes before your subrogation agreement is received.

Further, any charges for any medical or other treatment, service or supply to the extent that the cost of the professional care or hospitalization may be recovered by, or on behalf of, you or your Dependent(s) in any action at law, any judgment compromise or settlement of any claims against any party, or any other payment you, your Dependent(s) or your attorney may receive as a result of the accident, no matter how these amounts are characterized or who pays these amounts, are excluded from Plan coverage, as provided in this Section.

Under this provision, you and/or your Dependent(s) are obligated to take all necessary action and cooperate fully with the Fund in its exercise of its rights of reimbursement and subrogation, including notifying the Fund of the status of any claim or legal action asserted against any party or insurance carrier and of you or your Dependent(s)'s receipt of any recovery. If you are asked to do so, you must contact the Fund Office immediately. You or your Dependent also must do nothing to impair or prejudice the Fund's rights. For example, if you or your Dependent(s) chooses not to pursue the liability of a third party, you or your Dependent(s) may not waive any rights

covering any conditions under which any recovery could be received. Where you or your eligible Dependent(s) choose not to pursue the liability of a third party, the acceptance of benefits from the Fund authorizes the Fund to litigate or settle your claims against the third party. If the Fund takes legal action to recover what it has paid, the acceptance of benefits obligates you and your Dependent(s) (and your attorney if you have one) to cooperate with the Fund in seeking its recovery, and in providing relevant information with respect to the accident.

You or your Dependent(s) must also notify the Fund before accepting any payment prior to the initiation of a lawsuit or in settlement of a lawsuit. If you do not, and you accept payment that is less than the full amount of the benefits that the Fund has advanced you, you will still be required to repay the Fund, in full, for any benefits it has paid. The Fund may withhold benefits if you or your Dependent(s) waives any of the Fund's rights to recovery or fail to cooperate with the Fund in any respect regarding the Fund's subrogation rights.

If you or your Dependent(s) refuse to reimburse the Fund from any recovery or refuse to cooperate with the Fund regarding its subrogation or reimbursement rights, the Fund has the right to recover the full amount of all benefits paid by any and all other methods which include, but are not necessarily limited to, offsetting the amounts paid against your and/or any of your Dependents' future benefit payments under the Plan. "Non-cooperation" includes the failure of any party to execute a subrogation agreement and the failure of any party to respond to the Fund's inquiries concerning the status of any claim or any other inquiry relating to the Fund's rights of reimbursement and subrogation.

If the Fund is required to pursue legal action against you or your Dependent(s) to obtain repayment of the benefits advanced by the Fund, you or your Dependent(s) shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Fund in connection with the collection of any amounts owed the Fund or the enforcement of any of the Fund's rights to reimbursement. In the event of legal action, you or your Dependent(s) shall also be required to pay interest at the rate determined by the Trustees from time to time from the date you become obligated to repay the Fund through the date that the Fund is paid the full amount owed. The Fund has the right to file suit against you in any state or federal court that has jurisdiction over the Fund's claim.

D. ADVANCE BENEFITS FOR WORKERS' COMPENSATION CLAIMS

If you suffer an Injury or Illness that is work-related, you must file a claim for Workers' Compensation benefits with your employer. If you apply for Workers' Compensation and your claim is denied you may apply to the Fund for Loss of Time or medical benefits. The Fund will pay benefits so long as you agree to repay the Fund in full for any benefits the Fund pays in connection with an Injury or Illness that is ultimately determined to be compensable under Workers' Compensation or similar programs. Repayment will be required from any payment you receive whether by Workers' Compensation Commission award, judgment, settlement, or compromise and no matter how it is characterized. In addition, you will be required to sign an agreement on a form provided by the Fund agreeing to repay the Fund in accordance with this paragraph. The Fund will pay benefits provided that:

1. You file a claim with the Fund on time.
2. You submit a copy of the written denial from your employer or your employer's insurance carrier. The denial must state that the claim is not compensable under the Workers' Compensation laws.
3. You agree in writing to timely appeal the denial of your Workers' Compensation claim to the Workers' Compensation Commission for final adjudication.
4. If you fail to file an appeal within 30 days from the date the original claim is denied, all benefits terminate and payments made by the Fund to you and your provider must be immediately returned.
5. You obtain approval from the Fund Office prior to any settlement of your claim.
6. If the Workers' Compensation Commission denies your claim, for a reason other than your failure to appear, failure to file a timely appeal or failure to file supplementary materials if requested to do so, and you do not appeal, you may keep any payments advanced to you. However, if you decide to pursue your claim after that denial and you receive any recovery, whether by judgment, settlement, or compromise, you must repay the Fund the payments advanced to you.
7. If the Workers' Compensation Commission determines that your claim is compensable under relevant Workers' Compensation legislation but denies your claim for another reason, you must repay the Fund the payments advanced to you.

