Dear Participant:

The Board of Trustees of the Bricklayers and Allied Craftworkers Health and Welfare Fund of Indiana (“Plan”) is pleased to provide you with this booklet, which contains current health and welfare benefits information. Although this booklet is meant to be an easy-to-understand description of your Plan benefits, it also serves as the Plan’s official document and Rules and Regulations.

It is the Trustees’ goal to maintain a financially stable Plan while providing adequate health care coverage to our Participants and their families. This is becoming more challenging as health care costs continue to rise. The Plan has implemented some cost-saving methods such as medical and prescription drug deductibles and a Hospital certification requirement to ensure that we can meet your current and future health care needs. You can do your part in helping the Plan manage health care costs by:

- **Visiting In-Network providers** – In-Network providers including Hospitals, Physicians and other health care providers charge negotiated reduced rates. Also, the Plan pays a higher percentage of your bills when you use an In-Network provider.

- **Examining emergency treatment alternatives** – In the event of an emergency, the most important consideration is to seek medical care, especially in a life-threatening situation. However, in some cases, you can obtain the same level of care at a Physician’s office or an Urgent Care facility as in an emergency room. Keep your Physician’s telephone number easily accessible and locate the Urgent Care facility nearest to you beforehand so you’ll be prepared in case of emergency.

To help keep you and your family healthy, remember that the Wellness Benefit covers physicals, pap smears, prostate exams, well-baby visits and immunizations for you, your Spouse and Dependent Children.

Please keep this booklet with your other important papers and share this information with your family. If you have questions about information in this booklet, contact the Plan Administrator and/or Third Party Administrator (TPA).

Sincerely,

BOARD OF TRUSTEES

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The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant. Eligible Participants will be notified in writing of any Plan changes.

The Bricklayers and Allied Craftworkers Health and Welfare Fund of Indiana believes it is a “grandfathered health plan” under the Patient Protection and Affordable Care Act. Being a grandfathered health plan means that the Plan does not include certain consumer protections of the Affordable Care Act. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at the office of the Third Party Administrator (TPA). You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at www.healthreform.gov.
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Claim Filing Procedure Overview

To file a claim for benefits under this Plan, please refer to the back of your ID Card, which will indicate where the documentation needs to be submitted. The information you provide must be sufficient for the Plan to determine the benefits owed under this Plan. Canceled checks, balance due statements, payment receipts and cash register receipts will not be accepted as proof of your claim.

Generally claims must be submitted to the following:

- Medical Claims – File with Anthem Blue Cross and Blue Shield Claims Department
- Vision Claims – File with HealthSCOPE Benefits
- Dental Claims – File with Delta Dental
- Disability/Life Claims – File with HealthSCOPE Benefits
- Prescription Claims – File with SAVRX

When submitting claims to HealthSCOPE Benefits, you will need to complete a claim form to be submitted with the charges. The claim form is available online, or you can contact the TPA directly to have one sent to your address.

Claim forms or computerized billings from providers will generally be accepted if the form or billing includes the following information:

- Name of the patient;
- Name of the provider;
- Date(s) of the service(s);
- Charge for each treatment, service and supply and the nature of the treatment, service or supply;
- Diagnosis; and
- Professional status of provider.

For Prescription Drug claims, you must provide the prescription number and name of the drug.

Claims must be submitted in writing or filed electronically by your providers. Most medical service providers will file the claim on your behalf if you assign payment to them.

The Plan Administrator may require you to submit to a medical examination and provide medical records or other information when necessary to review any claim.

