

SOUTHERN PAINTERS WELFARE PLAN

[LOGO]

SUMMARY PLAN DESCRIPTION

**Effective January 1, 2017
(Except as Otherwise Stated)**

[INSIDE FRONT COVER]

SOUTHERN PAINTERS WELFARE PLAN

5 Hot Metal Street, Suite 200
Pittsburgh, PA 15203
(866) 487-2857 or (412) 432-0435
FAX: (412) 431-4067

Introduction

August 23, 2017

We are pleased to provide you with this Summary Plan Description (“SPD”) which, together with the documents that are described in this booklet and included by reference, make up the Plan Document for the Southern Painters Welfare Plan (“Plan”). It gives you an up-to-date description of the benefits and eligibility requirements under the Plan. It also provides important information on the procedures to follow when filing a claim or appealing a decision about a claim that has been filed. Other important information about the Plan as required by the federal law known as the Employee Retirement Income Security Act of 1974 (“ERISA”) is included. This booklet is current as of January 1, 2017 (except as otherwise stated). You will be notified in writing of material changes as required by law.

We urge you to read this booklet carefully to understand the benefits that are available to you and your family, as well as your obligations under the Plan. Please share this booklet with your family members, and keep it in a safe place for future reference. One of the most important things you can do is to make sure that we have your correct and up-to-date information, especially your current address, information on your dependents and any change to your marital status.

Possession of this booklet does not automatically entitle you to benefits. You must satisfy the eligibility requirements under the Plan to be eligible for benefits. This booklet is not a contract of employment. It does not give you a right to be employed or to continue employment with any Employer, nor does it interfere with any Employer’s right to terminate your employment.

The Plan is designed to help you and your family meet the costs of medical care and to provide some protection if you are unable to work because of layoff or disability. The benefits offered under the Plan are the result of the continuous efforts of the Board of Trustees to offer an excellent program of benefits that will help meet the needs of you and your family.

If you or a family member or beneficiary has a question about benefits, rights or obligations under the Plan, contact the Plan Administrator.

Sincerely,

**Board of Trustees
Southern Painters Welfare Plan**

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CONTACT INFORMATION - WHO TO CALL

If you have a question about this booklet or the Plan benefits, please use the following guide to help you determine whom to call:

- **MEDICAL BENEFIT:** For any questions on medical benefits or claims for medical benefits:

Highmark Blue Cross / Blue Shield
501 Penn Avenue Place
Pittsburgh, PA 15222
(800) 241-5704
www.highmarkbcbs.com

- **PRESCRIPTION DRUG BENEFIT:** For any questions on prescription drug benefits, either retail, mail-order or specialty medications:

For Retail Pharmacy Customer Service, Claim Inquiries and Questions:

Envision / RxOptions
2181 East Aurora Road, Suite 201
Twinsburg, OH 44087
(800) 361-4542
www.envisionrx.com

For Mail-Order Customer Services, Claim Inquiries and Questions:

Envision Mail-Order Pharmacy: (866) 909-5170

For Specialty Pharmacy Customer Service, Claim Inquiries and Questions:

Walgreens Specialty Pharmacy: (866) 823-2712

- **ALL OTHER BENEFITS:** For all other benefits such as reimbursements from health reimbursement and wage replacement accounts, dental, vision, life insurance, accidental death and dismemberment, employee weekly accident & sickness and eligibility questions, contact the **Plan Administrator:**

Plan Administrator
C/O Central Data Services, Inc.
5 Hot Metal Street, Suite 200
Pittsburgh, PA 15203-2351
(844) 851-7293 or (412) 432-0435
Fax: (412) 431-4067

**ARTICLE I
ELIGIBILITY**

SECTION 1 – ELIGIBILITY FOR EMPLOYEES¹

(a) Eligibility Rules for Coverage Effective On or After April 1, 2016:

(1) Bargaining Unit Employees: Bargaining unit Employees (i.e., those who participate pursuant to a Collective Bargaining Agreement) must satisfy the following requirements to qualify for coverage on or after April 1, 2016:

- (i) The Employee must be working or actively seeking work in Covered Employment; and
- (ii) The Employee must have a Health Reimbursement Account (“HRA”) balance of no less than the *minimum credit* amount (currently \$250.00). Beginning January 1, 2016, the Plan provides for a HRA to be established on behalf of each bargaining unit Employee. The HRA is credited with Employer Contributions received by the Fund on the Employee’s behalf as described in Article III. The amount of the *minimum credit* (sometimes called the *required balance*), is established by the Trustees and may be changed at their discretion. The *available amount* of an Employee’s HRA balance is the amount above (or in excess of) the *minimum credit*, that is available to satisfy the monthly charge for coverage; and
- (iii) The Employee must enroll by returning a completed enrollment form, with any required supporting documentation, to the Plan Administrator in a timely manner. Different Benefit Levels are offered by the Plan. Each Benefit Level and monthly charge, and the current Default Benefit Level, will be described on the enrollment form. Any Employee who does not elect a Benefit Level on the form will be enrolled in the Default Benefit Level then in effect. The Default Benefit Level is established by the Trustees. It may be changed from time to time by resolution of the Board. Written notice of any change will be included in the enrollment materials; and
- (iv) The Employee must satisfy the monthly charge for his Benefit Level and Coverage Level. If the *available amount* of his HRA balance is enough to satisfy the monthly charge, the monthly charge will be automatically deducted. If the *available amount* is not enough to cover the monthly charge, the Employee may self-pay the difference between the (A) monthly charge, and (B) *available amount*. An Employee who self-pays for coverage will also owe an additional amount for the Administrative Fee. It is calculated on the self-payment portion as described in Article III. Self-payments must be made in a timely manner.

(2) Non-Bargaining Unit Employees: Non-bargaining unit Employees (i.e., those who are not employed under a Collective Bargaining Agreement and participate pursuant to a Participation Agreement between their Employer and the Trustees), must satisfy the following requirements to qualify for coverage on or after April 1, 2016:

- (i) The Employee must be working with the Employer on a full-time basis as required by the Participation Agreement; and

¹Addendum “A” to SPD contains certain pre-04/2016 eligibility requirements and transitional eligibility rules related to merger of DC 78 Fund into this Fund effective 01/01/2017. It is available upon request.

- (ii) The Employee must return a completed enrollment form and any required supporting documentation to the Administrative Manager in a timely manner; and
- (iii) The Fund must receive timely payment from the Employer, on the Employee's behalf, of (A) the monthly charge for coverage, plus (B) the Administrative Fee calculated on that amount. The monthly charge will be based on the Employee's Coverage Level, as well as the Benefit Level that has been selected by the Employer for its non-bargaining unit Employees. The Administrative Fee is described in Article III.

Non-bargaining unit Employees are not eligible for the Health Reimbursement Account and the Wage Replacement Account.

(b) Termination of Coverage: An Employee's coverage under the Plan will terminate on the first of the following dates to occur, subject to the right, if any, to continue medical coverage under COBRA as described in Article VIII:

- (i) The last day of the last month for which the required payment for the Employee's monthly coverage is timely paid and received by the Fund;
- (ii) The last day of the month in which the Employee stops working or actively seeking work in Covered Employment;
- (iii) The date of the Employee's death; and
- (iv) The date the Plan is terminated or amended to exclude coverage for the Employee, or the date there are insufficient assets left in the Fund to pay benefits under the Plan.

If an Employee's coverage terminates for non-payment of the required monthly payment, he may continue to obtain reimbursements and payments from any remaining Personal Account balances to the extent permitted by the Plan, until they are exhausted or forfeited. Once an Employee's coverage under the Plan ends, the Employee must again meet the Plan's initial eligibility requirements to regain coverage.

SECTION 2 - ELIGIBILITY FOR DEPENDENTS

(a) Initial Eligibility: An Employee's Dependents, who fall within his Coverage Level, will be covered under the Plan at the Employee's Benefit Level effective on the later of (i) the date the Employee becomes covered, (ii) the date the Employee acquires the Dependent, or (iii) if applicable, the date specified in a Qualified Medical Child Support Order.

The Employee must complete a new enrollment form and submit it to the Administrative Manager whenever a new Dependent is acquired so that the Dependent can be added to the Plan's records of covered individuals. Upon timely enrollment, the Dependent's coverage will be retroactive to the date the Dependent was acquired. An Employee's failure to enroll a new Dependent within 60 days after acquiring the Dependent may affect the Dependent's coverage.

Employees and Dependents are required to notify the Administrative Manager of changes in address and family status, including divorce and loss of dependent child status.

(b) Termination of Dependent's Coverage: A Dependent's coverage under the Plan will terminate on the earliest of the following dates to occur, subject to the right, if any, to continue medical coverage under COBRA as described in Article VIII:

- (1) The date the Employee's coverage terminates for a reason other than death;
- (2) In the event of an Employee's death, the date the Employee's coverage would have terminated had he survived without working another hour (and without regard to his COBRA rights);
- (3) The date the Dependent no longer qualifies for Dependent status;
- (4) The date specified in a Qualified Medical Child Support Order;
- (5) The date an Employee effectively enrolls in a Coverage Level that does not include the Dependent;
or
- (6) The date the Plan or Fund is terminated or amended to exclude coverage of the Dependent.

ARTICLE II
BENEFIT LEVELS, AND FAMILY COVERAGE LEVELS, ENROLLMENT AND PAYMENT

SECTION 1 – BENEFIT LEVELS AND SCHEDULE OF BENEFITS

The Benefit Levels available under the Plan are as follows: (i) the Gold Plan; (ii) the Silver Plan; (iii) the Bronze Plan; and (iv) the Steel Plan. Bargaining unit Employees who satisfy the eligibility requirements must enroll and elect their Benefit Level. Employers of non-bargaining unit Employees must elect the Benefit Level to be provided for them.

The Schedule of Benefits, which is incorporated by reference as a part of this booklet, describes the benefits provided for each Benefit Level. The Trustees may review and modify the Schedule of Benefits from time to time at their discretion. Any changes will be reflected in a revised Schedule of Benefits with the effective dates noted. Participants who are affected by a change will be notified.

The current Schedule of Benefits should be carefully reviewed before a Benefit Level is elected. Any questions should be directed to the Administrative Manager. The Gold Plan generally requires Participants to pay the least out-of-pocket for medical expenses, followed (in the order stated) by the Silver Plan, Bronze Plan and Steel Plan, with the Steel Plan having the highest out-of-pocket cost for medical expenses. The Gold Plan has the highest required monthly charge, followed (in the order stated) by the Silver Plan, Bronze Plan and Steel Plan, with the Steel Plan having the lowest monthly charge.

SECTION 2 - COVERAGE LEVELS: The Coverage Levels are:

- (a) Employee Only (no Dependent spouse or children);
- (b) Employee + Dependent Spouse (no Dependent children);
- (c) Employee + Dependent Children (no Dependent spouse);
- (d) Employee + Family (Dependent spouse and children); and
- (e) No Medical Benefit (Opt Out).

An Employee's Coverage Level is determined on a calendar year basis. Employees must enroll themselves and all eligible Dependents (spouse and children) subject to the limited exceptions described below. At enrollment, an

Employee may elect the “No Medical Benefit (Opt Out)” option if the Employee and all eligible Dependents (spouse and children) have other group health coverage. The other group health coverage may not consist solely of Excepted Benefits and must provide minimum value as determined by the Plan in accordance with the Affordable Care Act. Excepted Benefits generally refers to benefits that are limited in scope (e.g., dental and/or vision). To exercise this option, the Employee must give the Administrative Manager adequate written proof of the other group health coverage during the annual or (if applicable) special enrollment period.

The “No Medical Benefit (Opt Out)” option is exercisable only by the Employee and only for the Employee and all eligible Dependents. It cannot be elected for one or more persons but not everyone. All determinations for the Plan in this regard, including the adequacy of proof, will be made by the Administrative Manager. **If the “No Medical Benefit (Opt Out)” option is elected, the only benefits available under the Plan will be the Health Reimbursement Account and Wage Replacement Account.**

If the “No Medical Benefit (Opt Out)” option is not elected or is not available, the Employee will automatically be provided with the Coverage Level that matches his family composition based on the information on file with the Plan, except as provided below. It will be at the current Default Benefit Level unless the Employee has affirmatively enrolled and elected a Benefit Level.

Employees must give the Administrative Manager written notice of the names of their Dependents (spouse and children), and any required supporting documents and proof of eligibility, upon initial, annual and special enrollment and as otherwise requested. The required documents may include, for example, birth certificates, marriage license or divorce decree. This notice requirement includes the obligation to give written notice to the Administrative Manager of any change to an Employee’s Dependents and required supporting documents, within 30 days after a change occurs.

Effective for enrollments after May 4, 2017, the following exceptions apply to the rule that an Employee’s Coverage Level must match his family composition:

- (a) An Employee may enroll in the “Employee Only (no Dependent spouse or children)” Coverage Level if his Dependent spouse and children (as applicable) are all enrolled in other group health coverage for which the Employee is not eligible, and the Employee provides satisfactory written proof of the other coverage and his ineligibility to the Administrative Manager; and
- (b) An Employee may enroll in the “Employee Only (no Dependent spouse or children)” Family Level if he has no spouse and his children are all required to have group health coverage through another plan or arrangement pursuant to a court order, a copy of which is provided to the Administrative Manager.

The other group health coverage may not consist solely of Excepted Benefits and must provide minimum value. The determination of whether an Employee qualifies for either exception will be made by the Administrative Manager for the Plan.

SECTION 3 – ANNUAL ENROLLMENT

There will be an annual enrollment period before the beginning of each calendar year. At that time, eligible Employees must enroll and, if applicable, elect their Benefit Level for the upcoming calendar year. Each year the Administrative Manager will provide written notice of the annual enrollment period and deadlines, as well as the enrollment forms. The annual enrollment period will normally be held from November 15 through December 15, effective for coverage for the next calendar year (for 2016 only, enrollment was for the coverage period of April 1, 2016 through December 31, 2016).

Employees must give written notice of their enrollment and election to the Administrative Manager before the coverage period begins and the enrollment period ends. Participating Employees who do not do so will be treated as having enrolled in their then current Benefit Level.

SECTION 4 – SPECIAL ENROLLMENT

If an Employee elects the “No Medical Benefit (Opt Out)” option and declines coverage or if a Dependent is not enrolled when he is first eligible, the Employee can later add coverage in accordance with the special enrollment rights required under HIPAA. Generally, an Employee or Dependent will have a special enrollment period in the following circumstances:

(a) **Loss of Other Medical Coverage:** If coverage or enrollment is declined because the person has other health coverage under COBRA or another health plan, he will qualify for a special enrollment period in the following circumstances: (1) when the COBRA health coverage is exhausted; (2) when the other non-COBRA health coverage terminates because (i) the employer has stopped contributing to the other health coverage, or (ii) there is a loss of eligibility (e.g., due to divorce, loss of dependent status, death, or termination or reduced hours of employment); (3) when the other coverage is an HMO and the individual losing coverage no longer lives or works in the HMO service area and has no other health coverage option available; or (4) when the health coverage no longer covers the class of individuals to which the individual belongs. A special enrollment period will **not** apply if loss of eligibility occurs because of nonpayment of premium or for cause.

To take advantage of this special enrollment period, the Employee or Dependent must notify the Administrative Manager in writing within thirty (30) days after the other coverage is exhausted or ends, and enrollment will be effective retroactive to such date.

(b) **Employee Marries or Gains a New Dependent.** If an Employee marries, he may enroll himself, his new Dependent spouse and any other new Dependent(s) that he gains due to the marriage. In addition, if an Employee gains a new Dependent due to birth, adoption or placement for adoption, the Employee may also enroll himself and his Dependents.

To take advantage of this special enrollment period, the Employee must notify the Administrative Manager in writing within thirty (30) days after the marriage, birth, adoption or placement for adoption.

(c) **Termination of Medicaid or CHIP Coverage.** If an Employee or his Dependent is covered under a state Medicaid plan or a state Child Health Insurance Program (CHIP) and the Medicaid or CHIP coverage terminates because of loss of eligibility, the Employee may enroll himself and his Dependents.

To take advantage of this special enrollment period, the Employee must notify the Administrative Manager in writing within sixty (60) days after the loss of the Medicaid or CHIP coverage.

(d) **Eligibility for Premium Assistance through Medicaid or CHIP.** If an Employee or his Dependent becomes eligible through Medicaid or CHIP for premium assistance to pay for medical coverage under this Plan, the Employee may enroll himself and his Dependents.

To take advantage of this special enrollment period, the Employee must notify the Administrative Manager in writing within sixty (60) days after he or his Dependent becomes eligible for the premium assistance.

SECTION 5 – PAYMENT FOR COVERAGE

Effective April 1, 2016, Plan coverage is provided on a month-to-month basis subject to payment of the required monthly charge and (if applicable) the Administrative Fee. The Trustees will determine the required monthly

charge for each combination of Coverage Level and Benefit Level. They may periodically review and modify the monthly charges in their discretion. The affected Participants and Employers will be notified of the current charges during each enrollment period and in the event of a change.

Payment for bargaining unit Employees will be handled as follows: A monthly statement showing the Employee's eligibility for the next month and amount payable will be mailed on approximately the tenth (10th) day of each month. Self-payments that are shown as payable are due by the twenty-fourth (24th) day of the month in which the statement is mailed. **There is no grace period for late payment.** If the amount payable is not received by the Fund (or as directed in the monthly statement) by the due date and the *available amount* of his Health Reimbursement Account balance is not enough to cover the amount due, coverage for the Employee and his Dependents will end as of the last day of the month in which self-payment is due, subject to any right to continue medical coverage under COBRA (see Article VIII).

Payment for non-bargaining unit Employees will be handled as follows: The required monthly charge plus related Administrative Fee is payable by the Employer. It is due on the first day of the month for the following month of coverage. There is a 15-day grace period. If the required amount is not received by the Fund by the 15th day of the month, coverage for that Employee and his Dependents will end as of the last day of the month in which payment is due, subject to any right to continue medical coverage under COBRA (see Article VIII).

If the required payment due for the initial month of coverage is not paid in a timely manner, coverage for the Employee and his Dependents will not take effect.

ARTICLE III PERSONAL ACCOUNTS

SECTION 1 – GENERAL RULES FOR PERSONAL ACCOUNTS

Personal Accounts consisting of a Health Reimbursement Account (“HRA”) and Wage Replacement Account (“WRA”) will be established and maintained on behalf of each bargaining unit Employee, beginning January 1, 2016. Non-bargaining unit Employees are *not* eligible for Personal Accounts. For that reason, any reference to “Employee” in relation to the Personal Accounts, HRA or WRA is limited to a bargaining unit Employee.

Personal Accounts are maintained for bookkeeping purposes only. They are available to provide benefits on or after April 1, 2016. There is no actual deposit or segregation of monies.

Each Personal Account is (i) credited for Contributions received by the Fund and allocated to that account, and (ii) debited for benefits paid from, and fees and expenses charged to, that account. Once amounts are properly credited to a Health Reimbursement Account or Wage Replacement Account, the credit cannot be transferred to the other account. Employees do not have or earn a vested right to their Personal Accounts or to any benefit offered by the Plan.

Employees will not be credited with Employer Contributions payable for their work until the Contributions and any required Employer reporting are received by the Plan.

SECTION 2 – ADMINISTRATIVE FEE

There is an “Administrative Fee” established by the Trustees to set aside within the Fund for the purpose of covering the Plan’s administrative expenses, such as fees for administrative, consulting, accounting and legal services and costs incurred for copying and mailing documents. The Trustees will periodically review and establish the amount of the Administrative Fee, taking into consideration the Plan’s experience and needs. It may be a flat

dollar amount or a percentage. The Trustees established an Administrative Fee of eight percent (8%) effective 01/01/2016, and reduced it to six percent (6%) effective 04/01/2017. Changes to the Administrative Fee may be adopted by resolution of the Board of Trustees. Written notice of any change and the effective date will be given to affected parties.

For each bargaining unit Employee, the amount of the Administrative Fee will be deducted from Employer Contributions as they are received by the Fund on behalf of his Covered Employment. The remaining portion of such Employer Contributions will then be allocated to his Personal Accounts.