E. FRAUD OR MISREPRESENTATION

The Fund reserves the right to retroactively rescind or cancel your coverage under the Plan if you or any of your Dependents engage in fraud and/or intentional misrepresentation of a material fact, or if you fail to timely pay premiums or contributions to the Fund. Failure to follow the terms of the Plan, such as failing to notify the Plan of a change in Dependent status, accepting benefits in excess of what is covered under the Plan or after you or your Dependent are no longer eligible for coverage, will be considered fraud and/or intentional misrepresentation. You are treated as having knowledge of all the eligibility terms of this Plan. If the Fund does retroactively rescind coverage under the Plan, it will provide you with 30 days advanced notice of its intention to retroactively terminate your coverage. In the event that the Fund has made benefits to you on your behalf in error as a result of any of the above events, you are required to reimburse the Fund for all benefits overpaid.

XI. HOW TO FILE A CLAIM

The claims process begins when you file a completed and signed claim form with the Fund Office. You may obtain the necessary forms for filing a claim by telephone or by writing to the Fund Office. Once the claim form is received by the Fund Office, your claims will be processed as quickly as practicable; if additional information is required in order to process your claim you will be notified and requested to furnish the necessary information.

A claim must be filed with the Fund Office within one year of the first day of the Illness or Injury for which charges were incurred. A claim is not deemed properly filed until all forms, bills, subrogation agreements and other information required to pay the claim have been provided to the Fund Office.

To assist the Fund Office in processing your claim, please follow the steps listed below in the order in which they appear.

Step 1: Obtain and complete a Statement of Claim form from the Fund Office. If you are claiming Loss of Time Benefits, have your employer fill out the lower portion of the form entitled "Employer's Statement."

Step 2: If you are filing a claim for Loss of Time Benefits, you must first submit a statement entitled Preliminary Statement of Disability. This form is available from the Fund Office.

Please be sure to read the Preliminary Statement of Disability since it contains important provisions concerning your eligibility for Loss of Time Benefits. When submitting this form, remember that you are not relieved of your duty to submit an Attending Physician's Statement at the request of the Fund Office. During your disability you will periodically be required to complete additional forms in order to receive additional benefits.

Step 3: Have the Physician who treated you during your Illness or Injury itemize his charges on the reverse side of the Statement of Claim form and provide a diagnosis or a copy of his bill. Should benefits be payable and you wish to have the Fund pay benefits directly to the Physician, please sign and date the section on the reverse side of the form reflecting your payment direction.

Step 4: Should you receive treatment at a Hospital, either on an inpatient or outpatient basis, have the Hospital forward an itemized bill directly to the Fund Office.

Step 5: Attach all statements of charges from all providers of service with your claim. If you are submitting prescription receipts, please be sure the name of the drug appears next to the prescription number as well as the date the drug was purchased. Prescription forms are also available upon request from the Fund Office. Please do

not send in cash receipts for services from Physicians or Hospitals. Please note that before a claim can be considered the Fund Office must receive an itemized statement of charges.

A. PROPERLY FILING A CLAIM

By following the steps below when filing a claim, you will assist the Fund Office in processing your claim as quickly as possible:

1. Secure a claim form from the Fund Office.

2. Complete your portion of the form by filling in all information requested and SIGNING YOUR NAME on the line specified. If certain questions are not applicable, answer "Not Applicable" or "N.A."