If the claim form or materials submitted are incomplete, you will be notified that the claim was not properly filed. The notice will include an explanation of the procedures that need to be followed to make a claim.
## Contact Information

<table>
<thead>
<tr>
<th>If You Have A Question About…</th>
<th>Contact…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility Issues</td>
<td><strong>Fund Administrator:</strong>&lt;br&gt;HealthScope Benefits&lt;br&gt;P.O. Box 50440&lt;br&gt;Indianapolis, IN 46250-0440&lt;br&gt;(800) 398-0921 or (317) 554-9000&lt;br&gt;www.healthscopebenefits.com</td>
</tr>
<tr>
<td>Medical, Vision and Short Term Disability Benefits</td>
<td><strong>For claims:</strong>&lt;br&gt;Plan Administrator:&lt;br&gt;c/o HealthSCOPE Benefits&lt;br&gt;P.O. Box 50440&lt;br&gt;Indianapolis, IN 46250-0440&lt;br&gt;(800) 398-0921 or (317) 554-9000&lt;br&gt;www.healthscopebenefits.com</td>
</tr>
<tr>
<td></td>
<td><strong>For In-Network Medical provider information:</strong>&lt;br&gt;Anthem Blue Cross and Blue Shield Claims Department&lt;br&gt;P.O. Box 37010&lt;br&gt;Lexington, KY 40233-7690&lt;br&gt;(800) 810-2583&lt;br&gt;www.anthem.com</td>
</tr>
<tr>
<td></td>
<td><strong>For Hospital Precertification:</strong>&lt;br&gt;Inetico&lt;br&gt;(877) 885-2211</td>
</tr>
<tr>
<td>Prescription Drug Card Provider</td>
<td><strong>Sav-RX</strong>&lt;br&gt;P.O. Box 8&lt;br&gt;Fremont, NE 68026&lt;br&gt;(800) 228-3108&lt;br&gt;www.savrx.com</td>
</tr>
<tr>
<td>OncoSentrics – Cancer Management Program</td>
<td><strong>Biologics</strong>&lt;br&gt;(800) 983-1590</td>
</tr>
</tbody>
</table>

NOTE: To verify benefits, contact the Plan Administrator, c/o HealthSCOPE Benefits.<br>(In some cases the Administrator will not be able to tell you whether a particular service is covered until it receives the claim that indicates the nature of the provided service.)
### Schedule of Benefits - Active and Early Retirees

#### Active Employees Only

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Benefits Begin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short Term Disability Benefit</td>
<td>$200.00 per week</td>
</tr>
<tr>
<td>Benefit Amount (disabled other than on your job)</td>
<td>$200.00 per week</td>
</tr>
<tr>
<td>Maximum Number of Weeks</td>
<td>6 weeks</td>
</tr>
<tr>
<td>Benefits Begin</td>
<td>1st day of Accident, 8th Day for Sickness</td>
</tr>
</tbody>
</table>

#### Active Employees and Early Retirees Only

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Benefit Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death Benefit Amount</td>
<td>$5,000.00</td>
</tr>
<tr>
<td>Accidental Death Benefit (Active Employees Only)</td>
<td>$5,000.00</td>
</tr>
</tbody>
</table>

#### Active Participants and Early Retirees

<table>
<thead>
<tr>
<th>Covered Service or Plan Category</th>
<th>Comprehensive Major Medical Expense Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cover</td>
<td>IN NETWORK</td>
</tr>
<tr>
<td>Maximum Annual Benefit</td>
<td>$2,000,000 per person for all Essential Benefits</td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td>Individual Deductible: $240</td>
</tr>
<tr>
<td>Out of Pocket Maximum</td>
<td>Individual: $2,000 per calendar year</td>
</tr>
<tr>
<td>(excluding deductible)</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>80% of Covered Charges</td>
</tr>
<tr>
<td>Non-Emergency Use of Emergency Room</td>
<td>$200 Co-pay, then 80% of covered charges after Deductible</td>
</tr>
<tr>
<td>Manual Manipulations and Treatment</td>
<td>Plan pays 80% of covered charges after Deductible.</td>
</tr>
<tr>
<td></td>
<td>$750 maximum per calendar year</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Plan pays 80% of covered charges after Deductible</td>
</tr>
<tr>
<td></td>
<td>Limited to 60 days per calendar year</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Plan pays 80% of covered charges after deductible</td>
</tr>
<tr>
<td></td>
<td>Limited to 50 Visits per calendar year</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Plan pays 80% of covered charges after deductible</td>
</tr>
<tr>
<td></td>
<td>Limited to a Lifetime Maximum of $10,000 per person</td>
</tr>
<tr>
<td>COVERED SERVICE OR PLAN CATEGORY</td>
<td>IN NETWORK</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Orthotics</td>
<td>Plan pays 80% of covered charges after deductible</td>
</tr>
<tr>
<td></td>
<td>Limited to $250 per calendar year</td>
</tr>
<tr>
<td>Preventive Care Wellness Benefit</td>
<td>100% of Covered charges up to $300 per calendar year. Charges in excess of the limit are subject to deductible and coinsurance</td>
</tr>
<tr>
<td>Substance Abuse Treatment</td>
<td>Plan pays 80% of covered charges after Deductible</td>
</tr>
<tr>
<td>Mental &amp; Nervous Conditions</td>
<td>Plan pays 80% of covered charges after Deductible</td>
</tr>
</tbody>
</table>