Example: This is an example of how the Administrative Fee is paid for a bargaining unit Employee who is not self-paying for coverage. Assume the Employer Contributions received by the Plan on the Employee's behalf total \$720.00 for the month, based on his number of hours worked and the hourly contribution rate. Further assume the Administrative Fee is 6%. Under these facts, the amount that is automatically deducted for the Administrative Fee, as Employer Contributions are received on his behalf and before they are allocated to his Personal Accounts, is \$43.20 ($\$720.00 \times 6\% = \43.20). The remaining \$676.80 in Employer Contributions is then credited to his Personal Accounts ($\$720.00 - \$43.20 = \$676.80$). The Employee's HRA is then used to cover the amount payable for his coverage but not the Administrative Fee, since the Administrative Fee has already been paid by deduction from the Employer Contributions.

Employees who self-pay for coverage must pay the Administrative Fee in addition to the cost of coverage. The Administrative Fee is calculated on the amount of the self-payment. Employers who pay for coverage for their participating non-bargaining unit Employees must also pay the Administrative Fee. It is calculated on the amount of the monthly coverage charge payable by the Employer.

Example: This is an example of how the Administrative Fee is paid for Employees who self-pay and for participating non-bargaining unit Employees. Assume the amount of the self-payment or monthly charge for coverage payable to the Fund is \$674.00, and the Administrative Fee is 6%. The amount payable for the month of coverage will be \$674.00 *plus* \$40.44 (i.e., 6% of \$674.00), for a total of \$714.44. This total amount due of \$714.44 is payable by Employees who self-pay and by Employers for their participating non-bargaining unit Employees.

SECTION 3 – HEALTH REIMBURSEMENT ACCOUNT (“HRA”)

(a) Purpose of HRA: Health Reimbursement Accounts are created to provide tax-free medical benefits to Participants. These medical benefits are (1) payment for medical coverage under the Plan, and (2) the health care reimbursement of Eligible Medical Expenses incurred by the Employee and his Dependents to the extent permitted by the Plan.

(b) Crediting HRA:² The *minimum credit* (or *required balance*) for each HRA is established by the Trustees. It is currently \$250.00. The Trustees may change the amount in their discretion by Board resolution. Employees will be notified of any change. Any reference in this booklet to \$250.00 shall mean the *minimum credit* (or *required balance*) then in effect.

Beginning with hours in Covered Employment worked after October 2015, Net Contributions (i.e. Employer Contributions minus the Administrative Fee) received by the Fund on an Employee's behalf will first be credited in full (100%) to his HRA until there is a \$250.00 balance. Thereafter, Net Contributions (upon receipt) will be allocated as described in the following subsection (c). If at any time the HRA balance falls below the *required*

² Addendum “A” to SPD contains provisions for the discontinuance of Hour Banks effective 10/31/2015 with a corresponding HRA credit, and is available upon request.

balance, Net Contributions (upon receipt) will again be credited in full (100%) to the HRA until there is a \$250.00 balance.

(c) **Allocation of Net Contributions**³: Once an Employee's HRA is credited with the *required balance*, Net Contributions received on his behalf will be allocated to his Personal Accounts in accordance with the following "Allocation Table For Net Contributions". The allocation percentages for the Employee's HRA and WRA will correspond to his Coverage Level at the time of receipt. The Trustees may review and amend the allocation percentages in their discretion by Board resolution. Employees will be notified of the allocation percentages during the annual enrollment period and before any changes are implemented.

ALLOCATION TABLE FOR NET CONTRIBUTIONS

Coverage Levels	Allocation of Net Contributions to HRA	Allocation of Net Contributions to WRA
Employee Only	85%	15%
Employee + Spouse	90%	10%
Employee + Children	90%	10%
Employee + Family	95% (100%*)	5% (0%*)
No Medical Benefit (Opt Out)	20%	80%

*Effective January 1, 2018

Example 1: If an Employee's HRA balance is \$250.00, the Administrative Fee is 6%, and his Coverage Level is Employee + Spouse, 90% of Net Contributions received on his behalf will be credited to his HRA, and 10% will be credited to his WRA. If the Employer contributes \$4.58 per hour worked, the Administrative Fee will be \$0.27 per hour (6% x \$4.58 = \$0.27). The Net Contribution will be \$4.31 per hour (\$4.58 - \$0.27 = \$4.31). For each hour worked, \$4.58 is received from the employer, \$3.88 (90%) will be credited to his HRA (\$4.31 x 90% = \$3.88), and \$0.43 will be credited to his WRA (\$4.31 x 10% = \$0.43).

Example 2: If an Employee's HRA balance is \$250.00, the Administrative Fee is 6%, and his Coverage Level is Employee + Spouse, 90% of Net Contributions received on his behalf will be credited to his HRA, and 10% will be credited to his WRA. If the Employer contributes \$4.90 per hour worked, the Administrative Fee will be \$0.29 per hour (6% x \$4.90 = \$0.29). The Net Contribution will be \$4.61 per hour (\$4.90 - \$0.29 = \$4.61). For each hour worked, \$4.90 is received from the employer, \$4.15 (90%) will be credited to his HRA (\$4.61 x 90% = \$4.15), and \$0.46 will be credited to his WRA (\$4.61 x 10% = \$0.46).

(d) **Payment of Monthly Charge:** The monthly charge for coverage is payable through the Health Reimbursement Account ("HRA") with the limited self-payment rights described below. **Remember, one condition of eligibility is that the Employee maintain a balance of \$250.00 in his HRA, or he will not be eligible for the Medical Benefit and other benefits provided at his Coverage Level.** The *available amount* of an Employee's HRA balance is the amount that is greater than \$250.00. For example, if an Employee's HRA balance is \$750.00, the *available amount* is \$500.00 (\$750.00 - \$250.00 = \$500.00).

Payment of an eligible Employee's monthly charge for coverage will be handled as follows.

- (1) If his available HRA balance is enough to pay the monthly charge, it will be automatically deducted, and the Employee will be covered for the next month. No action is needed on the Employee's part.

³ Addendum "A" to SPD contains the Allocation Table For Net Contributions in effect for 04/01/2016 through 12/31/2016. It is available upon request.

(2) If his available HRA balance **is not** enough to pay the monthly charge and a Contribution has been received by the Fund on his behalf during the month, he may self-pay the difference between the amount due and his available HRA balance. Provided the Fund receives a Contribution for at least one (1) hour on his behalf during the month, this right to self-pay will continue.

(3) If his available HRA balance **is not** enough to pay the monthly charge and **no** Contribution has been received by the Fund on his behalf during the month, he may self-pay the difference between the amount due and his available HRA balance. This right to self-pay is limited to a maximum of nine (9) consecutive months. If he does not self-pay for a month when he is eligible to do so, he may not then self-pay for any later month unless the Fund receives a Contribution on his behalf for at least one (1) hour.

(4) If his available HRA balance **is not** enough to pay the monthly charge and the Employee does not make a self-payment to maintain medical coverage, once there have been six (6) consecutive months in which no Contribution is received by the Fund on his behalf, the requirement to maintain the *required balance* will no longer apply. The Employee may then use his remaining HRA balance for reimbursement of Eligible Medical Expenses incurred by him or his Dependents as described Article IX.

SECTION 4 – WAGE REPLACEMENT ACCOUNT (WRA)

Wage Replacement Accounts are bookkeeping accounts maintained to provide taxable vacation and holiday pay to eligible Employees. Once an Employee has a Health Reimbursement Account balance of \$250.00, Net Contributions received on his behalf will be allocated to his WRA in accordance with the applicable percentage shown in the “Allocation Table For Net Contributions” and as described in the Examples following such table. The percentage is based on his Coverage Level at the time of receipt.

The Trustees may review and amend the allocation percentages in their discretion by Board resolution. Employees will be notified of the allocation percentages during the annual enrollment period and before any change is effective.

The purpose of the Wage Replacement Account is to provide Employees with taxable vacation pay and holiday pay. Employees are entitled to receive vacation pay for up to fifteen (15) weeks of vacation per calendar year, and holiday pay for up to ten (10) holidays per calendar year, depending upon their available WRA balance. The amount of the vacation benefit is \$500.00 (gross) per week, and the amount of the holiday benefit is \$100.00 (gross) per holiday. All applicable federal, state and local taxes will be deducted from the gross amount payable to reach the net amount payable to the Employee.

The total gross amount payable to an Employee from his Wage Replacement Account (vacation and holiday pay combined) cannot be more than \$8,500 in any calendar year or, if less, his available WRA balance for the calendar year.

Holiday pay is available only for the following holidays:

- New Year’s Day
- Martin Luther King Jr. Day
- President’s Day
- Good Friday
- Memorial Day
- Independence Day
- Labor Day
- Veteran’s Day
- Thanksgiving Day

- Christmas Day

To receive vacation or holiday pay, the Employee must complete a Vacation or Holiday Pay Request Form and file it with the Administrative Manager. These forms are available without charge upon request to the Administrative Manager. If the form is properly completed and filed by the 10th day of the month, a check should be mailed to the Employee on or about the 15th day of the month.

If there is a balance remaining in an Employee's Wage Replacement Account at the end of a calendar year and he has not received the maximum available benefit for that year, the Employee will automatically receive payment for the remaining available benefit after deduction for all applicable federal, state and local taxes. If an Employee dies during the calendar year before receiving the maximum available benefit, the remaining available benefit (net of taxes) will be paid to his beneficiary. His beneficiary will be determined in accordance with the beneficiary provisions for the Employee Life Insurance benefit.

If there is still a balance remaining in an Employee's Wage Replacement Account after payment of the maximum available benefit, it will be rolled over as a credit to his WRA for the following calendar year. If the Employee has died during the calendar year, any such balance remaining will be forfeited and added to the Fund's reserves.

SECTION 5 – FORFEITURE OF PERSONAL ACCOUNT BALANCES

(a) Forfeiture Rules for Health Reimbursement Account: If the following conditions are all satisfied during any two-year period with respect to an Employee and his Health Reimbursement Account ("HRA"), any HRA balance remaining at the end of such two-year period will be forfeited without right of reinstatement and added to the Fund's reserves:

- (1) No Contributions have been received by the Fund on the Employee's behalf; and
- (2) The Employee has not made any self-payments to the Fund; and
- (3) The Employee has not requested reimbursement from his HRA; and
- (4) The Employee has not completed the necessary enrollment forms for the Plan.

(b) Forfeiture Rules for Wage Replacement Account: If the following conditions are all satisfied during any two-year period with respect to an Employee and his Wage Replacement Account ("WRA"), any WRA balance remaining at the end of such two-year period will be forfeited with no right of reinstatement and added to the Fund's reserves:

- (1) No Contributions have been received by the Plan on the Employee's behalf; and
- (2) The Employee has not completed and submitted the forms required to receive payments from his WRA.

ARTICLE IV MEDICAL BENEFIT

SECTION 1 – EPO NETWORK (BLUE CROSS BLUE SHIELD) AND NETWORK PROVIDERS

The Plan participates in the Blue Cross Blue Shield ("BCBS") Exclusive Provider Organization Network ("EPO Network") for its Medical Benefit. Whenever the term "Network Provider" is used, it means a hospital, physician or other medical service provider that participates in the EPO Network and has agreed to charge certain negotiated

discounted rates for medical procedures performed for Participants. Whenever the term “Out-of-Network Provider” is used, it means a provider that does not participate in the EPO Network and is not a Network Provider.

Access to information about the Plan’s EPO Network and Network Providers is available via a toll-free customer service number and online at the EPO Network website. This contact information, as well as a listing or directory of the current Network Providers, will be provided or made available to Participants free of charge upon enrollment and upon request to Highmark or the Administrative Manager.

The Medical Benefit is provided only when a Participant uses a Network Provider to receive covered medical services or supplies. There is an exception for covered emergency care, which is covered regardless of whether the Participant goes to a Network Provider or Out-of-Network Provider. **IF A PARTICIPANT GOES TO AN OUT-OF-NETWORK PROVIDER FOR COVERED MEDICAL SERVICES OR SUPPLIES OTHER THAN COVERED EMERGENCY CARE, NO MEDICAL BENEFITS WILL BE PAYABLE.**

SECTION 2 – ADMINISTRATIVE SERVICES PROVIDER FOR MEDICAL BENEFIT (HIGHMARK)

The Plan has a services agreement with Highmark, an independent BCBS licensee, for Highmark to provide health plan administrative services for the Medical Benefit. All Participants with Medical Coverage will receive an Identification Card (“ID Card”) which identifies them as Plan Participants who are eligible for the Medical Benefit under the Plan. The ID Card also provides important contact information for Highmark and the EPO Network. Although Highmark provides administrative services for the Medical Benefit, which include services for claims processing and payment, the Medical Benefit is entirely self-funded by the Fund. Highmark is not an insurer of the Medical Benefit.

SECTION 3 – EPO BLUE PROGRAM BENEFIT BOOKLET

Highmark has issued separate booklets which describe the Medical Benefit provided by the Plan through the EPO Blue Program. There is one booklet for each available Benefit Level (Gold, Silver, Bronze and Steel Plans). Participants will receive a Highmark EPO Blue Booklet for the Benefit Level in which they participate. The Highmark EPO Blue Booklets for each Benefit Level (Gold, Silver, Bronze and Steel Plans) are included by this reference as a part of the Plan. Whenever the Highmark EPO Blue Booklet refers to the Participant’s group or program, it means the Plan, and whenever it refers to the Participant’s benefit period or contract year, it means the calendar year.

The Highmark EPO Blue Booklet includes a description of the Plan’s Medical Benefit and a Summary of Benefits which lists the important benefit limitations. This information includes a description of the health services and supplies that are covered; the health services and supplies that are not covered; the annual (calendar year) individual and family deductibles, the Plan’s coinsurance or payment levels based on the Plan allowance, the annual (calendar year) individual and family out-of-pocket limits, the copayments required for different types of office visits, and when applicable the annual limit on the number of visits covered per benefit period (calendar year); the health care management program (such as the care utilization process, precertification and preauthorization requirements and what happens if they are not followed); how to file a claim for a Medical Benefit, how to appeal a claim decision, and how to request external review of a claim denied on appeal; as well as other important information.

Please read the Highmark EPO Blue Booklet carefully to learn more about the Medical Benefit, and call Highmark or the Administrative Manager if you have questions. Participants should share this booklet with other covered family members, and keep it for future reference.

**ARTICLE V
PRESCRIPTION DRUG BENEFIT**

SECTION 1 – PHARMACY BENEFIT MANAGER (ENVISION)

The Prescription Drug Benefit under the Plan is available only as described in this Article and the Schedule of Benefits. The Plan has a pharmacy benefit management services agreement with Envision Pharmaceutical Services, Inc. (“Envision RX”), making Envision RX its Pharmacy Benefit Manager for the Prescription Drug Benefit. Envision RX assists the Plan with designing and maintaining its Standard Formulary; managing the Pharmacy Network and eligibility for the Prescription Drug Benefit; handling all related claims and appeal processing including external review requests; and managing the mail order services, specialty pharmacy distribution and clinical pharmacy services.

SECTION 2 – COVERAGE LIMITED TO PARTICIPATING PHARMACIES

(a) Envision Pharmacy Network: Envision RX maintains a national pharmacy network, as well as a designated mail order and specialty pharmacy (“**Envision Pharmacy Network**”). The Prescription Drug Benefit is available only for Covered Prescriptions that are purchased from a “Participating Pharmacy”. A “Participating Pharmacy” is a retail, mail order or specialty pharmacy that is in the Envision Pharmacy Network and has agreed to dispense Covered Prescriptions to Participants for certain negotiated amounts.

Envision RX maintains a list of the Participating Pharmacies. It is subject to change from time to time. Envision RX will make available to Participants a current list of Participating Pharmacies without charge. To obtain a current list, call Envision RX Customer Service at 1-800-361-4542, or consult the Pharmacy Locator found at www.envisionrx.com. **Please remember, the Prescription Drug Benefit is not payable if a non-Participating Pharmacy is used.**

(b) Using Participating Retail Pharmacies: There are many national and regional pharmacy chains that participate in the Envision Pharmacy Network and can provide Participants with broad access to pharmacy services. This Network consists of over 50,000 pharmacies, including some major chains. To qualify for the Prescription Drug Benefit when using a retail pharmacy, Participants must go to a Participating Pharmacy and show their Envision Prescription Drug ID Card.

(c) Using Envision Mail Order Pharmacy (up to 90-day supply): To qualify for the Prescription Drug Benefit when using a mail order pharmacy, Participants must use the Envision Mail Order Pharmacy, which is currently Orchard Pharmaceutical Services, located in North Canton, Ohio. Participants must first get a prescription from their physician allowing for a 90-day supply. If a short-term maintenance medication supply is needed right away, Participants can have their physician complete two prescriptions – one that can be filled immediately at a retail Network Pharmacy for a 15-day supply, and the other can then be submitted to the Envision Mail Order Pharmacy.

Mail order is a convenient way to receive maintenance medications or prescriptions that are being taken for a long time. To use this service, contact Envision RX and request an Orchard Pharmaceutical Services Brochure. The brochure will have further instructions and must be mailed with the original prescription(s) written for a 90-day supply (plus refills if applicable) and the first payment or payment information to the address provided.

Before mailing in a new prescription, Participants must register the required information with Orchard Mail Order Pharmacy using any of the following three options:

- (1) Online (recommended method) by visiting www.orchardrx.com and selecting “Not registered? Click here to register”. The account will be activated within 24 hours. By registering online, Participants can also track the progress of their orders; or
- (2) Phone by calling Orchard Pharmaceutical Services Customer Service at 1-866-909-5170 to speak with a representative; or
- (3) Mail by completing the Registration and Prescription Order Form that is available from EnvisionRx. Once registered, the Participant’s physician can fax prescription(s) to Orchard at 1-866-909-5171. Please be sure that the physician includes the Participant’s date of birth and contact information on the fax. Only faxes sent from a physician’s office will be valid.

For mail-order customer services, claim inquiries and questions, call Envision Mail-Order Pharmacy at 1-866-909-5170.

(d) Using Specialty Pharmacy: Walgreen’s Specialty Pharmacy has been selected as the exclusive provider for specialty medications for the Prescription Drug Benefit. Walgreen’s Specialty Pharmacy provides complex and costly therapies that have special storage and handling requirements or may not be carried in the local drug store (for example, costly injectable therapies and select chemotherapeutic agents). These covered medications are shipped directly to the patient’s home or address of choice. The Walgreen’s Specialty Pharmacy will handle all subsequent refills.

Because specialty medications can be more difficult to manage, Walgreen’s Specialty Pharmacy offers the following patient support services at no charge:

- (1) Personalized support to help the Participant achieve the best results from the prescribed therapy;
- (2) Convenient delivery to the Participant’s home or prescriber’s office;
- (3) Easy access to a care team who can answer medication questions, provide educational material about the Participant’s condition, help manage any potential medication side effects, and provide confidential support all with one toll free phone call; and
- (4) Assistance with specialty medication refills.

For Specialty Pharmacy Customer Service, Claim Inquiries and Questions, please call Walgreens Specialty Pharmacy toll free at 1-866-823-2712. **Effective July 1, 2017, prior authorization is required as a condition of coverage of specialty medications.**

SECTION 3 – PRESCRIPTION DRUG IDENTIFICATION CARD

Participants will be provided with a Prescription Drug Identification Card (“Rx Drug ID Card”), which identifies them as a Participant in the Plan. It also has the contact information for Envision Rx. Whenever a Participant purchases a prescription drug at a Participating Pharmacy, the Participant should show his Rx Drug ID Card to identify his eligibility for the Prescription Drug Benefit.

SECTION 4 – COVERED PRESCRIPTIONS AND PRIOR AUTHORIZATIONS

The Prescription Drug Benefit is payable only for “Covered Prescriptions” and only with prior authorization when required by the Plan. Covered Prescriptions are prescription medications or devices, whether a new prescription or refill, which are prescribed by a licensed physician and included on the Plan’s current preferred drug list or

formulary. The complete list of Covered Prescriptions is called the “Standard Formulary”. It is subject to review and modification from time to time. Information about the Standard Formulary and current list of Covered Prescriptions that require prior authorization from Envision Rx as a condition of coverage, is available without charge by calling EnvisionRx Customer Service at 1-800-361-4542, available 24 hours a day, 7 days a week, or by visiting www.envisionrx.com.