3. Have your doctor complete his portion of the claim form.

4. Obtain itemized hospital and doctor bills listing all services and treatments you have received.

5. Forward your completed form, with all itemized bills attached, to the Administrative Manager at:

UBC HEALTHCARE TRUST FUND
HealthSmart Benefit Solutions, Inc.
602 Virginia Street, East
P.O. Box 3262
Charleston, WV 25332-3262

B. CLAIMS REVIEW AND APPEAL PROCEDURES

1. General Procedures

For claims for life insurance and accidental death and dismemberment benefits from Standard , please consult your booklet from the insurer for a description of the applicable claims and appeals procedures. Standard is the named fiduciary for purposes of reviewing claims and appeals relating to those benefits. For all other benefits from the Fund, the following claims and appeals procedures apply:

You may name a representative to act on your behalf during the claims procedure. To do so, you must notify the Fund in writing of the representative's name, address, and telephone number and authorize the Fund to release information (which may include medical information) to your representative. Please contact the Fund Office for a form to designate a representative. The Fund does not impose any charges or costs to review a claim or appeal; however, regardless of the

outcome of an appeal, neither the Board of Trustees nor the Fund will be responsible for paying any expenses that you might incur during the course of an appeal.

The Board of Trustees, in making decisions on claims and appeals, will apply the terms of the Plan document and any applicable guidelines, rules and schedules, and will periodically verify that benefit determinations are made in accordance with such documents, and where appropriate, are applied consistently with respect to similarly situated claimants.

The Fund's procedures and time limits for processing claims and for deciding appeals will vary depending upon the type of claim you submit, as explained below. However, the Fund may also request that you voluntarily extend the period of time for the Fund to make a decision on your claim or your appeal.

2. Claim Review

a. Claims for Benefits Other Than Life Insurance, Accidental Death and Dismemberment, or Loss of Time.

i. Pre-Service Claims. A pre-service claim is any claim for benefits under the Plan, the receipt of which is conditioned, in whole or in part, on the Fund's approval of the benefit before you receive the medical care. For example, all Hospital stays require pre-certification as described at the beginning of this booklet, and would be pre-service claims.

If your pre-service claim is filed improperly, the Fund will notify you of the problem (either orally or in writing, unless you request it in writing) within five (5) days of the date you filed the claim. The Fund will notify you of its decision on your pre-service claim (whether approved or denied) within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after the claim is received by the Fund. The Fund may extend the period for a decision for up to fifteen (15) additional days due to matters beyond the control of the Fund, provided that the Fund gives you a written notice of such extension before the end of the initial fifteen (15) day period. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which the Fund expects to make a decision. If an extension is necessary due to your failure to submit the information required to decide the claim, the notice of extension will specifically describe the required information, and you will be given at least forty-five (45) days from receipt of the notice to provide the requested information.

If you do not provide the information requested, or do not properly re-file the claim, the Fund will decide the claim based on the information it has available, and your claim may be denied.

ii. Concurrent Care Claims. A Concurrent Care claim is a request for the Fund to approve, or to extend, an ongoing course of treatment over a period of time or number of treatments, when such approval is required by the Plan. If you have been approved by the Fund for Concurrent Care treatment, any reduction or termination of such treatment (other than by Plan amendment or termination of the Plan) before the end of the period of time or number

of treatments will be considered denial of a claim. The Fund will notify you of the denial of the claim at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a decision on review of the denial of the claim before the benefit is reduced or terminated.

iii. Post-Service Claims. A post-service claim is any claim under the Plan that is not a pre-service claim. Typically, a post-service claim is a request for payment by the Fund after you have received the services. If the Fund denies your post-service claim, in whole or in part, the Fund will send you a notice of the claim denial within a reasonable period of time, but not later than thirty (30) days after the claim is received by the Fund. The Fund may extend the period for a decision for up to fifteen (15) additional days due to matters beyond the control of the Fund, provided that the Fund gives you a written notice of such extension before the end of the initial thirty (30) day period. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which the Fund expects to make a decision. If an extension is necessary due to your failure to submit the information required to decide the claim, the notice of extension will specifically describe the required information, and you will be given at least forty-five (45) days from receipt of the notice to provide the requested information. If you do not provide the information requested, the Fund will decide the claim based on the information it has available, and your claim may be denied. Notwithstanding the above, providers of No Surprises Services will receive payment, or a denial, of a post-service claim for No Surprises Services within 30 days of the Fund's receipt of all information necessary to adjudicate the claim.

iv. If the Fund denies your claim, in whole or in part, the Fund will send you a written notice of the denial. The notice will provide (a) the specific reason or reasons for denial; (b) reference to specific Plan provisions on which the denial is based; (c) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (d) an explanation of the Plan's claims review procedures and the time limits applicable to such procedures; (e) a statement of the your right to bring a civil action under Section 502(a) of ERISA following a denial of your appeal; (f) if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your claim, a statement that the specific rule, guideline, protocol, or other similar criterion was relied upon in denying the claim and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and (g) if the denial is based on a determination of medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment related to your condition will be provided free of charge upon request.