**Prescription Benefit**

<table>
<thead>
<tr>
<th>Prescription Drug Card Benefit</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan pays 100% after a 25% co-payment per prescription. If a generic drug is available, the Plan will only pay up to the cost of the generic, less the co-payment, for Brand name drugs.</td>
<td>If a Non-Network pharmacy is used, the Covered Person will pay 100% of the drug cost, and must file the claim with SAVRX for reimbursement. (Refer to Prescription Drug Benefit Section.)</td>
</tr>
</tbody>
</table>

**Vision Benefit**

<table>
<thead>
<tr>
<th>Vision Benefit Maximum</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>$200 per person per Calendar Year</td>
<td>80% - all providers</td>
</tr>
</tbody>
</table>

**Services Covered**

- Complete Vision Exam
- Frames
- Lenses per pair
- Conventional Contacts
- Disposable Contacts

One per calendar year – Includes Refraction
One Frame per 2 consecutive calendar years
One set per calendar year
One set per calendar year
Subject to the calendar year maximum

**Dental Benefit**

Effective January 1, 2005, the Trustees contracted with Delta Dental Company for dental coverage under Policy No. 5022-001. **This is for the Active Participants Only.** Dental cards and certificates of coverage will be provided to you when you become eligible. **ALL DENTAL CLAIMS MUST BE FILED WITH DELTA DENTAL, P.O. BOX 9085, FARMINGTON HILLS, MI 48333-9085.**
Schedule of Benefits – Retirees who are Medicare Eligible

Once the Retired member becomes Medicare eligible, the following benefits apply. Please note that the covered spouse who is under the age of 65 continues to be covered by the Active Employee benefits. Once the covered spouse becomes Medicare eligible, these benefits apply. The intent of this Schedule of Benefits is to pay only Medicare approved charges that are not paid by Medicare, except as otherwise noted.

<table>
<thead>
<tr>
<th>Retirees age 65 and over</th>
<th>Benefit/Special Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death Benefit Amount</td>
<td>$2,500.00</td>
</tr>
</tbody>
</table>

Medicare Eligible Retirees

Medicare Supplement Medical Benefits

The Member on Medicare is entitled to the following benefits:

A. Full payment of the initial Medicare Part A deductible
B. From the 61st through the 90th day of hospital confinement, a daily benefit equal to 25% of the Medicare Deductible
C. From the 91st through the 150th day of hospital confinement, a daily benefit equal to 50% of the Medicare Deductible (once per patient lifetime)
D. Full Payment of Medicare Part B Deductible
E. Payment of the member’s share of covered Medicare approved charges, usually 20%.
Definitions

The following section contains definitions for terms used throughout this booklet.

**Accident** means an Injury, such as a cut, break, sprain or bruise, caused by a sudden unexpected, undesirable and unavoidable act. The term Accident does not include strained or aching arms and/or legs resulting from the overuse of muscles.

**Allowable Expenses** means all reasonable, customary and usual charges for treatment or services that are medically necessary, where at least part of the charge is covered under one or more of the plans that cover you.

**Ambulatory Surgical Center** is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by Registered Nurses (R.N.s) and does not provide for overnight stays.

**Bank Credits** are contributions credited to an employee’s Individual Account from contributions received from a Contributing Employer.