Covered Prescriptions that are compound medications and cost more than \$200.00 require pre-authorization and a letter of medical necessity from Envision RX as a condition of coverage.

SECTION 5 – DISPENSING LIMITATIONS

The dispensing limitations for coverage purposes are generally a 90-day supply for maintenance prescriptions and a 30-day supply for all other prescriptions. Refills will not be allowed unless at least seventy-five percent (75%) of the prescription is used pursuant to the physician’s directions. ***Effective July 1, 2017, prescriptions for maintenance drugs are subject to a mandatory 90-day supply after two 30-day prescriptions have been filled.***

SECTION 6 – PRESCRIPTION DRUG BENEFIT LIMITATIONS

The Prescription Drug Benefit is payable in accordance with the limitations described in the Schedule of Benefits. There is (a) an annual (calendar year) individual deductible; (b) an annual (calendar year) maximum out-of-pocket per individual and family; and (c) different co-payment and co-insurance amounts depending upon the category (generic, brand name medications with no generic available, and brand name medications with generics available) and whether it is a 30-day or 90-day prescription.

The annual (calendar year) individual deductible is the amount that each Participant must pay in a calendar year for Covered Prescriptions before the Plan begins to pay the Prescription Drug Benefit for that individual for the remainder of the calendar year.

The annual (calendar year) Out-of-Pocket Limit per individual and per family, is the most that a covered individual or covered family members must pay for Covered Prescriptions during a calendar year. The cost-sharing amounts that apply towards satisfaction of these limits include the annual individual deductible, coinsurance and co-payments.

If an individual Out-of-Pocket Limit for the Prescription Drug Benefit is satisfied for a calendar year, the Plan’s co-insurance level for the Prescription Drug Benefit will increase to 100% for Covered Prescriptions for that individual for the remainder of the calendar year. If a family Out-of-Pocket Limit for the Prescription Drug Benefit is satisfied for a calendar year, the Plan’s co-insurance level for the Prescription Drug Benefit will increase to 100% for all covered family members for Covered Prescriptions for the remainder of the calendar year.

SECTION 7 – REQUIRED STEP THERAPY PROGRAM

Certain Covered Prescriptions are subject to required step therapy requirements and are characterized as a “Step One Drug” or “Step Two Drug”. This means that the Prescription Drug Benefit will not be payable for a Step Two Drug, unless and until the Participant has tried a Step One Drug without success (meaning that it has not worked for the intended purpose). The list of Step One Drugs and Step Two Drugs that are subject to the Step Therapy Program is subject to review and change from time to time. A current list is available without charge by calling EnvisionRx Customer Service at 1-800-361-4542, available 24 hours a day, 7 days a week, or by visiting www.envisionrx.com.

SECTION 8 – COVERAGE OF PREVENTIVE SERVICES

The Affordable Care Act (“ACA”) requires that certain recommended preventive items and services, including the “A” or “B” recommendations of the U.S. Preventive Services Task Force (“USPSTF”), the recommendations of the U.S. Department of Health and Human Services’ Health Resources and Services Administration (“HRSA”), and the CDC-approved recommendations of the Advisory Committee on Immunization Practice (“ACIP”), be provided without cost-sharing to Participants (i.e., no deductible, coinsurance or co-payment). The list of what is required is subject to change from time to time. For further information about the preventive services that are available, contact Envision RX or the Administrative Manager.

SECTION 9 – ENVISION RX WEBSITE

Additional information about the Prescription Drug Benefit is available at www.envisionrx.com. Online registration will allow Participants to access information such as how to locate a Network Pharmacy, prescription drug coverage and pricing, their prescription drug history, Direct Member Reimbursement Forms for use in filing a reimbursement claim, and any special programs being offered to Participants.

SECTION 10 – EXCLUSIONS FOR PRESCRIPTION DRUG BENEFIT

In no event will the Prescription Drug Benefit be payable for any of the following: (a) any medication the cost of which is recoverable under a state or federal workers’ compensation law or occupational disease law; (b) any medication for which no charge is made to the patient; (c) any drug that is limited to investigational use or is considered an experimental drug; (d) injectable medications other than insulin; (e) medical supplies or devices unless otherwise specifically covered; and (e) over-the-counter medications.

ARTICLE VI DENTAL BENEFIT

SECTION 1 – DESCRIPTION OF DENTAL BENEFIT

The Dental Benefit is provided only for Participants who participate at a Benefit Level which includes the Dental Benefit, as described in the Schedule of Benefits, and have not elected the “No Medical Benefit (Opt Out)” option. The Dental Benefit is payable only to the extent of the benefit limitations described in the Schedule of Benefits. The limitations include the Coinsurance or Percent Payable by the Plan, an Individual Calendar Year Deductible and an Individual Calendar Year Maximum.

The Dental Benefit is self-insured by the Plan. It is payable only for the covered dental procedures described below, when provided by a Dentist to a covered Participant for routine dental care or for the treatment of a non-occupational illness or injury (“Covered Dental Procedures”). The Participant must first satisfy his Individual Calendar Year Deductible. Only expenses incurred by the Participant for Covered Dental Procedures during the calendar year are applied toward satisfaction of his Individual Calendar Year Deductible for that year. Once the Individual Calendar Year Deductible is satisfied, the Plan will pay its Coinsurance percentage of actual expenses incurred by the Participant for Covered Dental Procedures during the remainder of the calendar year, up to the Maximum Reimbursable Charge. There is an overall annual limit on the total Dental Benefit payable for a covered person in a calendar year. It is called the Calendar Year Maximum. An expense is considered incurred on the date the service or item giving rise to the expense is rendered.

For purposes of the Dental Benefit, the “Maximum Reimbursable Charge” means the lesser of (i) the provider’s actual charge for the service or supply, (ii) the provider’s normal charge for the service or supply, and (iii) the Plan-

selected percentile of charges made by providers of such service or supply in the geographic area where the charge is incurred, using such database or other guidelines adopted by the Plan.

SECTION 2 – COVERED DENTAL PROCEDURES

For purposes of the Dental Benefit, Covered Dental Procedures are the following services or supplies when rendered by a licensed Dentist for routine dental care or for a non-occupational illness or injury:

- (a) Routine periodic examinations, including bitewing X-rays at six month intervals;
- (b) Full mouth X-rays once in any 36-month interval;
- (c) Topical fluoride application for eligible Dependent Children once in any twelve-month interval;
- (d) Prophylaxis, including cleaning, scaling and polishing once every six months;
- (e) Emergency treatment for relief pain;
- (f) Restorative services; amalgam, synthetic porcelain and plastic restorations (fillings);
- (g) Oral surgery, including extractions, and pre- and post-operative care for such surgery;
- (h) Endodontics, including pulpotomy, pulp capping and root canal treatment;
- (i) Periodontics treatment (treatment of diseases of the gums);
- (j) Placement of space maintainers;
- (k) Gold restorations;
- (l) Crowns (plastic, plastic and metal, porcelain with metal, chrome or stainless steel);
- (m) Bridges;
- (n) Full and partial dentures; and
- (o) Relining, duplication and repair of full and partial dentures.

SECTION 3 – EXCLUSIONS AND LIMITATIONS

The Dental Benefit is NOT payable for any of the following services, supplies or charges:

- (a) Appliances or restorations necessary to correct temporomandibular joint dysfunction;
- (b) Loss or theft of a denture;
- (c) Gold foil restorations;
- (d) Charges for treatment, including prosthetics, that are incurred before the date the person becomes covered for the Dental Benefit or after such coverage has terminated;

- (e) Charges for services or supplies rendered by a Dentist beyond the scope of his license;
- (f) Charges which exceed the Maximum Reimbursable Charge for such treatment;
- (g) Services or supplies which are not specifically described in the list of Covered Dental Procedures;
- (h) Charges resulting from the transfer of care from one Dentist to another Dentist during treatment;
- (i) Charges resulting from optional techniques or other treatment that is more extensive or costly than the treatment the Plan determines is necessary (only the cost of the less expensive or less extensive treatment that the Plan determines is necessary will be covered);
- (j) Charges made by a hospital, institution or any other facility owned and operated by the United States, or any of its agencies (including without limitations, the Veterans Administration), unless otherwise prohibited by applicable law;
- (k) Charges made for full or partial dentures or bridgework and related expenses, and for replacement made less than three years after the appliance was originally made or last replaced;
- (l) Charges made for replacement of a crown or gold filling if the crown or filling is less than five years old;
- (m) Expenses incurred for dental procedures performed on an eligible Dependent child involving a crown, bridges, or dentures unless they are performed with respect to permanent teeth, or in the case of non-permanent teeth, are performed solely for maintaining the proper space between teeth, following injury and resulting tooth loss; and
- (n) Orthodontics.

**ARTICLE VII
VISION BENEFIT**

SECTION 1 – DESCRIPTION OF VISION BENEFIT

The Vision Benefit is provided only for Participants who participate at a Benefit Level which includes the Vision Benefit, as described in the Schedule of Benefits, and have not elected the “No Medical Benefit (Opt Out)” option. The Vision Benefit is payable only to the extent of the benefit limitations described in the Schedule of Benefits.

The Vision Benefit is self-insured by the Plan. It is payable only for the following vision care when provided to a covered Participant, up to the maximum dollar amounts shown in the Schedule of Benefits:

- (a) One complete eye examination by an Ophthalmologist or Optometrist per twelve (12) consecutive month period;
- (b) One pair of frames per twenty-four (24) consecutive month period; and
- (c) One pair of lenses or one pair of contact lenses per twelve (12) consecutive month period.

The Vision Benefit is payable for contact lenses on the same basis on which it would have been payable had conventional glasses been purchased. The “same basis” means the amount of the Vision Benefit that would have

been payable to the Participant if, instead of contact lenses, he had purchased one pair of frames, one pair of the comparable vision lenses (single, bi-focal, tri-focal or lenticular), and if applicable had an eye examination.

SECTION 2 – EXCLUSIONS AND LIMITATIONS

The Vision Benefit is not payable for any of the following:

- (a) Eye examinations more than once per twelve (12) consecutive month period;
- (b) More than one pair of lenses or one pair of contact lenses per twelve (12) consecutive month period;
- (c) More than one pair of frames per twenty-four (24) consecutive month period;
- (d) Sunglasses (including the frames) unless they are prescribed to be worn at substantially all times by a licensed Ophthalmologist or similar Physician, because of an ocular medical condition;
- (e) Routine eye examinations required by an employer in connection with the Participant's occupation;
- (f) Expenses resulting from an accidental bodily injury arising out of or during employment or for which benefits are payable under any state or federal workers' compensation law;
- (g) Services, frames, lenses or contact lenses to the extent paid for or furnished by or at the direction of any government agency, unless such exclusion is prohibited by law;
- (h) Services, frames, lenses or contact lenses for which the individual is not required to pay;
- (i) Surgical care of eye disease or injury;
- (j) Radial Keratotomy or Excimer Laser surgery;
- (k) Artificial eyes;
- (l) Visual training, reading rate and comprehension studies; and
- (m) Expenses incurred when the person is not covered for the Vision Benefit. An expense is considered incurred on the date the service or item giving rise to the expense is furnished.

ARTICLE VIII COBRA CONTINUATION COVERAGE

SECTION 1 – DESCRIPTION OF COBRA COVERAGE

The right to COBRA continuation coverage ("COBRA Coverage") was created by a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Coverage can become available to Participants whose group health coverage would otherwise end because of certain life events called Qualifying Events. For more information about a Participant's COBRA rights and obligations under the Plan and under federal law, please read the following information carefully.

There may be other options available to Participants when they lose group health coverage. For example, the Participant may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in

coverage through the Marketplace, the Participant may qualify for lower costs on the monthly premiums and lower out-of-pocket costs. Additionally, the Participant may qualify for a 30-day special enrollment period for another group health plan for which he is eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

COBRA Coverage is a continuation of a Participant's medical coverage under the Plan, as required by federal law, when it would otherwise end because of a Qualifying Event. The specific Qualifying Events are listed below. When a Qualifying Event occurs, COBRA Coverage must be offered to each person who is a Qualified Beneficiary. Under the Plan, Qualified Beneficiaries who elect to receive COBRA Coverage must pay for it.

SECTION 2 – QUALIFYING EVENTS AND QUALIFIED BENEFICIARIES

An Employee will become a Qualified Beneficiary if he loses medical coverage under the Plan because of any of the following Qualifying Events:

- (a) The Employee is not credited with enough hours of employment to satisfy the Plan's eligibility requirements and maintain medical coverage; or
- (b) The Employee's employment ends for any reason other than gross misconduct.

A Dependent spouse of an Employee will become a Qualified Beneficiary if the spouse loses medical coverage under the Plan because of any of the following Qualifying Events:

- (a) The Employee dies;
- (b) The Employee is not credited with enough hours of employment to satisfy the Plan's eligibility requirements and maintain medical coverage;
- (c) The Employee's employment ends for any reason other than gross misconduct;
- (d) The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- (e) The Employee divorces or is legally separated from the spouse.

An Employee's Dependent child will become a Qualified Beneficiary if the child loses medical coverage under the Plan because of any of the following Qualifying Events:

- (a) The parent-Employee dies;
- (b) The parent-Employee is not credited with enough hours of employment to satisfy the Plan's eligibility requirements and maintain medical coverage;
- (c) The parent-Employee's employment ends for any reason other than gross misconduct;
- (d) The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- (e) The parents become divorced or legally separated; or
- (f) The child no longer qualifies as a Dependent child who is eligible for medical coverage.

SECTION 3 – NOTICE OBLIGATIONS AND DETERMINATION OF QUALIFYING EVENT

The Plan will offer COBRA Coverage to each Qualified Beneficiary who loses medical coverage because of a Qualifying Event only after the Plan has been timely notified or determines that a Qualifying Event has occurred.

The Plan Administrator will determine when one of the following Qualifying Events has occurred:

- (a) The Employee does not have enough hours of employment to maintain medical coverage under the Plan;
- (b) The Employee's employment ends for any reason other than gross misconduct;
- (c) The Employee's death; or
- (d) The Employee's becomes entitled to Medicare benefits (under Part A, Part B, or both).

For all other Qualifying Events (divorce or legal separation of the Employee and spouse or a Dependent child no longer qualifying as a Dependent child under the Plan), the Employee and Dependent spouse and child must give written notice to the Plan Administrator (or as otherwise instructed by it) within 60 days after the Qualifying Event occurs. The notice must describe the type of Qualifying Event and date it occurred, the names of all Qualified Beneficiaries, and if applicable include a copy of the divorce decree or written proof of legal separation.

The required notice may be given by the Employee, any Qualified Beneficiary or a representative thereof on behalf of all Qualified Beneficiaries affected by the same Qualifying Event. Failure to give timely notice as required may result in the forfeiture of each Qualified Beneficiary's right to elect COBRA Coverage because of the Qualifying Event.

SECTION 4 – HOW TO ELECT COBRA COVERAGE

Once the Plan Administrator receives the required notice of a Qualifying Event or determines that a Qualifying Event has occurred, it will give written notice to each Qualified Beneficiary explaining the COBRA Coverage that is available and how to elect it. Each Qualified Beneficiary will have 60 days from the later of the date of the notice or the date medical coverage ends, in which to elect COBRA Coverage. If written notice of the COBRA Coverage election is given in a timely manner, COBRA Coverage will be effective retroactive to the date medical coverage would otherwise have ended, subject to timely payment of the required self-pay premium. If COBRA Coverage is not timely elected during this 60-day period, the right to do so will be forfeited.

Each Qualified Beneficiary who is eligible for COBRA Coverage has an independent right to elect it. COBRA Coverage may be elected for some Qualified Beneficiaries and not others. Covered Employees may elect COBRA Coverage on behalf of their spouses. A parent or legal guardian may elect COBRA Coverage on behalf of a minor Dependent child. A Qualified Beneficiary who elects and pays for COBRA Coverage is entitled to the same medical coverage that he had when the Qualifying Event occurred. If there is a change in the medical coverage provided by the Plan to similarly situated Employees and their families, the same change will apply to the person's COBRA Coverage.

SECTION 5 – LENGTH OF COBRA COVERAGE

COBRA Coverage is available for only a limited period of time, depending upon the type of Qualifying Event that triggers the right to elect it. The maximum period available for COBRA Coverage is as follows:

- (a) **18 Months:** If the Qualifying Event is an Employee's failure to work enough hours to maintain coverage or the Employee's termination of employment, COBRA Coverage will be available to the Qualified Beneficiaries for 18

months measured from the later of the date of the Qualifying Event or the date medical coverage ends because of it;

(b) **36 Months:** If a Dependent spouse or child experiences any other type of Qualifying Event, COBRA Coverage will be available to the Qualified Beneficiaries for 36 months measured from the later of the date of the Qualifying Event or the date medical coverage ends because of it. There is a special rule if the Employee becomes entitled to Medicare while covered by the Plan, and later experiences a Qualifying Event due to failure to work enough hours to maintain eligibility or a termination of employment. If this occurs, the maximum period of COBRA Coverage available for the Employee's spouse and Dependent children will be the longer of (i) 18 months from the date of the Qualifying Event (or up to 29 months if the disability extension applies), or (ii) 36 months from the date the Employee becomes entitled to Medicare.

(c) **Disability extension of COBRA Coverage From 18 To 29 Months:** If an Employee, Dependent spouse or child, who is receiving COBRA Coverage because of the same Qualifying Event, is determined by the Social Security Administration ("SSA") to be totally disabled and entitled to disability income benefits, and timely notice of the disability award is given to the Plan Administrator, the entire family may be entitled to extend their COBRA Coverage for an additional 11 months, for an overall maximum of 29 months. In order to be timely, notice of the disability award must be given (i) within 60 days after it is received or within the first 60 days of COBRA Coverage, and (ii) it must also be given within the first 18 months of COBRA Coverage. The total disability must have started at some time before the 60th day of COBRA Coverage.

If the SSA determines that the disabled person is no longer disabled and eligible for Social Security disability benefits during an 11-month disability extension, written notice thereof must be given to the Plan Administrator within 30 days after the determination. If this happens, COBRA Coverage will end sooner, as of the end of the first month that is more than 30 days after SSA's determination. All Qualified Beneficiaries who are receiving extended COBRA Coverage because of the disability are obligated to give this notice. However, notice that is given by any one of them or a representative thereof will satisfy the notice requirement for all Qualified Beneficiaries affected by the same event.

If the required notice is not given and claims are erroneously paid by the Plan, each Qualified Beneficiary who was obligated to give notice may be held responsible to the Plan for all amounts paid in error and all related collection costs incurred by the Plan. Such payment shall be due promptly after receipt of the Plan's request for reimbursement;

(d) **Second qualifying event extension of 18-month period of COBRA Coverage:** If, while a Dependent spouse or child is receiving COBRA Coverage for an 18 or 29 month period, a second qualifying event occurs because the Employee dies, becomes divorced or legally separated, or becomes entitled to Medicare (under Part A, Part B or both), or a child no longer qualifies as a Dependent for Plan eligibility purposes, the maximum period of COBRA Coverage that is available will be extended from 18 (or 29) to 36 months from the original Qualifying Event or (if later) the resulting loss of coverage. The most COBRA Coverage that any person may receive because of a Qualifying Event or this multiple Qualifying Event rule is 36 months. The Plan Administrator must be properly notified of the second Qualifying Event. The extension is only available if the second Qualifying Event would have caused the Dependent spouse or child(ren) to lose medical coverage under the Plan had the first Qualifying Event not occurred.

SECTION 6 – OTHER COVERAGE OPTIONS

Instead of enrolling in COBRA Coverage, there may be other coverage options for an Employee and his 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. Participants can learn more about many of these options at www.healthRAre.gov.