b. Loss of Time Benefit Claims. If the Fund denies your Loss of Time benefit claim, in whole or in part, the Fund will send you a notice of the denial within a reasonable period of time, but not later than forty-five (45) days after the claim is received by the Fund. The Fund may extend the period for a decision for up to thirty (30) additional days due to matters beyond the control of the Fund, provided that the Fund gives you a written notice of such extension before the end of the initial forty-five (45) day period. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which the Fund expects to make

a decision. The Fund may also extend the period for a decision for up to a second extension of thirty (30) additional days due to matters beyond the control of the Fund, provided that the Fund gives you a written notice of such extension before the end of the first thirty (30) day extension period. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which the Fund expects to make a decision. In addition, any notice of an extension will set forth the circumstances requiring an extension of time, an explanation of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve these issues.

If an extension is necessary due to your failure to submit the information required to decide the claim, you will be given at least forty-five (45) days from receipt of the notice to provide the requested information. If you do not provide the information requested, the Fund will decide the claim based on the information it has available and your claim may be denied.

If the Fund denies your claim, in whole or in part, the Fund's notice of denial will provide (a) the specific reason or reasons for denial; (b) reference to specific Plan provisions on which the denial is based; (c) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (d) an explanation of the Plan's claims review procedures and the time limits applicable to such procedures; (e) a statement of the your right to bring a civil action under Section 502(a) of ERISA following a denial of your appeal; (f) if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your claim, a statement that the specific rule, guideline, protocol, or other similar criterion was relied upon in denying the claim and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and (g) if the denial is based on a determination of medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment related to your condition will be provided free of charge upon request.

c. Notice of Denial of Disability Benefit Involving Discretionary Determination of Disability by the Fund. In addition to the information described above, in the case of a denial with respect to disability benefits that is based on a determination by the Fund (and not a third party acting independent of the Fund such as the Social Security Administration (SSA)), that you are not disabled under the Plan rules, the Fund's notice of denial also will include the following:

i. A discussion of the decision, including an explanation of the Fund's basis for disagreeing with or not following:

(a) The views you presented to the Fund of health care professionals treating you and vocational professionals who evaluated you (if any);

(b) The views of any medical or vocational experts whose advice was obtained on behalf of the Fund in connection with the denial of your claim, even if the advice was not relied upon in making the determination; and

(c) A disability determination made by the Social Security Administration, if you provided it to the Fund;

ii. A copy of the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist;

iii. A statement that you are entitled to receive, upon request, and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and

iv. A statement of your right to bring an action under Section 502(a) of ERISA after you exhaust the Plan's appeal procedures, including a description of any contractual limitations period that applies to your right to bring an action.

The written notice of denial will be provided in a culturally and linguistically appropriate manner clearly indicating how to access the language services provided by the Plan, if this applies to your claim. Additionally, a denial of your claim also includes a rescission of your disability coverage, unless it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

3. Appeal Procedures

You have the right to appeal a denial of your benefit claim to the Fund's Board of Trustees. Your appeal must be in writing and must be sent to the Board of Trustees at the address on page 2.

a. Claims for Benefits Other Than Life Insurance or Accidental Death and Dismemberment: If your claim for benefits has been wholly or partially denied, you will have one hundred and eighty (180) days from receipt of the denial notice to file an appeal with the Fund's Board of Trustees.

Pursuant to your right to appeal, you will have the right (a) to submit written comments, documents, records, and other information relating to your claim for benefits and (b) upon request, reasonable access to, and free copies of all documents, records, and other information relevant to your claim for benefits. In making a decision on review, the Board of Trustees or a committee of the Board of Trustees will review and consider all comments, documents, records, and all other information submitted by you or your duly authorized representative without regard to whether such information was submitted or considered in the initial claim determination. In reviewing your claim, the Board of Trustees will not automatically presume that the Fund's initial decision was correct, but will independently review your appeal. In addition, if the initial decision was based in whole or in part on a medical judgment (including a determination whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or

appropriate), the Board of Trustees will consult with a healthcare professional in the appropriate medical field who was not the person consulted in the initial claim (nor a subordinate of such person) and will identify the medical or vocational experts who provided advice to the Fund on the initial claim.