**Birthing Center** means any freestanding or Hospital-based facility which provides an “at home” atmosphere for the delivery of babies. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

**Board of Trustees and/or Trustees** mean those individuals, collectively, designated in the Trust Agreement, together with their successors designated and appointed in accordance with the terms of the Trust Agreement for the Bricklayers and Allied Craftworkers Health and Welfare Fund of Indiana. The Trustees, collectively, are the “Plan Administrator” of this Plan, “Plan Sponsor” and the “Named Fiduciaries” of the Plan, as those terms are defined in the Employee Retirement Income Security Act of 1974.

**Brand Name Drug** means any prescription drug which is not a Generic Drug.

**Chemical Dependency** is the condition caused by regular excessive compulsive drinking of alcohol and/or physical dependence on drugs that result in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

**Compound Medication** means a medication which contains at least one ingredient which cannot be legally given out without a written prescription from a Physician.

**Contributing Employer** means any employer who is required by a Collective Bargaining Agreement or other writing to contribute to this Plan.

**Contributions** means the total amount which is paid to the Plan by an Employer, based on the number of hours worked times the hourly contribution rate specified in a participation agreement or CBA, or the amount contributed by a Participant, as allowed, to maintain eligibility for benefits.
Co-Insurance means the percentage of each Allowable Expense paid by the Plan after the Deductible has been met.

Co-payment means the amount which you must pay to a Network Provider for certain Covered Services. The Co-payment amounts are listed in the Summary of Benefits.

These Co-payments cannot be used to meet your Deductible, and they do not count toward meeting your Out-of-Pocket Maximum expense for a year.

Cosmetic Dentistry means dentally unnecessary procedures.

Cosmetic Surgery means a surgery to change the texture or appearance of the skin, or the relative size or position of any part of the body when the surgery is performed primarily for psychological purposes or is not needed to correct or improve a bodily function.

Covered Person means an Employee, Spouse, Dependent Child and other person who is eligible for benefits under the Plan.

Dependent means, for an Employee:

- The spouse you are legally married to under the laws of the state in which you reside, but does not include same-sex domestic partners; or
- Your child under 19 years of age; or
- Your child who is adopted or placed for adoption prior to the age of 18 and who otherwise meets the eligibility criteria for a child as described herein; or
- Your child who is 19 years old until his or her 26th birthday if that child does not have any other employer-sponsored group health insurance available to them, or their spouse, if applicable, (except coverage of another parent); or
- Your child who reached his or her 26th birthday while a Covered Person, but who is incapable of earning his or her own living due to mental or physical handicap, which occurred prior to the child’s 19th birthday. In this circumstance, the child must permanently reside in your household and be financially dependent on the Covered Member for at least 50% of his or her support. The Plan will require proof of incapacity, residency and financial dependency. Such proof may be given at any time within 120 days after the date the limiting age is reached, and will not be required earlier than sixty days (60) before the limiting age is reached. The Plan may also require proof of continuing incapacity, residency and financial dependency. It may require such proof no more than once each year after initial proof is given. If proof is not given within sixty days of a request, coverage for the dependent will end sixty days (60) after the request is made.

You are responsible for notifying the Plan in the event of a divorce, legal separation, obtaining a new dependent, or when a child ceases to be a dependent as defined above. A new dependent will be effective at the time they became an eligible dependent, as long as the Plan is properly notified within 60 days of the date the new dependent was acquired. If notice is provided after 60 days, the dependent’s effective date will be the date the Plan is notified.
Dependents will not include (1) a foster child; (2) a stepchild; (3) a child or spouse who permanently resides outside of the United States of America; or (4) any person eligible for coverage as a covered employee.

An Employee’s children also include those children named as alternate recipients under a Qualified Medical Child Support Order (QMCSO).

Note: This Plan does not provide coverage to children of Dependent Children, nor does it provide coverage for pregnancy or child birth of Dependent daughters.

Note: If both husband and wife are covered under the Plan as Employees, either, but not both, may elect to cover children eligible as described above. (i.e. No coordination of benefits)

**Durable Medical Equipment** means equipment that (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an illness or injury, and (d) is appropriate for use in the home.