SECTION 7 – TERMINATION OF COBRA COVERAGE

COBRA Coverage will normally terminate on the last day of the maximum period for which it is available as explained above (e.g., 18, 29 or 36 months). However, it will terminate sooner upon the happening of any of the following events:

- (a) The required COBRA premium is not paid timely, in which case COBRA Coverage will terminate as of the end of the last paid up period;
- (b) The date after COBRA Coverage is elected, on which the Employee, spouse or child first becomes covered under another group health plan (assuming there is no pre-existing condition exclusion or limitation affecting the person) or first become entitled to benefits under Medicare;
- (c) The date the Employee's last Employer stops contributing to the Plan and makes other group health plan coverage available, or starts contributing to another multiemployer plan that makes group health plan coverage available, to a significant number of its employees who were formerly covered under this Plan; or
- (d) The date the Board of Trustees terminates all group health plans and no longer provides group health insurance coverage to Employees.

COBRA Coverage may not be rescinded except in cases of fraud or intentional misrepresentation of material fact. A "rescission" means a cancellation of coverage with retroactive effect, other than for non-payment of coverage.

SECTION 8 – REQUIRED COBRA SELF-PAY PREMIUM

COBRA Coverage is available on a self-pay basis only. Each year, the Trustees will review and set the amount of the COBRA self-pay premium in accordance with federal law. The Plan may charge up to 100% of the Plan's cost for providing its medical coverage to similarly situated persons, plus an additional 2% to cover administrative expenses. For COBRA Coverage that is provided during an extended 11-month period for disability, the Plan may charge up to 150% of the Plan's cost of such coverage.

The initial COBRA self-pay premium is due 45 days after the date COBRA Coverage is elected. It must cover the cost of coverage from the date it would otherwise terminate through the end of the month before payment is made. If COBRA Coverage is elected but the initial self-pay premium is not paid when due, COBRA Coverage will not take effect.

After the initial payment, the COBRA self-pay premiums are due on the first day of each month, subject to a 30-day grace period. This means that if a monthly payment is not made to the Plan by the 30th day of the month, COBRA Coverage will be cancelled as of the first day of such month and cannot be reinstated. If payment is not made by the due date (i.e., the 1st day of the month), the Plan has the option to cancel medical coverage pending payment. If payment is made by the end of the grace period (i.e., the 30th day of the month), medical coverage will then be reinstated as of the first day of the month for which timely payment is made. Payment is considered made when it is postmarked.

Please note that the Plan is not required to bill for COBRA Coverage. It is the responsibility of the Qualified Beneficiary to make timely payments.

SECTION 9 – ACQUIRING NEW DEPENDENTS AND SPECIAL ENROLLMENT

If a Qualified Beneficiary with COBRA Coverage acquires a new Dependent for whom enrollment would be available to an Employee, the Qualified Beneficiary may enroll the new Dependent in COBRA Coverage for the balance of the COBRA Coverage period. To do this, written notice and enrollment of the new Dependent must be

provided to the Plan within 30 days after the new Dependent is acquired. Notice of any change in the amount of the required COBRA self-pay premium to cover the new Dependent will be given.

If a Qualified Beneficiary with COBRA Coverage has a Dependent who was initially eligible but did not enroll because the Dependent had other group health coverage, the Dependent will have a special enrollment period in which to enroll for COBRA Coverage for the balance of the COBRA Coverage period in the following two instances:

- (a) When the other group health coverage was COBRA Coverage that is exhausted; or
- (b) When the other (non-COBRA) group health coverage ends because of a loss of eligibility or termination of employer contributions.

Special enrollment will not be allowed if the other coverage ends because of nonpayment of premium or for cause. To enroll the Dependent during a special enrollment period, a written request for enrollment and any required documentation must be sent to the Plan Administrator within 30 days after the Dependent's other coverage ends. Notice of any change in the amount of the COBRA self-pay premium to cover the new Dependent will be given.

SECTION 10 – CONTACT INFORMATION AND NOTIFYING PLAN OF CHANGES

Questions concerning the Plan or COBRA Coverage rights should be addressed to the Plan Administrator unless otherwise directed by it. For more information about rights under the ERISA, COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthHRAre.gov.

Keep your Plan informed of address changes: To protect your family's rights, let the Plan Administrator know about changes in the addresses of family members. Participants should also keep a copy, for their records, of any notices sent to the Plan Administrator.

ARTICLE IX REIMBURSEMENT FROM HEALTH REIMBURSEMENT ACCOUNT

SECTION 1 – REIMBURSEMENT OF ELIGIBLE MEDICAL EXPENSES

Health Reimbursement Accounts ("HRAs") may be used by Employees, who are not self-employed, for the reimbursement of "Eligible Medical Expenses" incurred by them or their covered Dependents, as described in this Article IX. The HRA is intended to qualify as a medical reimbursement plan under Code Sections 105 and 106, and as a "health reimbursement arrangement" within the meaning of IRS Notice 2002-45.

HRA reimbursements for Eligible Medical Expenses are intended to be eligible for exclusion from gross income under Code Section 105(b). However, the Plan makes no guarantee that any amount reimbursed from an HRA is tax-exempt. It is the Participant's obligation to determine if payments from the HRA are tax-exempt, to notify the Plan if they are not, and to indemnify and reimburse the Plan for any liability it incurs for failure to withhold federal income taxes, Social Security taxes, or other taxes. Reimbursements to Employees who are "highly compensated" within the meaning of Code Section 105(h), may be limited or treated as taxable compensation to comply with the Code, as determined by the Trustees.

"Eligible Medical Expenses" are expenses incurred by Employees and their Dependents for medical care, as defined in Code Section 213. They are reimbursable from the available HRA balance, but only to the extent (i) the Employee or Dependent has not been reimbursed for the expense and the expense is not reimbursable through

the Plan's medical coverage or other insurance or health coverage; (ii) the Employee has not taken an income tax deduction for the expense; and (iii) the expense was not incurred before the Employee or Dependent was effectively enrolled in the Plan. Eligible Medical Expenses may include amounts owed for COBRA self-pay premiums.

The *available amount* of the HRA account balance for reimbursement purposes is the amount that is greater than the *required balance* (\$250.00). Once an Employee has six (6) consecutive months with no Contribution or self-payment to the Fund on his behalf, there is no longer a *required balance*, and his entire remaining HRA account balance is available for reimbursement until it is forfeited.

The HRA will be administered in a manner consistent with it being integrated with a group health plan that provides minimum value, as provided in Notice 2013-54 and ERISA Technical Release 2013-03. It may not be used for reimbursement of premiums to buy individual market coverage.

SECTION 2 – HOW TO SUBMIT CLAIMS FOR REIMBURSEMENT

To obtain reimbursement from the HRA, a written claim must be submitted to the Administrative Manager within twelve (12) months from the date the Eligible Medical Expense was incurred. Expenses that are submitted after this deadline are not eligible for reimbursement. The claim for reimbursement must include the following information: (i) the name of the person who incurred the expense; (ii) the nature of the expense and date it was incurred; (iii) the reimbursement amount requested; and (iv) a signed statement that the expense has not otherwise been reimbursed and is not reimbursable by other health insurance or coverage. A medical reimbursement request form that may be used for this purpose is available without charge upon request to the Administrative Manager.

SECTION 3 – PROCESSING AND DECIDING REIMBURSEMENT CLAIMS

A claim that requires no additional information to process will be paid or denied by the Administrative Manager within 30 days after receipt of the claim. Written notice of the approval or denial will be given to the claimant by the Administrative Manager. If the claim is not approved, it will be handled in accordance with the Plan's Claims and Appeal Procedures described in Article XIII.

SECTION 4 – REIMBURSEMENT FOLLOWING TERMINATION OF HRA

When participation in the Plan terminates, the Employee may be reimbursed for Eligible Medical Expenses incurred after termination only in accordance with the following provisions:

(a) The Employee may claim reimbursement from any remaining HRA balance for Eligible Medical Expenses incurred by the Employee or his Dependents during the 12-month period immediately after termination; and

(b) If the termination occurs because of the Employee's death, the Employee's Dependents or estate may claim reimbursement from any remaining HRA balance for Eligible Medical Expenses incurred by the Employee before death or by his Dependents during the 12-month period immediately after termination. Any balance remaining cannot be used to provide a death benefit or for any reason other than to continue medical coverage or for reimbursement of Eligible Medical Expenses.

SECTION 5 – OPT-OUT AND WAIVER OF PARTICIPATION RIGHTS

Employees who are eligible to participate or are participating in the HRA have the right to permanently opt-out of participation in the HRA and to waive future allocations to or reimbursements from it as described in this Section. This right may be exercised at any time by written notice to the Administrative Manager before the intended

effective date, which must be stated in the notice. Once an opt-out is effective, the Employee is no longer eligible to participate in the HRA or to receive allocations to or reimbursements from the HRA, and any existing HRA balance will be forfeited without the right of reinstatement.

This permanent opt-out and waiver right might be beneficial to an Employee who loses health coverage under the Plan, and wants to buy individual health insurance from the Health Insurance Marketplace and qualify for a premium tax credit in doing so. The HRA may be considered employer-provided health coverage if there is a remaining HRA balance to “spend down”. The provisions of this Section will be interpreted and administered in a manner that is consistent with the guidance set forth in Technical Release No. 2013-03, for the integration of HRAs with group health plans. Employees are urged to proceed with caution before exercising this opt-out and waiver right, since the HRA is a valuable benefit provided at no cost.

ARTICLE X
EMPLOYEE WEEKLY ACCIDENT AND SICKNESS BENEFIT

SECTION 1 – DESCRIPTION OF WEEKLY ACCIDENT AND SICKNESS BENEFIT

The Weekly Accident and Sickness Benefit is provided only for Participants who participate at a Benefit Level which includes the Weekly Accident and Sickness Benefit, as described in the Schedule of Benefits, and have not elected the “No Medical Benefit (Opt Out)” option. An Employee who becomes Totally Disabled while covered will qualify for the Weekly Accident and Sickness Benefit as described in this Article. This benefit is self-insured by the Plan and payable in the amount set forth in the Schedule of Benefits.

“Total Disability” or “Totally Disabled” means that because of a non-occupational accident or sickness, an Employee is completely and continuously unable to perform the material and substantial duties of his regular occupation and is not engaging in any work for profit for which he is suited by education, experience and training. The Weekly Accident and Sickness Benefit is not payable for a Total Disability that arises because of an occupational accident or sickness.

To qualify for this benefit, the Employee must provide written notice and satisfactory medical evidence of the Total Disability to the Administrative Manager, initially upon becoming Totally Disabled and on an ongoing basis as required. The Employee must also be under the care of a licensed Physician for the period of the Total Disability.

SECTION 2 – PAYMENT PROVISIONS AND DURATION OF PAYMENT

If the Total Disability is the result of an accidental bodily injury, payment of the benefit will begin on the first (1st) day of the Total Disability. If the Total Disability is the result of a sickness, payment of the benefit will begin on the eighth (8th) day of the Total Disability. If there is a hospital confinement or disabling outpatient surgery that occurs before the eighth (8th) day of Total Disability, payment of the benefit will begin at the time of the confinement or surgery.

The Weekly Accident and Sickness Benefit is payable for a maximum period of thirteen (13) weeks for any one period of Total Disability.

The Weekly Accident and Sickness Benefit is not payable for any period for which an Employee receives unemployment compensation benefits or workers’ compensation benefits. Employees who become eligible for and receive unemployment compensation or workers’ compensation benefits must promptly report such fact to the Administrative Manager.

Payment of the Weekly Accident and Sickness Benefit will be made for each separate and distinct period of Total Disability. Successive periods of Total Disability separated by less than two consecutive weeks of full-time active work will be considered one period of Total Disability, unless they arise from different and unrelated causes. Successive periods of Total Disability due to unrelated causes will be considered separate periods if they are separated by a return to full-time active work for at least one full work day.

SECTION 3 – RIGHT TO EXAMINATION

The Plan reserves the right to require the Employee to be examined by a Physician of its choice and at its expense. If that Physician believes that the Employee is able to return to work, or if the Employee refuses to submit to examination upon request, the Plan will have the right to discontinue payment of the Weekly Accident and Sickness Benefit.

SECTION 4 – EXCLUSIONS AND LIMITATIONS

The Weekly Accident and Sickness Benefit will not be payable for any of the following periods or circumstances:

- (a) A period in which the Employee is doing work of any kind and anywhere for pay or profit;
- (b) A period before the first treatment date for the Total Disability;
- (c) A period in which the Employee is not under a Physician's direct and continuous care;
- (d) A Total Disability that is due to an occupational accident or sickness;
- (e) A period in which the Employee is not covered for this benefit under the Plan; and
- (f) A period in which the Employee is covered solely because of COBRA Coverage.

ARTICLE XI EMPLOYEE LIFE INSURANCE BENEFIT AND EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

SECTION 1 – EMPLOYEE LIFE INSURANCE BENEFIT

(a) Policy and Insurer: The Employee Life Insurance Benefit is provided only for Participants who participate at a Benefit Level which includes the Employee Life Insurance Benefit, as described in the Schedule of Benefits, and have not elected the “No Medical Benefit (Opt Out)” option. This benefit is fully insured through a group life insurance policy (“Policy”) purchased by and issued to the Fund. While the Employee Life Insurance Benefit is described in this Section, in all cases it will be payable in accordance with the terms of the Policy in effect at the time of a covered Employee's death. The Group Life Insurance Contract and Certificate of Insurance for the Policy are included by reference as a part of the Plan. A copy of the Policy is available upon request to the Administrative Manager.

The Insurer of the current Policy is the Union Labor Life Insurance Company.

(b) Life Insurance Benefit: The Life Insurance Benefit is payable if a covered Employee dies while he is insured for this benefit.

The amount of the Life Insurance Benefit is the amount payable under the Policy in effect on the date of the covered Employee's death. The amount of the current Life Insurance Benefit is shown in the Schedule of Benefits.

(c) Beneficiary and Payment: An Employee may name one or more Beneficiaries who, if surviving, will be entitled to receive any benefits payable under the Policy upon his death. These benefits may include the Life Insurance Benefit and Accidental Death Benefit. The Beneficiary will be determined based on the Insurer's records at the time of payment.

An Employee may change the Beneficiary at any time, without the consent of the previously named Beneficiary. Any change must be requested in writing on a form furnished by or satisfactory to the Insurer. It will take effect upon receipt of the signed form at the Insurer's Executive Office or as otherwise permitted by the Policy.

Upon receipt of satisfactory Proof of Claim timely submitted, the Insurer will pay the death benefit due under the Life Insurance Benefit or Accidental Death and Dismemberment Benefit to the Employee's surviving named Beneficiary as follows:

- (1) If there is more than one surviving named Beneficiary, they will share equally unless otherwise indicated by the Employee in the Beneficiary designation;
- (2) If there is no named Beneficiary, or if no named Beneficiary is surviving at the time of the Employee's death, payment will be made to the first surviving class in the following order of preference:
 - (i) The surviving spouse;
 - (ii) The children, in equal shares;
 - (iii) The parents, in equal shares;
 - (iv) The brothers and sisters, in equal shares; or
 - (v) The executors or administrators of the Employee's estate.

To determine which class of individuals is entitled to the death benefit, the Insurer may rely on an affidavit made by any individual listed above. If payment is made based on such an affidavit, the Insurer, Plan and Fund will be discharged of their liability for the amount so paid, unless written notice of claim by another individual listed above is received before payment is made.

(3) If the Beneficiary is a minor or someone not able to give a valid release for payment, the Insurer will pay the death benefit to the Beneficiary's legal guardian. If there is no legal guardian, the Insurer may pay the individual or institution that has, in its opinion, custody and principal support of such Beneficiary. The Insurer, Plan and Fund will be fully discharged of their liability for any amount of death benefit so paid in good faith.

(d) Proof of Claim: Satisfactory Proof of Claim will include a certified copy of the Employee's death certificate and any other data required by the Insurer to establish the validity of the claim. Proof of Claim must be submitted to the Insurer or its designated claims administrator within 90 days after the date of death, unless it was not reasonably possible to do so and Proof of Claim is submitted as soon as reasonably possible.

(e) Facility of Payment: If a person appears to the Insurer to be equitably entitled to reimbursement for expenses incurred for the Employee's burial, the Insurer may reimburse such person for the burial expenses up to the lesser of \$500 or the amount of the Life Insurance Benefit, and such reimbursement will reduce the amount otherwise payable to the Beneficiary.

If any benefit is payable to the Employee's estate, to a minor or to a person who lacks the capacity to give a valid release for payment, the Insurer may pay the benefit, up to \$1,000, to any relative by blood or marriage who is deemed by it to be equitably entitled to the benefit.

The Insurer, Plan and Fund will be fully discharged of their liability for any amount of benefit paid under these Facility of Payment provisions in good faith. Death benefit proceeds, other than the portion, if any, paid under these Facility of Payment provisions, will be paid to the surviving Beneficiary in one lump sum.

(f) Maximum Amount of Life Insurance Benefit Payable: The total benefit payable for the Life Insurance Benefit will never be more than the amount of Life Insurance payable under the Policy in effect at the Employee's death. Payment shall not be made under more than one of the following life insurance provisions under the Policy: (1) the Life Insurance Benefit; (2) Waiver of Premium; or (3) Conversion Privilege.

(g) Right to Examination and Autopsy: The Plan and Insurer, at their own expense, have the right to have (1) an Employee examined by a doctor of their choice, and (2) an autopsy performed if it is not prohibited by law.

(h) Conversion Privilege:

(1) Triggering Events for Conversion Right: If an Employee's Life Insurance Benefit, or any portion thereof, terminates due to one of the triggering events under the Policy, the Insurer may allow the Employee to convert the terminated life insurance coverage to an individual policy of life insurance then offered by the Insurer ("Conversion Policy"), without having to submit proof of good health.

(2) Individual Termination or Class Change: If an Employee's Life Insurance Benefit, or any portion thereof, terminates because the Employee (i) is no longer eligible under the Plan, or (ii) transfers from one class of eligible persons to another and the class to which he transfers offers lesser benefits, the Employee may convert the terminated amount, less any amount for which he becomes eligible under the Policy or any other group policy within 31 days from the date of termination.

(3) Policy or Class Termination: If an Employee's Life Insurance Benefit terminates because the Policy terminates or is amended to terminate coverage for a class of eligible persons under which he was insured, he may convert such coverage if he was continuously insured for at least five years. The amount eligible for conversion will be (i) the amount of Life Insurance Benefit in effect on the date of termination, less any amount for which he is eligible under the Policy or its replacement within 31 days after the date of termination, or if less (ii) \$2,000.00.

(4) Notice of Conversion Privilege and Conversion Period: Employees with conversion rights must be notified in writing of their right to convert. They will have a 31-day Conversion Period measured from the date their Life Insurance Benefit terminates. If a notice of conversion rights is not given by the 16th day of the 31-day Conversion Period, the Employee will have an additional period in which to convert. The additional period will end on the earlier of (i) 15 days from the date notice is given, or (ii) 91 days from the date his Life Insurance Benefit terminates. An Employee's Life Insurance Benefit will not be extended beyond the end of the 31-day Conversion Period, regardless of whether notice of conversion rights is given.

(5) Conversion Application and Payment: To qualify for a Conversion Policy, the Employee must submit a written application to the Insurer and pay the first premium due within 31 days from the termination date of his Life Insurance Benefit unless an additional period to convert has been granted.

(6) Conversion Policy: An Employee who is eligible to convert may convert to any individual policy which is then being offered by the Insurer, other than term insurance or insurance which provides disability or other supplemental benefits.

(7) Premium Rates: The premium rates for the Conversion Policy will be the Insurer's premium rates in effect for the amount and type of converted policy based on the Employee's class of risk and attained age.

(8) Effective Date: The individual life insurance Conversion Policy will take effect at the end of the 31-day conversion period or, if applicable, the extended period to convert, provided the application and first premium are submitted by such date.

(9) Death Within the Conversion Period: If an Employee dies during the 31-day or (if applicable) the extended Conversion Period, the maximum amount of Life Insurance eligible for conversion will be paid as a benefit to the Beneficiary under the Policy, regardless of conversion and payment of premium. If application was made for a Conversion Policy, it will be null and void regardless of issuance, and no death benefit will be paid thereunder. Any premium paid for it will be returned.

(10) Limitation on Amount Converted: No one who is insured or becomes insured under the Policy and holds a converted individual life insurance policy will again be entitled to exercise conversion rights while the converted policy is in effect.