In the case of an appeal of a pre-service claim as defined above, the Board of Trustees will notify you of the decision on your appeal within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days after the Fund's receipt of your appeal. The Fund may also request that you voluntarily extend the period of time for the Board of Trustees to make a decision on your appeal.

For appeals of all other claims, the Board of Trustees or a committee of the Board of Trustees will hear your appeal at their next scheduled quarterly meeting following receipt of your appeal unless your appeal was received by the Fund within 30 days of the date of the meeting. In that case, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. If special circumstances require an extension of the time for review by the Trustees, you will be notified in writing before the extension of the circumstances and the date on which a decision is expected. In no event will a decision be made later than the third quarterly meeting after receipt of your appeal. The Trustees will send you a written notice of their decision (whether approved or denied) within 5 days of the decision.

If the Board of Trustees has denied your appeal, the notice will provide:

(a) the specific reason or reasons for the denial;

(b) references to specific Plan provisions on which the denial is based;

(c) a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits; and

(d) a statement of your right to bring an action under Section 502(a) of ERISA, including a description of any contractual limitations period that applies to your right to bring an action, including the calendar date on which the contractual limitations period expires for the claim.

In addition, in the case of a denial with respect to medical benefits, the notice will state that:

(a) if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your appeal, a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and

(b) if the denial of your appeal was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation will be provided free of charge upon request.

In addition, in the case of a denial with respect to disability benefits that is based on a determination by the Fund (and not by a third party acting independent of the Fund such as the SSA), that you are not disabled under the Plan rules, the notice will provide:

(a) either the specific rules, guidelines, protocols, standards or other similar criteria of the Fund relied upon in denying your claim or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Fund do not exist;

(b) if the denial of your appeal was based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation will be provided free of charge upon request; and

(c) a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

i. the views presented by you to the Plan of health care professionals treating you and vocational professionals who evaluated you (if any);

ii. the views 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 denying the claim; and

iii. any disability determination regarding you that was made by the Social Security Administration and presented by you to the Fund.

Prior to issuing a denial of an appeal of a claim for a disability benefit that is based on a determination by the Fund (and not by a third party acting independent of the Fund such as the SSA), that you are not disabled under the Plan rules, the Fund Office will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund in connection with the claim, and/or with any new or additional rationale for denying the claim, as soon as possible and, to the extent possible, sufficiently in advance of the date the appeal is to be considered to give you a reasonable opportunity to respond prior to the date the appeal will be considered.

You have a right to file suit in federal or state court under Section 502(a) ERISA on your claim for benefits; however, you must exhaust your administrative remedies by appealing the denial to the Board of Trustees before you have the right to file suit in state or federal court. Failure to exhaust these administrative remedies will result in the loss of your right to file suit as described in Section XIII below.

If a Covered Person wishes to file suit for a denial of a claim of benefits, he or she must do so within 2 years of the date the Trustees denied his or her appeal. For all other actions, a claimant must file suit within 2 years of the date on which the violation of Plan terms is alleged to have occurred. These rules apply to Participants and Dependents, their beneficiaries, and any provider who provided services to a Participant, Dependent, or beneficiary. This Section applies to all litigation against the Fund, including litigation in which the Fund is named as a third party defendant.

b. For all claims and appeals, The Board of Trustees has the power and sole discretion to interpret, apply, construe and amend the provisions of the Plan and make all factual determinations regarding the construction, interpretation and application of the Plan. The decision of the Board of Trustees is final and binding.

XII. YOUR RIGHTS UNDER ERISA

As a Participant in the UBC HealthCare Trust Fund, you are entitled to 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
Examine, without charge, at the Plan Administrator's office and at all other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain upon written request to the Plan Administrator copies of documents governing 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 administrator may charge a reasonable amount for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of the Summary Annual Report.

Continue Group Health Plan Coverage
Continue group health care coverage for yourself, spouse or Dependent(s) if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependent(s) may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan if you have creditable coverage from another plan. You should be provided a certificate of Creditable Coverage free of charge from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA

continuation coverage, or when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. 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 a fine of up to $110.00 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal Court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal Court. If it should happen that Plan Fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal Court. The court will decide who should pay the court costs and legal 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 Your 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.

XIII. GRANDFATHERED STATUS

The notice below is required by the U.S. Department of Labor:

This group health plan believes this plan or coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the to the UBC HealthCare Trust Fund at 1-800-360-6581. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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