**DESI Drugs** mean drugs determined by the Food and Drug Administration as lacking in substantial evidence of effectiveness.

**Developmental Disability** means a substantial handicap which results from mental retardation, cerebral palsy, epilepsy or other neurological disorder which a Physician says is a permanent or long-term continuing condition.

**Disability** means the inability of a covered Employee to perform the material duties of his or her occupation as a result of a non-occupational illness or injury.

**Employee** means an individual who is covered by a Collective Bargaining Agreement (CBA) or a participation agreement that requires his Employer to make contributions to this Fund on his behalf. Contributions on an Employee’s behalf are made for hours paid or worked in accordance with the applicable CBA or participation agreement. The term Employee would also include the full-time supervisory and clerical employees of the Union and the Fund, subject to approval by the Trustees.

**Employer** means an entity who is signatory to a collective bargaining agreement with the Union, or other agreement, which requires contributions to the Fund.

**Experimental or Investigative Treatment or Procedure** means any drugs, devices, procedures or treatments such that:
- Its use requires approval by the appropriate federal or other governmental agency which has not been granted, such as, but not limited to, the Federal Drug Administration (FDA); or
- Its use is not yet recognized as acceptable medical practice throughout the United States to treat that illness or injury; or is subject to either:
  - a written investigational or research protocol; or
- a written informed consent or protocol used by the treating facility in which reference is made to the drug, device, procedure or treatment as being experimental, investigative, educational, for a research study, or posing an uncertain outcome, or having an unusual risk; or
- a written protocol, protocols or informed consent used by any other facility studying substantially the same drug, device, procedure or treatment which states it is experimental, investigative, educational, for a research study, or posing an uncertain outcome, or having an unusual risk; or
- an ongoing review by an Institutional Review Board (IRB); or

- It does not have either:
  - the positive endorsement of national medical bodies or panels, such as the American Cancer Society, the Agency for Health Care Policy and Research, or the National Cancer Institute; or
  - multiple published peer review articles, in a recognized professional medical journal, concerning such drug, device, procedure or treatment and reflecting its reproducibility by non-affiliated sources which the Plan determines to be authoritative; or
  - trial results which indicate the drug, device, procedure or treatment are at least as effective as the current standard therapy; or

- It does not meet all applicable state mandated criteria required to not be considered experimental/investigational

The Trustees have the authority to determine whether a service, procedure, drug, device or treatment modality is Experimental or Investigative. The fact that a Physician has prescribed, ordered, recommended or approved the service, procedure, drug, device or treatment modality does not, in itself, make it eligible for payment.

**Fund** means the Bricklayers and Allied Craftworkers Health and Welfare Fund of Indiana.

**Generic Drug** means a Prescription Drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

**Home Health Care Agency** is an organization the main function of which is to provide Home Health Care services and supplies and which is federally certified as a Home Health Care Agency and licensed by the state in which it is located, if licensing is required.

**Hospice Care Agency** is an organization the main function of which is to provide Hospice Care services and supplies and which is licensed by the state in which it is located, if licensing is required.

**Hospital** means a lawfully operating institution that meets all of the following requirements:

- Is accredited as a Hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations, is legally operated, has 24-
hour supervision by a staff of Physicians, has 24-hour nursing service by registered graduate nurses and complies with one of the following:

- Mainly provides general In-Patient medical care and treatment of sick and injured persons by the use of medical, diagnostic and major surgical facilities; or
- Mainly provides specialized In-Patient medical care and treatment of sick and injured persons by the use of medical and diagnostic facilities (including X-ray and laboratory); or

- Is an institution that provides care and treatment of mental, psychoneurotic and personality disorders; alcoholism or drug abuse through one or more specialized programs and meets each of the following tests:
  - Is staffed by registered graduate nurses and other mental health professionals; and
  - Provides for the clinical supervision of such specialized programs by Physicians who are licensed in the state in which it is located; and
  - Each specialized program it provides must:
    - Provide treatment for no less than three (3) hours and no more than twelve (12) hours per day; and
    - Furnish a written, individual treatment plan that states specific goals and objectives; and
    - Maintain, at a minimum, ongoing, weekly progress notes that demonstrate periodic review and direct patient evaluation by the attending Physician; and
    - Meet either of these two tests:
      - Is accredited by the Joint Committee on Accreditation of Healthcare Organizations to provide the type of specialized program described above; or
      - Is licensed, accredited or approved by the appropriate agency in the state in which it is located to provide the type of specialized program described above.