(i) Waiver of Premium:

(1) Total Disability Before Age 60 and Waiver of Premium Benefit: If an Employee becomes Totally Disabled before age 60 while insured under the Policy and the Total Disability continues for at least nine consecutive months, the Life Insurance may be continued without payment of premium while the Total Disability continues. The initial continuation of insurance under this provision will be for 12 months from the date premium payments for the Employee have ceased, but in no event longer than 24 months from the date Total Disability began.

"Totally Disabled" and "Total Disability", for Waiver of Premium purposes, means a complete inability, due to injury or illness, to engage in any business, occupation or employment for which the Employee is qualified or becomes qualified due to education, training or experience for pay, profit or compensation.

(2) Initial Proof Requirement: To qualify for Waiver of Premium, an Employee must send a written request and satisfactory proof of eligibility ("Initial Proof") to the Insurer within 12 months after premium payments for the Employee have ceased, but no longer than 24 months after the Total Disability began. If it is not received within 12 months after premium payments for the Employee have ceased, the Life Insurance will terminate at the end of such 12-month period. If the request for Waiver of Premium is approved, the Life Insurance will continue while the Employee remains Totally Disabled and submits satisfactory written proof of eligibility to the Insurer as required.

(3) Notice of Determination: Within 10 days of receipt of a Waiver of Premium request, the Insurer will provide written notice of its approval or, if applicable, disapproval and reasons for the disapproval. If a Waiver of Premium request is disapproved, the Employee may continue the Life Insurance only on a premium-paying basis.

(4) Continued Waiver of Premium for Successive Periods of Total Disability: If the Insurer approves the Employee's initial request and proof so that the Life Insurance is continued under Waiver of Premium, it may be continued for successive 12-month periods if the Employee remains Totally Disabled and continues to provide acceptable written proof thereof to the Insurer. Proof of continued Total Disability will be due

within three months before the anniversary of the date the Insurer received the Initial Proof, to qualify for another 12-month extension. The Employee must send this continued proof on an annual basis on his own initiative. The Insurer is not required to request or provide notice of the need for continued proof, as a condition of continued Waiver of Premium.

If an Employee is on Waiver of Premium at the time of death, the Insurer will require written proof that the Employee's Total Disability existed continuously from the date of the last anniversary of the Insurer's receipt of the Initial Proof to the date of death.

(5) Benefit Amount Continued: The amount of Life Insurance that will be continued under a Waiver of Premium is the amount that was in force for the Employee on the date premium payment ceased, subject to any subsequent reduction or termination of the Plan's Life Insurance Benefit.

(6) Right to Require Examination: The Insurer has the right to have an Employee examined by a Doctor of its choice and at its expense at any reasonable time while the Employee is Totally Disabled. The Insurer will not require such an examination more than once a year after the Employee's Life Insurance has continued for at least two (2) full years under Waiver of Premium.

SECTION 2 - EMPLOYEE ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

(a) Policy and Insurer: The Employee Accidental Death and Dismemberment Benefit is provided only for Employees who participate at a Benefit Level which includes the Employee Accidental Death and Dismemberment Benefit, as described in the Schedule of Benefits, and have not elected the "No Medical Benefit (Opt Out)" option. It is fully insured through a group life insurance policy ("Policy") purchased by and issued to the Fund. While the AD&D Benefit is described in this Section, in all cases it will be payable in accordance with the terms of the Policy in effect at the time of the accident giving rise to a covered Employee's accidental death or dismemberment. The Group Life Insurance Contract and Certificate of Insurance for the Policy are included by reference as a part of the Plan. A copy of the Policy is available upon request to the Administrative Manager. The Insurer of the current Policy is the Union Labor Life Insurance Company.

(b) Accidental Death and Dismemberment ("AD&D") Benefit: The AD&D Benefit is payable if an Employee suffers an accident while he is covered for this benefit, and as a direct result of the accident and independent of all other causes, the Employee suffers a Covered Loss within 90 days after the accident.

A "Covered Loss" means permanent loss of any of the following: (1) life; (2) a hand by complete severance at or above the wrist joint; (3) a foot by complete severance at or above the ankle joint; or (4) an eye involving irrecoverable and complete loss of sight.

(c) Amount of AD&D Benefit: The amount of the AD&D Benefit is the amount payable under the Policy in effect on the date of the accident giving rise to the Covered Loss, based on the type of Covered Loss. The following Table describes the types of Covered Losses and corresponding benefits. The amount of the "Principal Sum" is shown in the Schedule of Benefits.

TABLE OF COVERED LOSSES AND CORRESPONDING BENEFIT

FOR COVERED LOSS OF:	THE BENEFIT IS:
LIFE	THE PRINCIPAL SUM
TWO HANDS	THE PRINCIPAL SUM
TWO FEET	THE PRINCIPAL SUM
SIGHT OF TWO EYES	THE PRINCIPAL SUM
ONE HAND AND ONE FOOT	THE PRINCIPAL SUM
ONE HAND AND SIGHT OF ONE EYE	THE PRINCIPAL SUM
ONE FOOT AND SIGHT OF ONE EYE	THE PRINCIPAL SUM
ONE HAND OR ONE FOOT	ONE-HALF THE PRINCIPAL SUM
SIGHT OF ONE EYE	ONE-HALF THE PRINCIPAL SUM

If an Employee suffers more than one Covered Loss in an accident, payment will be made only for the Covered Loss with the largest benefit.

(d) Workplace Accidental Death Benefit: If an Employee suffers a Covered Loss due to a Workplace Injury, a Workplace Accidental Death Benefit will be payable in addition to any other benefit that is payable under the Policy.

“Workplace Injury” means a bodily injury caused by an accident that occurs (i) while the Employee is at his workplace and performing his regularly scheduled union work or serving in an official capacity for his local, state or national labor organization, or (ii) while the Employee is traveling from his residence to his workplace to begin performing such work, or (iii) while the Employee is traveling from his workplace to his residence after having performed such work.

The Workplace Injury must be the direct cause of a Covered Loss and must be independent of all other causes.

(e) Exclusions: In no event will an AD&D Benefit or Workplace Accidental Death Benefit be paid for any loss (covered or otherwise) that is caused directly or indirectly, in whole or part, by any of the following:

- (1) Bodily or mental illness or disease of any kind;
- (2) Ptomaines or bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound);
- (3) Suicide or attempted suicide while sane or insane;
- (4) Intentional self-inflicted injury;
- (5) War or act of War, declared or undeclared; or any act related to War, or insurrection;
- (6) Medical or surgical treatment of an illness or disease;
- (7) Intake of any drug, medication or sedative unless prescribed by a doctor, or the intake of any alcohol in combination with any drug, medication or sedative; or
- (8) Driving while intoxicated as defined by applicable state law.

ARTICLE XII
HIPAA PRIVACY AND SECURITY RIGHTS

Section 1 -Definitions Related to HIPAA Privacy and Security Rights

When the following terms are used in this Article as capitalized terms, they will have the meaning set forth below. Other terms used in this Article but not defined will be interpreted in a manner consistent with HIPAA.

- (a) **"E-PHI"** or **"Electronic Health Information"** means PHI transmitted by or maintained in electronic media, limited to E-PHI that the Plan Sponsor creates, receives, maintains or transmits on the Plan's behalf;
- (b) **"HHS"** means the Secretary of the U.S. Department of Health and Human Services;
- (c) **"HIPAA"** means the privacy standards and implementation specifications set forth in 45 CFR Parts 160 and 164, subparts A and E; the security standards and implementation specifications set forth in 45 CFR Parts 160 and 164, subparts A and C; the standards and implementation specifications for notification of breaches of unsecured protected health information set forth in 45 CFR Parts 160 and 164, subparts A and D; and the enforcement provisions set forth in 45 CFR 160, all issued pursuant to HIPAA;
- (d) **"Information System"** means an interconnected set of information resources, under the same direct management control, that shares common functionality (such as hardware, software, information, data, applications, communications and people);
- (e) **"PHI" or "Protected Health Information"** means health information that (1) is collected from a Participant or created or received by the Plan in any form (oral, written or electronic); (2) relates to a Participant's past, present or future physical or mental health or condition, the provision of health care to a Participant, or the past, present or future payment for health care provided to a Participant; and (3) identifies a Participant or provides a reasonable basis for believing that it can be used to identify a Participant;
- (f) **"Plan Sponsor"** means the Trustees in their role as sponsor of the Plan; and
- (g) **"Security Incident"** means an attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an Information System.

Section 2 - Uses and Disclosures of PHI by Plan

The Plan may use and disclose PHI as permitted by an individual's HIPAA compliant authorization. It may also use and disclose PHI without an individual's consent or authorization, for uses and disclosures that are permitted or required by HIPAA which include the following:

- (a) **Treatment, Payment & Health Care Operations:** The Plan may use and disclose PHI for purposes of an individual's health care treatment and for health care payment and health care operations. Health care treatment is the provision, coordination or management of health care treatment and related services by one or more health care providers. Payment for health care means activities undertaken to obtain premiums, contributions or other self-payments, to determine or fulfill the Plan's responsibility for coverage and health care benefits, or to obtain or provide reimbursement for health care (e.g., actions related to coordination of benefits, claims management, subrogation, reimbursement, medical necessity reviews and utilization reviews). Health care operations is the Plan's business operations and activities related to its functioning as a health plan and provision of health benefits

to Participants (e.g., it may include insurance activities, legal services and auditing functions). Genetic information will not be used for underwriting purposes;

(b) **Other Permitted Uses and Disclosures:** The Plan may use and disclose PHI in the following circumstances: (1) as required by law; (2) as permitted for public health activities and health oversight activities; (3) as permitted for disclosures about victims of abuse, neglect or domestic violence; (4) in response to a court or administrative order or to a subpoena, discovery request or other lawful process permitted under HIPAA; (5) disclosures for law enforcement purposes; (6) to coroners, medical examiners and funeral directors concerning decedents; (7) to facilitate organ, eye or tissue procurement or transplantation when the Participant is an organ donor; (8) for research purposes when individual identifiers have been removed or when an institutional review or privacy board has reviewed and approved the proposal and established privacy protocols; (9) as necessary to prevent a serious threat to a person's health or safety; (10) for specialized government functions and to disaster relief organizations to assist with disaster relief; (11) as necessary to comply with workers' compensation or similar programs providing benefits for work-related injuries or illness; and (12) in response to HHS requests related to the Plan's HIPAA compliance; and

(c) **Uses and Disclosures Requiring an Opportunity to Agree or Object:** The Plan may disclose to a Participant's family member, close friend or other person identified by the Participant, PHI directly related to his involvement with or payment for the Participant's health care. The Participant must be informed in advance and given an opportunity to agree or object or to limit the disclosure unless the Plan is unable to do so because of the Participant's incapacity or emergency circumstances, provided the Plan decides that disclosure is in the Participant's best interest.

Section 3 - Disclosure of PHI by Plan to Plan Sponsor

The Plan Sponsor will have access to PHI from the Plan only as permitted by this Section or as otherwise required or permitted under HIPAA.

(a) **Permitted Disclosures of the Following PHI to Plan Sponsor:** The Plan (or health insurance issuer or HMO for the Plan) may disclose the following PHI to the Plan Sponsor without regard to compliance with this Article:

- (1) An individual's enrollment or disenrollment information related to the Plan;
- (2) Summary health information requested by the Plan Sponsor (i) to obtain premium bids to provide health coverage; or (ii) to modify, amend or terminate the Plan; and
- (3) PHI when permitted by a HIPAA-compliant authorization.

(b) **Disclosures of PHI to Plan Sponsor for Plan Administration Purposes:** The Plan (or health insurance issuer or HMO for the Plan) may disclose PHI to the Plan Sponsor for Plan administration purposes, which are administration functions that it performs on the Plan's behalf, including quality assurance, claims processing, claims appeals, auditing, monitoring, fiduciary oversight functions and other operational functions. This disclosure is subject to satisfaction of all of the following conditions:

- (1) The Plan's Privacy Notice must include a statement about its permitted disclosures of PHI to the Plan Sponsor;
- (2) For PHI that is disclosed by or for the Plan to the Plan Sponsor (other than the permitted disclosures described in subsection (a)), the Plan Sponsor must agree that it will do the following:

- (i) Not use or further disclose PHI other than as permitted or required by the Plan or required by law;
- (ii) Bind any agent or subcontractor, to whom it provides PHI, to the same restrictions and conditions for use and disclosure that apply to it;
- (iii) Not use or disclose PHI for employment-related actions or decisions, or for any of its other benefits or employee benefit plans, unless pursuant to a HIPAA compliant authorization;
- (iv) Report to the Plan any impermissible use or disclosure of PHI of which it becomes aware;
- (v) Permit an individual to inspect and copy his PHI, and request and receive an accounting of disclosures of his PHI, as required under HIPAA;
- (vi) Make PHI available to a Participant for amendment and to incorporate amendments to PHI as required under HIPAA;
- (vii) Make its internal practices, books and records, relating to the use and disclosure of PHI received from the Plan, available to HHS for purposes of determining the Plan's HIPAA compliance;
- (viii) To the extent feasible, return or destroy all PHI received from the Plan and maintained in any form and retain no copies when it is no longer needed for the purpose for which disclosure was made, or if return or destruction is not feasible, limit further uses and disclosures to the purposes that make return or destruction of the information infeasible;
- (ix) Establish and maintain adequate separation between it and Plan; and
- (x) Provide written certification to the Plan of this Plan provision permitting disclosure of PHI by or for the Plan to the Plan Sponsor and its agreement to these conditions of disclosure.

Section 4 - Plan Sponsor's Security Obligations For E-PHI

If the Plan Sponsor creates, receives, maintains or transmits E-PHI on the Plan's behalf, it will do the following as required by the security standards under HIPAA:

- (a) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of such E-PHI;
- (b) Ensure that adequate separation between the Plan and Plan Sponsor is supported by reasonable and appropriate security measures;
- (c) Ensure that any agent or subcontractor to whom it provides E-PHI agrees to implement reasonable and appropriate security measures to protect the E-PHI; and
- (d) Report to the Plan any Security Incident involving E-PHI of which it becomes aware.

Section 5 - Adequate Separation Between Plan and Plan Sponsor

Only the Trustees and Welfare Fund Coordinators for the Union District Councils with whom the Trustees have an agreement for assistance with Plan administration (while such agreement remains in effect), will be given access

to PHI disclosed by the Plan to the Plan Sponsor. The access given will be restricted to administrative functions performed by such persons for Plan.

Section 6 - Disciplinary Policy For Non-Compliance Issues

The Plan Sponsor will establish and maintain an effective disciplinary policy to resolve issues of non-compliance by individuals with authorized access to PHI, with the restrictions and limitations described in this Article and the Plan's HIPAA administrative policies and procedures. This disciplinary policy may include any of the following disciplinary actions as the Plan Sponsor deems appropriate based on the circumstances and severity of the non-compliance: verbal reprimands, written reprimands, counseling, retraining and discharge.

ARTICLE XIII CLAIMS AND APPEAL PROCEDURES

Section 1 – Purpose of Claims and Appeal Procedures

Under Department of Labor (“DOL”) regulations, Claimants are entitled to receive a full and fair review of any Claims made under the Plan. The procedures described in this Article XIII are intended to comply with those regulations by providing reasonable procedures that govern the filing of Claims for Plan benefits, notification of benefit decisions, and appeal of Adverse Benefit Determinations.

Section 2 – Related Definitions

Whenever the following terms appear as capitalized terms in this Article XIII, they will have the special meaning set forth below:

- (a) “**Adverse Benefit Determination**” means any denial, reduction, termination or failure to provide or make payment (in whole or part) of a Plan benefit. A rescission of coverage is treated as an Adverse Benefit Determination (regardless of whether it has an adverse effect on any benefit at that time). A rescission is a retroactive cancellation of coverage other than for failure to pay required self-payments;
- (b) “**Claim**” means any request for a benefit under the Plan that is made in accordance with the Plan's Claims Procedure. A communication about benefits that is not made in accordance with the Claims Procedure will not be treated as a Claim. Any request for a Plan benefit not made in accordance with the Plan's Claims Procedure is called an incorrectly filed claim; and
- (c) “**Claimant**” means an Employee, Dependent or beneficiary (or authorized representative thereof) who makes a request for a Plan benefit in accordance with Plan's Claims Procedure.

Section 3 – Authorized Representative

A Claimant has the right to appoint an authorized representative to act on the Claimant's behalf in filing a Claim and seeking an appeal of an Adverse Benefit Determination. No person will be recognized as an authorized representative until the Plan receives written notice from the Claimant of the name, address and telephone number of the authorized representative and any required supporting documentation of appointment and authority. For an Urgent Care Claim, a health care professional with knowledge of the Claimant's medical condition, such as the treating physician, will be recognized by the Plan as the Claimant's authorized representative.

Once an authorized representative is appointed, the Plan shall direct all information and notification to the authorized representative. An assignment for purposes of payment, such as to a health care provider, is not the

appointment of an authorized representative under the Plan's Claims Procedure.

Section 4 – Types of Claims

There are different categories of Claims that can be made under the Plan as discussed below. The DOL regulations have different requirements based on the type of Claim, primarily for the timeframe within which determinations must be made. It is important to follow the requirements that apply to the type of Claim being filed or appealed.

(a) “**Pre-Service Claim**” is a Claim for a benefit, the receipt of which is specifically conditioned, in whole or part, on receiving Plan approval before obtaining the medical care. This required advance approval is also called Pre-Certification. If a benefit is *not* described as being subject to Pre-Certification, no advance approval is required. Any request for advance approval of a benefit for which it is not required will not be treated as a Claim. If the Pre-Service Claim involves urgent care as described below, it will instead be treated as an Urgent Care Claim;

(b) “**Urgent Care Claim**” is a special type of Pre-Service Claim that involves urgent care. Urgent care is medical care or treatment for which application of the Pre-Service Claim time periods could seriously jeopardize the Claimant's life or health or ability to regain maximum function or would, in the opinion of a physician with knowledge of the Claimant's medical condition, subject the Claimant to severe pain that cannot be adequately managed without such care or treatment. On receipt of a Pre-Service Claim, the Plan will determine if it involves urgent care; however, if a physician with knowledge of the claimant's medical condition indicates that the Claim involves urgent care, it will be treated as an Urgent Care Claim;

(c) “**Concurrent Care Claim**” occurs when the Plan approves an ongoing course of treatment to be provided over a specified timeframe or number of treatments, and (1) there is a reconsideration of previously approved care that results in a reduction or termination of the initially approved course of treatment, or (2) there is a request to extend the initially approved course of treatment;

(d) “**Disability Related Claim**” is a Claim that is conditioned on the Plan's determination of an Employee's Total Disability based on the medical evidence presented, rather than another party's determination of Total Disability for other purposes, such as the Employee Weekly Accident and Sickness Benefit;

(e) “**Life Insurance/AD&D Claim**” is a Claim for the Employee Life Insurance Benefit or the Employee Accidental Death and Dismemberment Benefit under the Plan; and

(f) “**Post-Service Claim**” is a Claim for a benefit under the Plan that is not included in the categories of Claims defined above (i.e., is *not* a Pre-Service Claim, Urgent Care Claim, Concurrent Care Claim, Disability Related Claim or Life Insurance/AD&D Claim).

The type of Claim is determined initially when the Claim is filed. However, a Claim may be recharacterized if the nature of the Claim changes as it proceeds through the claims process. For example, a Claim may initially be an Urgent Care Claim, but if the urgency subsides, it may be recharacterized as a Pre-Service Claim.

Section 5 – Claims Procedure

(a) **How to File a Claim for Benefits:** To receive a Plan benefit or determination affecting a Plan benefit (other than an Urgent Care Claim), a Claimant (or authorized representative) must file a written claim with the Plan, or with such other person or entity that has been designated by the Plan to receive and handle Claims. Claims must be timely filed based on the requirements described below. Unless otherwise stated, Claims must be filed within one year after the date on which the claimed expense was incurred, or the date of the loss giving rise to the Claim. An expense is incurred on the date the service or supply giving rise to the expense is furnished.

Claim forms that may be used for filing purposes are available without charge upon request to Highmark Blue Cross Blue Shield (“Highmark”) for Medical Benefit Claims, or to the Administrative Manager for the Plan. Due to the expedited timeframes that apply, Urgent Care Claims may be filed by sending the following information by telephone, fax or email, to Highmark (unless otherwise instructed by Plan Administrator): (i) the identity of the Claimant; (ii) the specific medical condition or symptom; and (iii) the specific treatment, service or product for which approval or payment is requested.

(1) **Filing of Medical Benefit Claims:** The Plan Administrator has contracted with Highmark to receive, process and determine Claims for the Medical Benefit on the Plan’s behalf. These Claims may include Pre-Service Claims, Urgent Care Claims, Concurrent Care Claims and Post-Service Claims. Participants should refer to the separate Highmark EPO Blue Booklet (“Highmark Booklet”) for their Benefit Level (Gold, Silver, Bronze or Steel plan), for a complete description of the Claims Procedure to be followed for all Claims involving the Medical Benefit. EPO Network providers will generally file these Claims on behalf of Participants who receive their medical services and treatment. In the limited circumstances in which medical services are received from a non-EPO Network provider (such as for emergency services), the Participant must file the Claim. Participants who have questions after reading the Highmark Booklet should contact Highmark using the contact information on their ID Card or by going to www.highmarkbcbs.com. They may also call the Plan’s Administrative Manager for general assistance.

(2) **Filing of Prescription Drug Benefit Claims:** The Plan Administrator has appointed Envision RX as its Pharmacy Benefit Manager to administer the Prescription Drug Benefit. To receive this benefit, Participants should present their Rx Drug Identification Card from Envision (“ID Card”), with the physician’s prescription for a Covered Prescription, to any Participating Pharmacy. The pharmacist will fill the prescription and charge the Participant the co-payment due under the Plan. The pharmacist may ask the Participant to sign a form indicating receipt of the prescription. Any additional required filing with Envision RX will be done by the Participating Pharmacy. The presentation of a prescription at a Participating Pharmacy, with payment of the required co-payment, is not generally considered the submission of a Claim.

If a Participant pays for a Covered Prescription at a Participating Pharmacy and is eligible for reimbursement under the Prescription Drug Benefit, or pays the co-payment charged but believes the Participating Pharmacy has applied the wrong amount, the Participant can file a Claim with Envision RX to receive direct member reimbursement. The following steps must be taken to file such a Claim: (i) obtain a direct reimbursement claims form from Envision RX (available without charge upon request), and complete the top portion; (ii) ask the Participating Pharmacy to complete the remainder of the claims form, or attach an itemized receipt that includes all requested information; and (iii) mail the completed direct reimbursement claims form to the address noted on the form. All Claims for direct member reimbursement must be filed no later than one year after the date of payment for which reimbursement is claimed, or the claim will be denied as untimely. Reimbursements that are payable will be mailed directly to the Claimant.

(3) **Filing of Employee Life Insurance and Accidental Death and Dismemberment (“AD&D”) Benefit Claims:** These benefits are fully insured through a group life insurance policy (“Policy”) issued to the Fund. The current issuer of the Policy (“Insurer”) is the Union Labor Life Insurance Company. Written notice and proof of loss of a Claim for these benefits should be given to the Plan’s Administrative Manager within 90 days after the date of loss covered under the Policy, or as soon as it is reasonably possible to do so. The Administrative Manager will forward the notice and proof of loss to the Insurer for determination and payment. The Claim will not be considered received until the notice and proof of loss are received by the Insurer. The proof of loss should include all information necessary to determine the nature and date of loss, including a certified copy of the Employee’s death certificate if applicable. If approved, death and accidental death benefit proceeds will be paid directly to the Beneficiary, and accidental dismemberment

benefits will be paid directly to the Employee.

(4) **Filing of Employee Weekly Accident and Sickness Benefit Claims:** Written notice and satisfactory proof of an Employee's Total Disability must be given to the Administrative Manager as soon as possible after Total Disability begins. The Plan Administrator has appointed the Administrative Manager to handle Claims for this benefit.

(5) **Filing of Claims for All Other Benefits:** Claims for all other benefits under the Plan (such as the Dental Benefit, Vision Benefit, and reimbursement from Health Reimbursement Account) must be filed with the Plan's Administrative Manager no later than one year after the claimed expense was incurred. The Claimant should include written notice and adequate proof of the expense incurred. An expense is incurred on the date the service or supply giving rise to the expense was furnished. The Plan Administrator has appointed the Administrative Manager to handle Claims for these benefits.

Claims that are to be filed with the Plan Administrator or Administrative Manager should be mailed or faxed to:

Southern Painters Welfare Fund
Member Claims
5 Hot Metal Street, Suite 200
Pittsburgh, PA 15203-2351
(412) 431-4067 (Fax)

(b) **Incorrectly Filed Claims and Incomplete Claims:** The Plan's Claims Procedure does not apply to any request for benefits that is not made in accordance with it. For an incorrectly filed pre-service claim, the Claimant will be notified as soon as possible and no later than five days after receipt by the Plan, of the incorrectly filed claim. For an incorrectly filed urgent care claim, the Claimant will be notified as soon as possible and no later than 24 hours after receipt by the Plan, of the incorrectly filed claim. The notice will explain that the request is not a Claim and describe the proper procedures for filing a Claim. The notice may be oral unless written notice is specifically requested by the Claimant.

If the reviewer for the Plan determines that information needed to process the Claim is missing, the Claim will be treated as an incomplete claim. If an urgent care claim is incomplete, the Claimant will be notified as soon as possible and no later than 24 hours after the Plan's receipt of the incomplete claim. The notice may be oral unless written notice is specifically requested by the Claimant. It will explain the information necessary to complete the Claim and specify a reasonable time of at least 48 hours in which to complete the Claim. The Claim will be decided as soon as possible, and within 48 hours after the earlier of receipt of the necessary information or the end of the period allowed to complete the Claim.

For any other type of incomplete claim, the Plan's reviewer may deny the Claim or grant an extension of time. If it grants an extension of time, the Claimant must be given notice which describes the missing information and a period of at least 45 days in which to provide it. The timeframe for deciding the Claim will then be suspended from the date notice is received by the Claimant until the earlier of receipt of the information or the end of the period allowed to provide it. If the information is provided within the time allowed, the reviewer will decide the Claim within the extended period described in the notice. If it is not provided within the time allowed, the Claim may be decided without the requested information.

(c) **Timeframes for Deciding Initial Claims:** Each Claim will be processed by the reviewer for a determination of whether and in what amount it is covered under the Plan. The Plan documents and governing instruments will be consulted as needed. Notice of the determination will be given to the Claimant within a reasonable time after receipt of the Claim and the following timeframes, unless the parties voluntarily agree to an

extension of time:

(1) **Medical Benefit Claims:** Refer to the Highmark Booklet for a complete description of the timeframes for Highmark to process and decide the Claim, and provide an Explanation of Benefits (“EOB”) to the Claimant. The EOB will describe what is covered, what is not covered with an explanation of why it is not covered, and other important information including a description of appeal rights and any available expedited review process. The EOB is intended to satisfy the Plan’s notice requirements for the initial Claim determination. The timeframes differ depending upon the category of Claim and are generally as follows.

Pre-Service Claims should be decided within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the Claim.

Urgent Care Claims should be decided as soon as possible considering the medical exigencies, but no later than 72 hours after receipt of the Claim.

Concurrent Care Claims that involve a request to extend urgent care treatment and are made at least 24 hours before the initially approved treatment ends, should be decided within 24 hours after receipt of the Claim; otherwise, they should be decided within the timeframe that applies for that type of Claim. Concurrent Care Claims that involve a decision to reduce or terminate an initially approved course of treatment should be decided, and notice given, sufficiently in advance of the reduction or termination to allow an appeal before the reduction or termination.

Post-Service Claims should be decided within a reasonable time, but no later than 30 days after receipt of the Claim.

(2) **Prescription Drug Benefit Claims:** In most cases, this benefit will be provided at the time the Covered Prescription is filled at the Participating Pharmacy. If it is not and a Claim for direct member reimbursement is filed with Envision RX, notice of the determination should be given within 30 days after the Claim is filed. If more time is needed due to matters beyond the control of Envision RX, this 30-day period may be extended for up to 15 days if written notice is given to the Claimant before the end of the 30-day period. This notice must explain why more time is needed and when a determination is expected.

(3) **Life Insurance and AD&D Benefit Claims:** Notice of determination will be given to the Claimant within 90 days after the Claim is filed. If more time is needed due to matters beyond the reviewer’s control, this 90-day period may be extended for up to 90 days if written notice is given to the Claimant before the initial 90-day period ends. This notice must explain why more time is needed and when a determination is expected. If it is needed because the Claimant did not provide information necessary to decide the Claim, the reviewer’s response period will be suspended from the date of notice until the information is provided (or until the deadline for providing it, if earlier). These Claims will be decided and if approved, paid, by the Insurer.

(4) **Employee Weekly Accident and Sickness Benefit Claims:** If the Claim is a Disability Related Claim because the Plan decides if the Claimant is “Totally Disabled” based on the medical evidence submitted, notice of determination will be given within 45 days after the Claim is filed. If more time is needed due to matters beyond the Plan’s control, this 45-day period may be extended for up to 30 days if written notice is given to the Claimant before the initial 45-day period ends. This notice must explain (i) why more time is needed and when a determination is expected, (ii) the standards on which entitlement to the benefit is based, (iii) the unresolved issues that prevent a determination, and (iv) the additional information that is needed to resolve those issues with a response deadline of at least 45 days. A second 30-day extension is permitted subject to the same requirements that apply the first 30-day extension, if notice is

given before the first 30-day extension ends. If the extension of time is needed because sufficient information has not been provided, the reviewer's response period will be suspended from the date of notice until the information is provided (or until the deadline for providing it, if earlier).

(5) **All Other Claims:** For all other Claims that are not governed by the above timeframes, notice of determination will be given to the Claimant within 30 days after the Claim is filed. If more time is needed due to matters beyond the Plan's control, this 30-day period may be extended for up to 15 days if written notice is given to the Claimant before the 30-day period ends. This notice must explain why more time is needed and when a determination is expected. If it is needed because the Claimant did not provide information necessary to decide the Claim, it must describe the specific information that is needed and provide a response deadline of at least 45 days. In this case, the reviewer's response period will be suspended from the date of notice until the information is provided (or until the deadline for providing it, if earlier).

(d) **Notice of Initial Benefit Decision:** For Pre-Service and Urgent Care Claims, written notice of the decision will be provided regardless of whether it is adverse. Otherwise, written notice is required only if the decision is an Adverse Benefit Determination. For Urgent Care Claims, notice may be provided orally but written notice must be furnished within three days after the oral notice. Written notice of the decision must be provided in a manner calculated to be understood by the Claimant and include the following information to the extent applicable:

- (1) Information sufficient to identify the Claim, including date of service, health care provider and Claim amount;
- (2) The specific reasons for the Adverse Benefit Determination, including any denial code and its meaning and any Plan standard used in denying the Claim;
- (3) A reference to the specific Plan provisions on which the decision is based;
- (4) A statement advising the Claimant of the right to request diagnosis and treatment codes and their corresponding meanings;
- (5) A description of any additional material or information necessary to perfect the Claim and why it is necessary;
- (6) A copy or description of the Plan's claims and appeal procedures, time periods for appeal of the decision, any external review rights, the right to obtain information about such procedures and the right to sue in federal court after exhausting them;
- (7) A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or statement that such information will be provided free of charge upon request);
- (8) If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided at no charge upon request;
- (9) If the decision is based on a Plan standard (such as a medical necessity standard), a description of such standard;
- (10) An explanation of any expedited review methods available; and

(11) Contact information for the DOL's Employee Benefits Security Administration and any applicable state consumer assistance program.

Section 6 – Appeal Procedure

(a) **How to Appeal an Adverse Benefit Determination:** Claimants have the right to appeal an Adverse Benefit Determination and receive a full and fair review in accordance with the Appeal Procedures described in this Section. Except for appeals of Urgent Care Claims which may be submitted orally, an appeal is filed by submitting a written request for review to the appropriate party, with an explanation of why the requested benefit should be paid and any supporting information or documentation, in accordance with the following requirements.

(1) Appeals of Medical Benefit Claims:

First Level of Internal Appeal With Highmark (Mandatory): To appeal an Adverse Benefit Determination of a Claim for a Medical Benefit, the Claimant must follow the Appeal Procedure described in the Highmark Booklet for the Claimant's Benefit Level (Gold, Silver, Bronze or Steel Plan). The appeal must be submitted to Highmark within 180 days after the Claimant receives notice of the Adverse Benefit Determination on the initial filing. For an appeal of the Plan's decision to reduce or terminate an initially approved course of treatment, the Claimant must file the appeal within 30 days after receiving notice of this decision, or the Plan may reduce or terminate such course of treatment. Failure to comply with the filing deadlines may cause the Claimant to forfeit any right to further review of the Adverse Benefit Determination under the Plan's Appeal Procedures or in a court of law.

For appeals that are timely and properly submitted, Highmark will receive, process and determine the appeal. If Highmark makes an Adverse Benefit Determination on the appeal, written notice of the decision will be provided to the Claimant.

The Claimant may request a second level of internal appeal with the Plan. It is described in the following Section and is a voluntary level of appeal.

If the Adverse Benefit Determination by Highmark qualifies for "External Review", the Claimant may also choose to pursue that process as described below.

Second Level of Internal Appeal With Plan (Voluntary):

Claimants who receive an Adverse Benefit Determination from Highmark on the first level of internal appeal, may request a second level of internal appeal with the Plan. *This second level of internal appeal is voluntary.* Claimants will have sixty (60) days after receipt of an Adverse Benefit Determination from Highmark in which to request a further review by the Plan. The request must be in writing and mailed or faxed to the Plan Administrator at the address listed below. It should include an explanation of why the requested benefit should be paid and any supporting information or documentation.

The following rules apply to this voluntary second level of internal appeal:

- (i) The Plan waives any right to assert that a Claimant has failed to exhaust administrative remedies because of failure to submit to it;
- (ii) Any statute of limitations or other defense based on timeliness will be tolled while it is pending;
- (iii) It is available only after timely exhaustion of the first level of appeal with Highmark;

(iv) Additional information is available upon request to enable an informed judgment about whether to participate in the process (this decision will have no effect on other Plan benefits). It will include an explanation of any representation rights, the process for selecting a decision-maker and any circumstances that may affect its impartiality; and

(v) No fees or costs will be imposed for participation.

External Review by Independent Review Organization: Certain Adverse Benefit Determinations by Highmark are eligible for “External Review” by an Independent Review Organization (“IRO”). The External Review procedures, and related rules and requirements, are described in greater detail in the Highmark Booklet. The External Review process is available only for Adverse Benefit Determinations that involve medical judgment (such as medical necessity or appropriateness, health care setting, level of care, effectiveness of a covered service or determination that a treatment is experimental or investigational), or rescissions of coverage. If an IRO performs an external review of an internal Adverse Benefit Determination in accordance with the External Review procedures and reverses that decision, coverage or payment for the claimed benefits will be paid immediately upon the Plan’s receipt of the IRO notice. Claimants who receive notice of an Adverse Benefit Determination that is eligible for External Review will have four months in which to request it.

(2) **Appeals of Life Insurance/AD&D Benefit Claims:** To appeal an Adverse Benefit Determination of a Claim for Life Insurance or AD&D Benefits, the Claimant must mail or fax written notice to the Plan Administrator at the address listed below, within 60 days after receipt of the notice of Adverse Benefit Determination (or as otherwise instructed in the notice received from the Insurer).

(3) **Appeals of All Other Claims:** To appeal an Adverse Benefit Determination for any other type of Claim, the Claimant must mail or fax written notice to the Plan Administrator at the address listed below within 180 days after receipt of the Adverse Benefit Determination (or as otherwise instructed in the notice).

If a request for appeal is not filed timely in accordance with these requirements, the Adverse Benefit Determination on the initial filing of the Claim will be final. The address to be used for submitting appeals to the Plan Administrator is as follows:

Southern Painters Welfare Fund
Member Appeals
5 Hot Metal Street, Suite 200
Pittsburgh, PA 15203-2351
(412) 431-4067 (Fax)

(b) **General Appeal Rights and How Appeals Will be Decided:** This Section describes a Claimant’s general rights for internal appeals and how they will be decided. Note that internal appeals for Medical Benefit Claims will be handled as described in the Highmark Booklet, and internal appeals for Life Insurance/AD&D Benefits will be handled by the Insurer in accordance with the Policy through which they are provided.

Claimants may submit written comments, documents, records and other information in support of the appeal, as well as testimony in the appeal process. If the Plan or its designated reviewer considers, relies upon or generates new or additional evidence in deciding the Claim, the Claimant will be provided with such evidence sufficiently in advance of the due date for the final decision to give Claimant an opportunity to respond, in accordance with applicable law.

Claimants will, upon request and free of charge, be given reasonable access to and copies of all documents, records and other information relevant to the Claim, which may include the right to review the Claim file. The Plan will determine which information is relevant in accordance with applicable law. If the advice of a medical or vocational expert was obtained by the reviewer for consideration in its review of the initial Claim, the names of the experts will be provided to the Claimant upon request, regardless of whether the advice was relied on by the Plan.

Before issuing a final decision on appeal that is based on a rationale that was not included in the initial determination, the Claimant will be provided, free of charge, with that rationale as soon as possible and sufficiently in advance of the final decision to give Claimant an opportunity to respond, in accordance with applicable law.

The reviewer on appeal will consider all comments, documents, records and information submitted by Claimant and relating to the Claim, without regard to whether it was submitted and considered in the initial determination. No deference will be given to the initial benefit decision.

The review on appeal will be conducted by the Plan Administrator or person or entity appointed by it to consider and decide the appeal, provided the reviewer on appeal did not make, and is not a subordinate of the person who made, the initial decision.

If the Adverse Benefit Determination is based in whole or part on medical judgment, the reviewer will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment, who was not consulted, and is not a subordinate of a health care professional who was consulted, for the initial benefit decision.

(c) **Timeframes For Deciding Appeals:** Each appeal will be reviewed for a determination of whether and in what amount the Claim is covered under the Plan. Notice of the decision will be given to the Claimant within a reasonable time after receipt of the appeal and the following timeframes, unless the parties voluntarily agree to an extension of time:

(1) **Medical Benefit Claims:** Refer to the Highmark Booklet for a complete description of the timeframes that apply for a first level internal appeal or External Review of a Claim. A voluntary second level of internal appeal will be presented to the Board of Trustees for consideration and a decision at its next regularly scheduled Board meeting. The Board may, in its discretion, hear and decide the appeal in a more expeditious manner or appoint another person or entity to decide the appeal;

(2) **Life Insurance/AD&D Claims:** The Claimant will be notified of the decision within 60 days after the appeal is filed. If additional time is needed due to special circumstances, this 60-day period may be extended for up to 60 days if the Claimant is notified in writing of the extension, why it is needed and when a decision is expected, before the end of the initial 60-day period;

(3) **Employee Weekly Accident and Sickness Benefit Claims:** If it qualifies as a Disability Related Claim because of the Plan's determination of Total Disability based on the medical evidence submitted, and the reviewer on appeal is someone other than the Board of Trustees, the Claimant will be notified of the decision within 45 days after the appeal is filed. If additional time is needed due to special circumstances, this 45-day period may be extended for up to 45 days if the Claimant is notified in writing of the extension, why it is needed and when a decision is expected, before the end of the initial 45-day period.

If the reviewer is the Board of Trustees, a decision on the appeal will be made no later than the first regularly scheduled Board meeting that immediately follows the filing. If the appeal is filed within 30 days of such meeting, the Board will have until its second regularly scheduled Board meeting to decide the appeal. If more time is needed because of special circumstances, the Board will have until its third regularly scheduled Board meeting to decide the appeal provided the Claimant is notified in writing, before such

second Board meeting, of the extension, why it is needed and when a decision will be made. Written notice of the final decision on appeal must be given to the Claimant as soon as possible and within five days after it is made;

(4) **All Other Claims:** For all other Claims on appeal that are not governed by the above timeframes and are decided by the Board of Trustees, a decision on the appeal will be made no later than the first regularly scheduled Board meeting that immediately follows the filing. If the appeal is filed within 30 days of such meeting, the Board will have until its second regularly scheduled Board meeting to decide the appeal. If more time is needed because of special circumstances, the Board will have until its third regularly scheduled Board meeting to decide the appeal provided the Claimant is notified in writing, before such second Board meeting, of the extension, why it is needed and when a decision will be made. Written notice of the final decision on appeal must be given to the Claimant as soon as possible and within five days after it is made.