The term **Hospital** does not include a nursing home or an institution, or part of one, that:

- Is used mainly as a place for convalescence, rest, nursing care or for the aged;
- Furnishes mainly home like or custodial care, or training in the routines of daily living; or
- Is mainly a school.

**Illness** means a bodily disorder or disease, pain or fever, mental or nervous disorder or a drug or alcohol abuse condition not caused by an Accident. This term also includes pregnancy and childbirth for female Employees and Spouses of male Employees.

**Immediate Family** includes the patient’s mother, father, sister, brother, Spouse and children.

**Individual Account** means Bank Credits held in reserve by the Fund to establish and maintain each employee’s qualifying status and cost of coverage.

**Injury** means a bodily injury which occurs at a definite time and place and results from an Accident.

**In-Patient** means a person who, while confined in a Hospital or Skilled Nursing Care Facility, is assigned a bed in any department of a Hospital or Skilled Nursing Care Facility other than in its Out-Patient department and for whom a charge for room and board is made by the Hospital or Skilled Nursing Care Facility.
**Intensive Care Unit** is defined as a separate, clearly designated service area that is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a “coronary care unit” or an “acute care unit.” It has facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one Registered Nurse (R.N.) in continuous and constant attendance 24 hours per day.

**Medical Emergency** means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

**Medically Necessary** means drugs, devices, procedures, treatments, services or supplies provided by a provider facility or a provider individual which are required for treatment of a Covered Person’s illness, injury, diseased condition, or impairment, and are:

- Consistent with the diagnosis or symptoms and the Covered Person is an appropriate candidate for the proposed treatment;
- Appropriate treatment, according to generally accepted standards of medical practice;
- Not provided only as a convenience to the Covered Person or for the provider;
- Not Experimental or Investigational
- Not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment. Any service or supply provided at a facility will not be considered medically necessary if the symptoms or condition indicate that it would be safe to provide the service or supply in a less comprehensive setting.

The fact that any particular provider individual may prescribe, order, recommend, or approve a service, supply, pr level of care does not, of itself, make such treatment medically necessary or make the charge a covered charge.

**Medicare** means the Hospital and Supplementary Medicare Insurance Plans established by Title XVIII of the Social Security Act of 1965, as then constituted and as later amended.

**Mental Disorder** means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of *International Classification of Diseases*, published by the U.S. Department of Health and Human Services.

**Morbid Obesity** is defined as being 100% or 100 pounds over a Participant’s ideal body weight.

**Out-Patient** means Hospital services and treatments incurred by a person who is not an In-Patient and/or is not charged room and board.

**Over-the-Counter Drugs** mean drugs that can be purchased without a Physician’s prescription including, but not limited to, topical contraceptives such as spermicides and condoms.

**Participant** means an Employee, Spouse, Dependent Child and other person who is eligible for benefits under the Plan.
Physical Handicap means a substantial physical or mental impairment which results from an Injury, Accident, congenital defect or Illness which a Physician says is a permanent or long-term dysfunction or malformation of the body.

Physician, Doctor and/or Surgeon means a person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) and authorized to practice medicine, to perform surgery and to administer drugs, under the laws of the state or jurisdiction where the services are rendered and who is acting within the scope of such license. These terms also include Doctors of Podiatry, Doctors of Dental Medicine, Doctors of Dental Surgery, Doctors of Ophthalmology, Certified Nurse Anesthetists, Nurse Practitioners, Nurse Assistants and Doctors of Chiropractic Treatments. Providers practicing within the scope of their license are permitted to perform services for which coverage is provided under this Plan. Psychologists and social workers are also included when practicing within the scope of their license if a MD or DO makes referral to the psychologist or social worker.

Physician Office Visit means a visit to the office of a Physician.