If the reviewer on appeal is someone other than the Board of Trustees, the Claimant will be notified of the decision within 60 days after the appeal is filed. If additional time is needed due to special circumstances, this 60-day period may be extended for up to 60 days if the Claimant is notified in writing of the extension, why it is needed and when a decision is expected, before the end of the initial 60-day period.

(d) **Notice of Adverse Benefit Determinations on Appeal:** Written notice of an Adverse Benefit Determination on appeal will be provided to Claimant. It must be written in a manner calculated to be understood by Claimant and include the following information as applicable:

- (1) Specific reasons for the decision including any denial codes and their meanings and any Plan standard used in denying the Claim, with a discussion of the decision;
- (2) A reference to specific Plan provisions on which the decision is based;
- (3) A statement advising Claimant of the right to request diagnosis and treatment codes and their meanings;
- (4) A statement disclosing any internal rule, guidelines, protocol or similar criterion that was relied upon in making the decision (or a statement that it was relied upon and will be provided free of charge upon request);
- (5) A description of any available external review process;
- (6) A statement of the right to sue in federal court;
- (7) An explanation of the right to receive, on request and free of charge, reasonable access to or copies of all documents, records and other information relevant to the determination;
- (8) If the determination involves scientific or clinical judgment, either an explanation of such judgment applying the Plan's terms to the Claimant's medical circumstances, or a statement that it will be provided at no charge on request; and
- (9) Contact information for the DOL's Employee Benefits Security Administration and any applicable state consumer assistance program.

Notice of an adverse determination on appeal of an Urgent Care Claim may be provided orally, but written notification must be furnished within three days after the oral notice.

(e) **Finality of Decision on Appeal:** Any decision on appeal of a Claim that is made in accordance with the Plan's Appeal Procedure is final and binding on all persons and entities.

(f) **Legal Action:** In no event may legal action be brought by or on behalf of any individual to recover benefits under the Plan unless the individual or his authorized representative has first timely filed a written notice of Claim and fully complied with and exhausted all requirements of the Plan's Claims and Appeal Procedures. Further, in no event may legal action be brought later than one year after a final determination of a Claim under the Plan. For Life Insurance/AD&D Claims, the time limit and limitations for bringing legal action will be modified by any conflicting provisions of the Policy through which such benefits are insured and provided.

ARTICLE XIV COORDINATION OF BENEFITS

Section 1 – General Rules for Coordination of Benefits

The Plan has coordination of benefit ("COB") rules that apply whenever a Participant has medical coverage under any Other Plan in addition to this Plan. The COB rules are generally described in this Article. Highmark will administer coordination of benefits for the Medical Benefit on the Plan's behalf. Refer to the Highmark Booklet for a further discussion of the COB rules that Highmark will follow. The purpose of the COB rules is to coordinate medical coverage so that the total medical benefits paid are not more than 100% of the Allowable Expense. Participants who have medical coverage under any Other Plan (in addition to this Plan) are obligated to promptly notify Highmark or the Administrative Manager of such other medical coverage so that the COB rules can be properly applied to the processing and payment of Claims involving medical benefits.

Section 2 – Definitions for COB Rules

(a) **"Allowable Expense"** means any necessary, reasonable and customary medical expense, at least a portion of which is covered by one of the plans covering the Participant for whom claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

(b) **"Other Plan"** means any plan providing hospital or medical benefits or services, including but not limited to the following:

- (1) Group, blanket or franchise insurance or arrangement of coverage for individuals in a group (whether insured or self-insured);
- (2) Service plan contracts, group practice, individual practice and other pre-payment coverage;
- (3) Any coverage under labor-management trustee plans, union welfare plans, employer plans, employer organization plans or employee benefit organization plans;
- (4) Any coverage under governmental programs or required or provided by any statute, including Medicare Parts A, B and C;
- (5) Automobile medical insurance including uninsured or underinsured motorist coverage, no-fault insurance coverage, or medical payment coverage;
- (6) School-sponsored insurance;
- (7) Casualty and liability insurance; and

- (8) Excess insurance.

Section 3 - Effect of COB Rules on Benefits

Under the COB rules, payment is made on a primary-secondary basis. The primary plan will calculate its benefits and pay first without regard to the other plan. The secondary plan will then reduce its benefits as needed, based on the amount paid by the primary plan, so that the total benefits paid or provided by all plans do not exceed 100% of the Allowable Expense. No plan will pay more than it would pay without the coordinating provision.

Any type of automobile medical insurance, as well as casualty, liability and excess insurance coverage, is always the primary plan.

A plan without a coordinating provision is always the primary plan.

If all plans have a coordinating provision, the follow COB rules apply:

- (a) If there is both employee coverage and dependent coverage, the employee coverage is primary and the dependent coverage is secondary;
- (b) If a dependent child is covered under both parents' plans, the plan covering the parent whose birthday, excluding the year of birth, occurs earlier in the calendar year is the primary plan, and the plan covering the parent whose birthday, excluding the year of birth, falls later in the calendar year is the secondary plan.

If both parents have the same birthday, the plan covering the parent longer is the primary plan, and the plan covering the parent for the shorter time is the secondary plan;

- (c) If the dependent child's parents are separated or divorced or have never been married, the following rules apply:
- (1) A plan of the custodial parent pays first;
 - (2) A plan of a married custodial parent's spouse pays next;
 - (3) A plan of the non-custodial parent pays next; and
 - (4) A plan of a married non-custodial parent's spouse pays next.

Regardless of the above rules, if there is a court decree which specifies the parent who is financially responsible for the child's medical expenses, the coverage of that parent pays first;

- (d) Coverage for a child of parents who live together but have never been married is determined in the same way as for children of married parents (i.e., the birthday rule applies). If there is a court decree which awards joint custody of a child without assigning financial responsibility for medical expenses and the child is covered under more than one group health plan, the birthday rule also applies; and
- (e) If none of the above rules applies, the plan covering the person for the longest time is the primary plan. However, the plan covering the person as an employee other than a laid-off or retired employee or as such employee's dependent, will be determined before the plan covering the person as a laid-off or retired employee or such person's dependent. If the other plan does not have this rule for laid-off or retired employees and the plans do not agree on the order of benefits, this rule is disregarded.

Section 4 - Coordination of Benefits with Medicare and Medicaid

When the Other Plan is Medicare, the benefits of this Plan will be coordinated in a manner that complies with Medicare and its regulations and, when permissible, will be determined after the benefits of Medicare. A Participant who is eligible for Medicare will be considered insured under Medicare regardless of whether he has registered or enrolled. There are certain instances in which the Plan is required to pay primary to Medicare, such as for Employees with active current employment status who are age 65 or older and their Dependent spouses who are age 65 or older; Participants with end-stage renal disease for a limited time; and disabled Participants under age 65 with current employment status and their Dependents under age 65.

When the Other Plan is Medicaid, the Plan will assume primary payer status for any Participant or Alternate Recipient who is entitled to benefits under a state plan for medical assistance approved under Medicaid, unless otherwise required by law. If the Plan has a legal obligation to pay benefits and payment has been made under Medicaid, payment for benefits under the Plan will be made in accordance with state Medicaid law, which provides that the state acquires the rights of the Participant or Alternate Recipient for payment of such benefits.

Section 5 - Right to Receive and Release Necessary Information

The Plan may release to or obtain from any other person or entity information that it deems necessary to administer the coordination of benefit (COB) rules, and to pay to any person or entity any amount it determines is owed to satisfy the intent of these provisions and applicable law. Any amount so paid will fully discharge the Plan from further liability under the Plan to the extent of such payment. If a Participant or other person claiming benefits does not provide the Plan with the information it needs to administer the COB rules, the claim may be denied.

Section 6 – Overpayments and Underpayments

If benefits have been paid by the Other Plan that should have been made by the Plan under the coordination of benefit (COB) rules, the Plan has the right, exercisable solely in its discretion, to pay the amount owed to the Other Plan. If the Plan pays a Participant more than it owes under the Plan, the Participant shall promptly reimburse the Plan for the excess. The Plan reserves the right to recover any overpayment that it makes by legal action or offset of future benefit payments owed to the Participant to or for whom the overpayment was made.

ARTICLE XV ADDITIONAL MISCELLANEOUS BENEFIT PROVISIONS

SECTION 1 - NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

The Plan will comply with this federal law for the medical benefits it provides for pregnancy and childbirth. It will not restrict those medical benefits or require pre-authorization for a hospital stay for childbirth, for the mother or newborn child, of up to 48 hours following a normal vaginal delivery or 96 hours following a delivery by cesarean section. Also, it will not set the level of medical benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96 hour) stay is treated less favorably than the earlier portion of the stay. Federal law does not prohibit the attending provider, after consulting with the mother, from discharging the mother or newborn earlier than such 48 or 96-hour period. The Plan may require that a provider obtain authorization if a longer period of hospital stay is required.

SECTION 2 – USERRA AND QUALIFIED MILITARY SERVICE LEAVE OF ABSENCE

The Plan will be administered in a manner that complies with the federal law known as the Uniformed Services Employment and Re-Employment Rights Act of 1994 as amended and the Plan's related administrative policies and procedures ("USERRA").

If an Employee takes a qualified military service leave of absence that is protected under USERRA (e.g., active or inactive duty training or active duty in the United States Armed Forces or National Guard), Employer contributions that have been credited to his benefit under the Plan will be protected as required. If his qualified military service ends honorably and he returns to work or seeks re-employment with an Employer timely, his Personal Account balances will be reinstated. If an Employee is discharged dishonorably or does not return to work or seek re-employment timely, he will forfeit any reinstatement rights that would otherwise be required under USERRA.

Employees who have medical coverage under the Plan when they begin a qualified military service leave of absence may continue that medical coverage for up to 24 months while performing qualified military service. If the leave of absence is less than 31 days, the medical coverage will be provided on the same terms that were in effect before it began. If the leave of absence is longer than 30 days, the right to continue medical coverage under USERRA will be provided in the same manner as COBRA Coverage (e.g., the COBRA Coverage self-payment rates and election and payment deadlines will apply). Failure to comply with the COBRA Coverage rules will result in a loss of the right to continue medical coverage under USERRA. The Plan may, in its discretion, extend an election period if it determines that it was impossible or unreasonable for an Employee to make a timely election due to the qualified military service. Any continuation coverage that is provided will concurrently satisfy the Plan's obligations under COBRA and USERRA.

Employees with an honorable or protected discharge from qualified military service must return to employment or seek reemployment with an Employer within the following time periods in order to be protected by USERRA:

- (a) 90 days from the date of discharge if the qualified military service is more than 180 days;
- (b) 14 days from the date of discharge if the qualified military service is more than 30 days but less than 180 days; and
- (c) By the start of the first full regularly scheduled work period after the date of discharge (plus travel time and 8 hours) if the qualified military service is less than 31 days.

If an Employee is hospitalized for or recovering from an illness or injury incurred during qualified military service, these time periods will be extended for a recovery of up to two years.

Employees who have questions about taking military leave should speak directly with their Employer. They should contact the Administrative Manager if they have questions about how military leave will affect their coverage under the Plan. USERRA rights are subject to change as the law changes. Plan coverage will be provided only as required by law. An Employee who leaves employment for military service should notify the Employer and Administrative Manager as soon as possible to ensure protection of his rights.

SECTION 3 – FAMILY AND MEDICAL LEAVE OF ABSENCE

The Plan will be administered in a manner that complies with the federal law known as the Family and Medical Leave Act of 1993 and its corresponding regulations, as amended ("FMLA"). Employees who take a family and medical leave of absence ("FMLA Leave") under FMLA may continue their medical coverage under the Plan on the same terms as if they were still working, as required by FMLA and the Plan's related administrative policies.

Not all Employers are required to grant FMLA Leave, and Employees must satisfy certain minimum work requirements with a FMLA-covered Employer to qualify. Depending upon the reason for the absence, FMLA Leaves may be taken on an unpaid basis for up to 12 or 26 weeks during a 12-month period. Generally, they are available when an Employee is unable to work for any of the following reasons: (a) birth or care of a newborn child; (b) a child's placement with the Employee for adoption or foster care; (c) to care for a spouse, child or parent with a serious health condition; (d) an Employee's serious health condition; (e) qualifying needs that arise due to family members being called to or on certain active duty for the National Guard or Reserve; or (f) to care for a current member of the Armed Forces, National Guard or Reserves, who is medically unfit to perform duties due to a serious injury or illness incurred in the line of duty, when the Employee is the spouse, child, parent or next of kin to such person.

The Employer must properly grant the FMLA Leave, provide notice to the Administrative Manager and comply with the Plan's administrative policies. Employees will also have certain obligations, such as notifying the Employer of the need and reason for the leave and providing the necessary substantiating information. Employees with questions about their eligibility or obligations should contact their Employer or the Administrative Manager.

SECTION 4 - WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

As required by this federal law, the Plan's medical coverage includes medical and surgical benefits for breast reconstructive surgery that is part of a covered mastectomy procedure. This coverage will include coverage for: (a) reconstruction of the breast on which the mastectomy is performed; (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (c) prostheses and physical complications for all stages of the mastectomy including lymphedemas, all in a manner determined in consultation with the attending physician and the patient. These benefits are subject to the Plan's appropriate cost control provisions, such as deductibles and coinsurance.

SECTION 5 – QUALIFIED MEDICAL CHILD SUPPORT ORDERS (“QMCSO”) AND NATIONAL MEDICAL SUPPORT NOTICES

As required by federal law, the Plan will enroll an Employee's Dependent children in the Plan for medical coverage when required by a Qualified Medical Child Support Order (“QMCSO”). A QMCSO is a judgment, decree or order (“Order”) that is issued by a court of competent jurisdiction and satisfies the requirements of ERISA Section 609(a). The Plan will also comply with a National Medical Support Notice (“Notice”) that is required to be treated as a QMCSO under ERISA Section 609(a). A Notice is a standardized medical child support order used by state child support enforcement agencies to enforce medical child support obligations.

Upon receiving an Order or Notice, the Plan will notify the affected Employee and representative of the child (which may include the issuing state or local agency) of its administrative procedures for determining QMCSO status and of its determination as soon as it is made.

To qualify as a QMCSO, the Order or Notice must satisfy the following requirements:

- (a) Be issued by a state court or agency of competent jurisdiction pursuant to a domestic relations law or other state law relating to medical child support;
- (b) Require that the child be provided with the medical coverage available under the Plan regardless of whether the Employee has custody;
- (c) Clearly specify the Employee's name and last known mailing address, and the name and address of each child covered by the Order or Notice (or for a Notice, the address of an official of a state or political subdivision that may be substituted for the child);

(d) Provide a reasonable description of the medical coverage and length of time for which it is to be provided; and

(e) Identify this Plan as being affected by the Order or Notice.

Promptly upon receipt, Employers should forward Notices to the Administrative Manager for handling.

Participants may obtain a copy of the Plan's QMCSO procedures, free of charge, upon written request to the Administrative Manager. These procedures explain, in greater detail, the requirements for QMCSOs, the actions to be taken by the Plan upon receipt of an Order or Notice, and how a determination will be made as to its qualified status.

SECTION 6 –SUBROGATION AND REIMBURSEMENT RIGHTS FOR RECOVERY

The Plan's medical coverage is intended to provide financial protection for Participants (Employees and Dependents) for illness or injury only when no other party is legally obligated to pay for it. If a Participant suffers an illness or injury that results or is alleged to result from a third party's negligence or wrongful action, or for which worker's compensation benefits are payable or allegedly payable, the Plan will have subrogation, reimbursement and recovery rights for medical benefits that it advances or pays for such illness or injury (collectively called an "Injury").

To recover any benefits that it pays for an Injury, the Plan will have all claims, demands, actions and rights of recovery that the Participant has against a responsible third-party or insurer (including but not limited to the Participant's insurer including for uninsured or under-insured motorist coverage or homeowner's coverage), because of the alleged negligence or wrongful action, or for worker's compensation benefits that are payable for the Injury. By participating in the Plan, Participants automatically assign these rights to the Plan.

The Plan may condition payment of benefits on the Participant and, if applicable, the Participant's attorney, signing its subrogation, assignment and reimbursement agreement, containing language acceptable to the Plan. The Plan may require that the Participant and, if applicable, the Participant's attorney, sign this agreement before it will pay any benefits or at any time thereafter pending recovery of the benefits. The Plan may also withhold all future benefit payments if the Participant signs the agreement but later violates its terms.

If the Plan has already paid benefits to the Participant or a medical provider on the Participant's behalf for the Injury when another person or entity is legally liable for it, the Plan has an automatic right of reimbursement for its payments from the first proceeds of any award, settlement, judgment or other amount that may be received by the Participant or by another person or entity (such as an attorney or trust) on the Participant's behalf, regardless of how the proceeds are characterized (for example, as payment for pain and suffering, lost income, past or future medical benefits, worker's compensation benefits, disability benefits, loss of consortium, emotional distress or other specified damages). The Plan's right of recovery shall be a prior lien against the proceeds and will not be defeated or reduced by any make-whole or other equitable doctrine that allocates the proceeds to non-medical expense damages. The Participant agrees to reimburse the Plan from any such recovery up to the amount paid by the Plan to or for the Participant. Any recovery received by or for the Participant shall be held in constructive trust for the benefit of the Plan, to the extent of the Plan's prior payments. If the Participant is represented by an attorney and there is a dispute over the amount required to reimburse the Plan, the money will be held in escrow by the attorney until the dispute is resolved. The Plan also has the right to withhold future payments and offset future obligations against any benefits the Participant, or a person or entity on the Participant's behalf, have received as a third-party recovery.

As part of the Plan's subrogation and reimbursement rights, any recovery from a third-party will be applied first to reimburse the Plan or discharge its obligations for future payments, before payment of attorneys' fees and costs or other legal expenses, even if the Participant is not paid for all of the Participant's claim for damages against the third-party, and even if the payment received is for (or described as being for), damages other than health care expenses paid or covered by the Plan. This means that any third-party payment will be automatically deemed to first cover medical expenses previously paid or covered by the Plan for the Participant, and will not be allocated to or designated as reimbursement for any other costs or damages the Participant may have incurred, until the Plan is reimbursed in full or otherwise made whole. The Plan has no obligation to pay any amounts spent by the Participant or the Participant's attorneys in legal fees and costs of litigation in pursuing claims against others. The Plan Administrator may, in its sole discretion, reduce the amount to be restored to the Plan by the attorneys' fees and legal expenses in part or whole.

The Plan's subrogation and reimbursement rights apply to and against all Participants and their beneficiaries, heirs, guardians, legal representatives, assignees and estate. By participating in the Plan, Participants agree to execute any documents and instruments and take any legal or other action that the Plan considers necessary to protect its rights. Participants also agree to take no actions that could jeopardize the Plan's position or otherwise prejudice its rights. Participants agree to notify the Plan Administrator before starting legal action or filing a lawsuit against a third-party that is allegedly liable or an insurer with respect to the Injury, to allow the Plan to intervene if it asks to do so, and to make no settlement and grant no release without the prior written consent of the Plan. Any violation of these requirements will automatically release the Plan from its obligation to pay benefits otherwise payable under the Plan. If the Plan takes legal action to enforce its rights, it has the right to recover its costs, expenses and attorneys' fees in doing so.

The Plan shall also have the right to recover benefits paid in error because of false or erroneous representations made by the Participant, a provider or other third party, or a Participant's failure to notify the Plan as required (such as notice of a change in Dependent status or other change affecting coverage). If the Plan makes an improper payment of benefits for any of these reasons and does not recover it in full after notice and demand, the Plan may take legal action to recover the benefits paid, or may withhold payment of other benefits due to or for the Participant for related or unrelated claims as an offset against what is owed until recovery in full.

SECTION 7 – PLAN'S RIGHT TO DEFEND CLAIMS

Upon request by the Plan, a Participant will execute the Plan's assignment of right to defend claims (e.g., in the event a health care provider demands more than the maximum reimbursable charge for services that the Plan has agreed to pay, or has improperly charged amounts which the Plan has paid, or for which a claim for payment has been made). The Plan's assignment of right to defend claims may include an assignment to the Plan of full Power of Attorney to defend an action against the Participant by a service provider for any charge which is covered by the Plan, the full right to prosecute counterclaims that the Participant or Plan may have against the service provider, and the right to settle, compromise, or defend an action by a service provider as the Plan determines to be appropriate.

The Fund will pay charges covered by the Plan if a final judgment is rendered against the Plan on behalf of a service provider or if the Plan determines to settle or not to contest an action for amounts payable under the Plan. The Plan will not be responsible for consequential, punitive, or other damages caused by the Participant's actions. The Participant agrees to pay amounts for which he is responsible under the Plan or which are determined to be owed by the Participant to the service provider, to cooperate fully with the Plan, and to execute all documents and papers and appear at all proceedings as the Plan deems necessary to defend or prosecute an action arising from the assignment. The Plan may exercise this right to defend claims solely in its discretion and is not obligated to do so.

SECTION 8 – PLAN’S BENEFITS ARE NOT IN LIEU OF WORKERS’ COMPENSATION

This Plan is not in lieu of and does not affect any requirement for coverage by state or federal worker’s compensation law. None of the benefits provided under the Plan (unless otherwise specifically provided) are payable when the accident or illness necessitating the hospitalization, loss of time or treatment is covered by a state or federal worker’s compensation law. If the Plan pays benefits for an injury or illness that is later found to be subject to a state or federal worker’s compensation law, the Participant will notify the Plan and reimburse the Fund for benefits paid in error within sixty (60) days after written demand by the Plan Administrator. If the Plan finds it necessary to retain an attorney to collect benefits paid in error, the Participant will also reimburse the Plan for its attorneys’ fees and related expenses.

SECTION 9 - ADMINISTRATION AND INTERPRETATION OF PLAN

The Plan is administered by its Board of Trustees (“Board” or “Trustees”). The Trustees are the fiduciaries of the Plan, and except as they may delegate from time to time, have sole, discretionary and complete authority to interpret the Plan documents and to determine all issues arising thereunder. The Trustees are free to use their own judgment and discretion in all things pertaining to the Plan and are not personally liable for any action done or omitted to be done when acting in good faith and in the exercise of their best judgment. The Board’s determinations, constructions and interpretations adopted in good faith are conclusive and binding on all parties having dealings with the Plan. They will also be given deference in any arbitration, mediation or judicial appeal or proceeding and may be overturned only if the decision is determined to be arbitrary and capricious.

For purposes of carrying out their responsibilities and duties, the Trustees will have all necessary and appropriate powers to do the following:

- (a) To determine all matters arising under the Plan and Fund;
- (b) To interpret the Plan documents, to determine all questions of eligibility and coverage, methods of providing for benefits, and rules for processing and reviewing claims, and to decide any ambiguities, inconsistencies and omissions in the Plan documents;
- (c) To establish, from time to time as needed, administrative rules and procedures for the administration of the Plan and Fund and the carrying out of their duties and powers, including the delegation of duties as they see fit;
- (d) To employ, appoint or retain such persons and entities as they deem necessary or desirable for administration of the Plan and Fund, including but not limited to auditors, accountants, actuaries, consultants, third party administrators, legal counsel, investment advisors and insurance companies;
- (e) To require Participants to furnish information and complete forms as needed for proper administration and as a condition of receiving benefits;
- (f) To provide Plan documents and related information as permitted or required by law and, if permitted and deemed appropriate, charge for the related costs;
- (g) To determine facts affecting eligibility and participation or the receipt of benefits and the amount of benefits payable;
- (h) To determine how benefits are to be paid under the Plan (if discretionary) and the persons who are entitled thereto, to authorize and direct the payment of benefits due under the Plan, and to purchase insurance contracts if and as deemed necessary or desirable to provide for benefits;

- (i) To employ personnel as needed to carry out daily functions of the Plan and Fund; and
- (j) To authorize reimbursement of expenses incurred by or on behalf of the Plan and Fund.

Any Participant who is dissatisfied with a decision of the Trustees or its designee may appeal the decision as outlined in the Claims and Appeal Procedures Section. The Claims and Appeal Procedures must be timely followed and exhausted before a lawsuit may be filed against the Plan and Fund. The decisions of the Trustees are entitled to judicial deference.

SECTION 10 - NO VESTED BENEFITS

There are no vested benefits under the Plan and Fund.

SECTION 11 – RECIPROCAL AGREEMENTS

The Trustees may adopt reciprocal agreements (“Reciprocal Agreements”) with the trustees of other welfare benefit trust funds. The purpose of a Reciprocal Agreement is to allow an Employee, who works outside of the Fund’s jurisdiction and in a jurisdiction covered by the Reciprocal Agreement, to elect to have all welfare fund contributions that are received by the other reciprocating fund transferred to this Fund to help the Employee remain eligible under the Plan. Alternatively, such Employee could elect to have all welfare fund contributions that are received by this Fund transferred to the other reciprocating welfare fund. If an Employee works or has worked outside the Fund’s jurisdiction and wants to know if there is a Reciprocal Agreement in effect that applies to his work, he should contact the Administrative Manager. The Administrative Manager can provide Employees with information about existing Reciprocal Agreements and Employees’ rights and obligations thereunder.

ARTICLE XVI PLAN AMENDMENT AND TERMINATION

While the Board of Trustees (“Board”) intends to continue operation of the Plan, it reserves the right to modify or terminate the Plan at any time, and to merge with any other fund established for similar purposes. This right includes but is not limited to the right to change the level of benefits, the method of paying benefits or amounts to be contributed by Employers or Participants, or the classes of eligible persons. This right is exercisable by the Board, in whole or part and at any time, in its sole discretion.

Changes authorized by a vote of the Board will take effect on the date specified. The changes will apply to all affected Participants without regard to status, illness or injury in effect before the date of change, and without regard to future medical care or services required because of an illness, injury or condition occurring before the date of change. Eligibility and benefits under the Plan are not guaranteed and are subject to change at any time.

The Board will notify Participants of any material modifications to the Plan as required by law. If the Plan is terminated, the Board will, within the limits of the remaining Fund assets, adopt a plan to discharge all outstanding obligations and provide that all remaining assets be used in a manner which best carries out the purpose for which the Plan was established, which may include the transfer of assets to another welfare plan to provide benefits to Employees, or are otherwise disposed of in a manner that is consistent with applicable law.

ARTICLE XVII
IMPORTANT INFORMATION ABOUT YOUR PLAN

The following information about the Plan is being provided in accordance with the federal law known as ERISA.

1. **NAME OF PLAN**

The name of the Plan is the Southern Painters Welfare Plan. The Plan was initially adopted effective January 1, 1990. It has been amended and restated from time to time. This SPD Booklet, and the other booklets and documents described herein and included by reference, comprise the Plan documents and the provisions of the Plan that are in effect as of January 1, 2017 (unless otherwise stated).

2. **PLAN TYPE, PLAN NUMBER AND EMPLOYER IDENTIFICATION NUMBER**

The Plan is a welfare plan which provides medical and prescription drug benefits, dental and vision benefits, health care reimbursement, vacation and holiday pay, weekly accident and sickness benefits, and life insurance and accidental death and dismemberment benefits. The life insurance and accidental death and dismemberment benefits are fully insured and provided through an insurance policy issued to the Fund by the Union Labor Life Insurance Company. All other Plan benefits are self-insured by the Fund and payable out of Plan assets.

The Trustees have assigned Plan Number 501 to the Plan. The Employer Identification Number (EIN) assigned by the Internal Revenue Service to the Board of Trustees is 58-1910292.

3. **PLAN SPONSOR AND PLAN ADMINISTRATOR**

The Plan is sponsored and administered by a joint labor-management Board of Trustees ("Board"). The Board is responsible for the overall operation and administration of the Plan. The Board consists of an equal number of Union Trustees and Employer Trustees. The Union Trustees are selected by the District Councils for the Unions that have adopted a Collective Bargaining Agreement which provides for contributions to the Plan. The Employer Trustees are selected by the Employers through the Employer Trustees.

The following is a list of the individuals currently serving on the Board and their addresses:

UNION TRUSTEES

Charles R. Hill
Painters District Council 77
248 Main Street
Forest Park, GA 30297

Herbert R. Santos, Jr.
Painters District Council 80
2400 Crestview Avenue
Kenner, LA 70062

David Wenninger
Painters District Council 88
5425 Spindle Drive
Houston, TX 77086

EMPLOYER TRUSTEES

Waldo P. Emerson
Emerson Associates, Inc.
2094 Azalea Circle
Decatur, GA 30033-2638

Darryl Traylor, Jr.
Glassman of Louisiana, LLC
8401 Parc Place
Chalmette, LA 70043

Garold May
L.H. Land Painting, Inc.
2424 Edinburgh
Mesquite, TX 75150

Walter J. Ilczyszyn*
Painters District Council 78
2153 West Oak Ridge Road
Orlando, FL 32809

Nikitas N. Manias*
CL Industrial Coatings
5840 Brannen Road South
Lakeland, FL 33813

*Signed acceptance 02/03/2017.

The Board's contact information is as follows:

Board of Trustees
C/O Central Data Services, Inc.
5 Hot Metal Street Suite 200
Pittsburgh, PA 15203-2351
Phone (844) 851-7293 or (412) 432-0435
Fax (412) 431-4067

The Board of Trustees is the named fiduciary charged with the responsibility to administer the Plan in accordance with the Plan documents and applicable law. The Board may, in its sole discretion, contract with outside parties for the provision of administrative services, or delegate its authority and responsibility in whole or part from time to time. The Board may expand, reduce or cancel coverage for Participants and beneficiaries, change eligibility requirements or the amount of self-payment and otherwise exercise prudent discretion at any time without legal right or recourse by a Participant, beneficiary, retiree or other person. This Plan and the benefits provided hereunder are not guarantees for employment or otherwise a contract for employment.

4. **ADMINISTRATIVE MANAGER FOR PLAN**

The Board of Trustees has delegated certain day-to-day administrative duties to a third party to act as the Plan's Administrative Manager. The Administrative Manager's name and address is:

Central Data Services, Inc.
5 Hot Metal Street, Suite 200
Pittsburgh, PA 15203-2351
Phone: (844) 851-7293 or (412) 432-0435.
Fax: (412) 431-4067

The Administrative Manager keeps the records of the Plan. The Board has authorized the Administrative Manager to respond in writing to any questions Participants and beneficiaries may have about the Plan. The Administrative Manager may respond informally to oral questions as a courtesy. However, oral questions and answers are not binding upon the Board and cannot be relied upon in any dispute concerning a person's benefits and rights under the Plan. Persons who have an important question should request a written response.

5. **AGENT FOR SERVICE OF LEGAL PROCESS**

The name and address of the Plan's agent for service of legal process is:

Louis L. Robein, Esq.
Robein, Urann, Spencer, Picard & Cangemi, APLC
2540 Severn Avenue, Suite 400
Metairie, LA 70002
Phone (504) 885-9994

Legal process may also be served on any individual Trustee, or on the Plan Administrator by writing to the Trustees as outlined under Plan Sponsor above.

6. COLLECTIVE BARGAINING AGREEMENTS, PARTICIPATION AGREEMENTS, PLAN DOCUMENTS AND REPORTS

The Plan is maintained pursuant to one or more Collective Bargaining Agreements (“CBAs”) and written Participation Agreements. The CBAs require the signatory Employers to contribute to the Fund on their Employees’ behalf at fixed rates for hours in Covered Employment.

The Participation Agreements require the signatory Employers to contribute to the Fund on their non-bargaining unit Employees’ behalf at specified rates to provide for their Plan coverage.

Participants and beneficiaries may examine the following documents at the Administrative Manager’s office during regular business hours, Monday through Friday except holidays:

- (a) Trust Agreement;
- (b) Collective Bargaining Agreements and Participation Agreements;
- (c) Plan documents and all amendments;
- (d) Form 5500s and full Annual Reports filed with the Internal Revenue Service and Department of Labor; and
- (e) A complete list of all participating Employers and employee organizations.

They may also obtain copies of these documents by making a written request to the Administrative Manager’s office. As there may be a copying fee, any person requesting a copy should ask what the charge will be before requesting copies. Upon written request, Participants and beneficiaries may receive from the Administrative Manager information as to whether a specific Employer or employee organization participates in the Plan and, if so, the address. A summary of the Plan’s Annual Report, which gives details of the financial information about the Plan’s operations, is furnished free of charge to all Participants.

7. BENEFITS

The Plan’s benefits are provided in accordance with the provisions described in this SPD Booklet and in any other booklets, Policies and documents included by reference herein.

8. IDENTITY OF FUNDING MEDIUM USED FOR ACCUMULATION OF ASSETS

The Plan’s assets are held in a trust fund (“Fund”) established and administered by the Trustees, for the purpose of providing benefits to Participants and beneficiaries and paying the reasonable administrative expenses of the Plan. The Fund is governed by the Trust Agreement by which it was established and is maintained. The Fund’s assets are held in the custody of a national bank. The Trustees have appointed, and may appoint from time to time, qualified investment advisors to assist with the investment of Plan assets. The Trustees may also, from time to time, contract with an insurance company to underwrite Plan benefits. Currently, the Life Insurance and Accidental Death and Dismemberment Benefits are fully insured by the Union Labor Life Insurance Company, Administrative Office located at 8403 Colesville Road, Silver Springs, MD 20910, (202) 682-0900 or 1-800-431-5425. All other Plan benefits are payable solely out of the assets of the Fund. There is no obligation or liability of any Employer, Trustee or Union to provide Plan benefits if the Fund does not have enough assets to do so.

9. **PLAN YEAR**

The Plan's records are maintained on the basis of a 12-month period known as the "Plan Year". The Plan Year is a calendar year that begins on January 1st and ends on December 31st.

**ARTICLE XVIII
STATEMENT OF RIGHTS UNDER ERISA**

As a Participant in the Southern Painters Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("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 other specified locations such as worksites and union halls, all documents governing the Plan including insurance contracts, Collective Bargaining Agreements and Participation 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 the operation of the Plan including insurance contracts, Collective Bargaining Agreements and Participation Agreements, copies of the latest annual report (Form 5500 Series), and an updated summary plan description. The Plan Administrator may make a reasonable charge 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 this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, your Dependent spouse and children if there is a loss of coverage under the Plan due to a qualifying event. You or your Dependents must pay for such coverage. Review this booklet and the documents governing the Plan for rules governing your COBRA coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for operation of an 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 case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits 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 court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

However, in all cases including those described above, a person must first exhaust his administrative remedies under the Plan by following the Plan's Claims and Appeal Procedures as described in this booklet, before the person may file a lawsuit in any court. The person will then have one year from the date a final decision on the claim is reached under the Plan, in which to start a lawsuit. In no event may legal action be brought in court, by or on behalf of the person, later than this one year period.

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 your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should do the following: (i) contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory; or (ii) call EBSA's Toll-Free Employee and Employer Hotline at 1-866-444-EBSA (3272); or (iii) write to EBSA's Office of Participant Assistance at the following address: Office of Participant Assistance, 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 EBSA's Toll-Free Employee and Employer Hotline at 1-866-444-EBSA (3272).

ARTICLE XIX DEFINITIONS

Certain terms used in this booklet have special meanings. These terms will be capitalized and will have the meaning set forth below. Whenever "you" is used in this SPD, it assumes that you are an Employee unless otherwise indicated by the context.

"Benefit Level" means the level of benefit for which a Participant is eligible (e.g., the Gold Plan, Silver Plan, Bronze Plan or Steel Plan). It is described in greater detail in Article II, Section 1.

"Code" means the Internal Revenue Code of 1986 and corresponding regulations, as amended.

"Collective Bargaining Agreement" means a written bargaining agreement between an Employer and Union that requires the Employer to make periodic Contributions to the Fund on behalf of its Employees' Covered Employment, as such agreement may be extended, renewed or amended.

“Contribution” means the payment an Employer is required to make to the Fund on behalf of its Employees’ Covered Employment pursuant to the Collective Bargaining Agreement.

“Coverage Level” means the level of coverage for which an eligible Employee is enrolled (e.g., Employee Only, Employee and Dependent Spouse, Employee and Dependent Children, Employee and Family, or No Medical Benefit (Opt Out). It is described in greater detail in Article II, Section 2.

“Covered Employment” means employment of a type covered by a Collective Bargaining Agreement for which Contributions to the Fund are required.

“Default Benefit Level” means the Benefit Level that will automatically be provided to an eligible Employee who does not affirmatively elect a Benefit Level. The Default Benefit Level will be established by the Board of Trustees. It is described in greater detail in Article I, Section 1.

“Dependent” means any of the following:

- (a) Employee’s lawfully married spouse;
- (b) Employee’s children from the date of birth until they reach age 26 (at which time they will no longer qualify under this subsection (b)), who are his blood descendants, legally adopted children, children who have been placed with him for adoption (irrespective of whether the adoption becomes final), or stepchildren;
- (c) Employee’s unmarried children as described in (b) except that they are age 26 or older, who are disabled and incapable of self-support because of the disability provided the following requirements are also satisfied: (1) the disability occurred before age 26; (2) the Employee provides more than one-half of the child’s support; and (3) satisfactory proof of the disability and dependency is provided to the Plan when the child reaches age 26 and on an ongoing basis upon the Plan’s request; and
- (d) An Alternate Recipient.

“Employee” means any person employed by an Employer and covered by a Collective Bargaining Agreement or Participation Agreement.

“Employer” means an employer who is required under a Collective Bargaining Agreement to make Contributions to the Fund on behalf of its Employees’ Covered Employment, or is required under a Participation Agreement to contribute to the Fund for the participation of its non-bargaining unit Employees.

“ERISA” means the Employee Retirement Income Security Act of 1974 and corresponding regulations as amended.

“Fund” means the entire trust estate of the Southern Painters Welfare Fund as established and maintained by the Trustees under an agreement and declaration of trust, which includes all funds received in the form of Employer Contributions or payments, insurance policies, investments, income, earnings, increments, profit and other things of value, which are held for the purpose of providing benefits under the Plan and paying the reasonable administrative expenses of the Plan.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996 and corresponding regulations as amended.

“Insurer” means the insurance company (if any) that has issued a group insurance policy purchased by the Trustees for the purpose of providing benefits under the Plan.

“Participant” means an Employee or Dependent who is eligible and covered by the Plan.

“Participation Agreement” means a written agreement between an Employer and the Trustees that provides for the participation of the Employer’s non-bargaining unit Employees in the Plan and the payments required to be made by the Employer to the Fund on their behalf.

“Plan” means the plan of benefits payable from the Fund as adopted by the Trustees from time to time and the related eligibility rules, all as set forth in the Plan documents. The Plan documents shall include this SPD Booklet, the Trust Agreement by which the Fund was established and is maintained, and any Policy and separate booklets or documents that govern the payment of benefits under the Plan and are included as part of the Plan by reference in this SPD Booklet.

“Plan Administrator” means the Board of Trustees of the Southern Painters Welfare Fund and, to the extent applicable, any person or entity to which the Board has delegated responsibility for part or all of its administrative duties under the Plan.

“Schedule of Benefits” means the schedule that is attached to and made a part of the Plan, which summarizes the benefits for each Benefit Level offered by the Plan.

“Trustees” and **“Board of Trustees”** means the individuals who are appointed from time to time to serve and are serving on the Board of Trustees in a trustee capacity for the Fund, in accordance with the terms of the agreement and declaration of trust by which the Fund was established and is maintained.

“Union” means a local union affiliated with any of the following District Councils for the International Union of Painters and Allies Trades: District Council 77; District Council 78 (effective January 1, 2017); District Council 80; District Council 88; and any other district council or local union affiliated with the International Union, its successors and assigns, which has a Collective Bargaining Agreement with an Employer.