Plan and/or Welfare Plan means the Bricklayers and Allied Craftworkers Health and Welfare Fund of Indiana, as set out in this document as adopted by the Trustees and as hereafter amended by the Trustees. The Plan may, from time to time, be amended.

Plan Sponsor is the Board of Trustees, Bricklayers and Allied Craftworkers Health and Welfare Fund of Indiana.

Reasonable and Customary Charge means the charge for the service or supply that is no higher than the usual amount charged in the locality where the charge is incurred for similar services or supplies. In determining a Reasonable and Customary Charge, the Plan also considers the complexity of the service. The Plan may decline to pay flat rate charges when procedures, fees and/or time involved are not itemized. Reasonable and Customary only applies to Out-of-Network claims.

Rehabilitation Facility means an inpatient medical facility that is licensed as a Hospital or freestanding Rehabilitation Facility, where licensure is required, or it may be CARF accredited. Physicians and Registered Nurses are on staff and available. This type of facility provides physical, occupational and speech therapy by licensed therapists and also have available a program of structured cognitive therapy. Social work and discharge planning are provided, to include planning for care and equipment needs after discharge.

Rest Home means a home for the aged or a place for treatment of mental disease, drug addiction or alcoholism, which is not a Skilled Nursing Care Facility.

Skilled Nursing Care Facility means a lawfully operated institution for the care and treatment of persons convalescing from an Illness or Injury, which provides room and board and 24-hour nursing service by registered licensed nurses and is under the full-time supervision of a legally qualified Physician or Surgeon or a registered nurse (RN).

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a
Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

**Trust** means the trust account in which all of the Plan’s assets, including but not limited to, policies of insurance, cash deposits, investments, Employer contributions and other assets are accumulated and invested by the Trustees.

**Union and/or Local Union** means the Bricklayers and Allied Craftworkers Local Union No. 4, Indianapolis, Bloomington and Terre Haute Chapters, whose Collective Bargaining Agreements require contributions to this Fund.

**Urgent Care** means medical care required for an unexpected episode of Illness or Injury requiring treatment which cannot reasonably be postponed for regularly scheduled care, but which is not an Emergency. An Urgent Care Center is a health care facility that is separate from a Hospital and whose primary purpose is providing immediate, short-term Urgent Care, without appointment.
Plan Administration

This Plan is administered by a Board of Trustees which is governed by this Plan and by a Trust Agreement. The names of the Trustees are listed with the Plan Information at the back of this booklet.

This booklet is both the plan document and the Summary Plan Description for this Plan.

The Trustees have a contract with a Third Party Administrator (“TPA”). The TPA processes medical, dental and short term disability claims. The TPA also processes hour reports, contributions, and manages eligibility records. The name, address and phone number of the TPA is listed on the Contact Information page at the beginning of this Book.

Eligibility

WHO IS ELIGIBLE:

Employees employed by Employers who contribute to the Bricklayers and Allied Craftworkers Health and Welfare Fund of Indiana, (hereinafter referred to as “Fund”), in accordance with the provisions of the Agreement and Declaration of Trust (hereinafter referred to as “Employees”).

You are also eligible to have coverage under this Plan if you previously have been covered as a bargaining unit participant and now work as an estimator, project manager, superintendent or supervisor if:

- Your Employer has a CBA with the Local Union, and
- Your Employer pays contributions on each hour that you perform any work. You cannot use Bank Credits to maintain eligibility as long as you are working.

An Employer, whether or not he performs any bargaining unit work, may, upon approval by the Trustees, participate in the Plan at a monthly contribution rate to be set from time to time by the Trustees. Failure to pay contributions under the collective bargaining agreement when due, or under the Non-Bargained Participation Agreement will void participation under this provision.

Employees (see page 13 for definition of an Employee)

Retirees (see page 23 for retiree eligibility)

Surviving Spouse, and eligible dependents (See Family Security Benefits, page 23)
Eligibility Rules

When You Become Eligible

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New Participating Employees:

A new Employee shall become eligible for benefits one month following the completion of six (6) consecutive months of credited employment in the jurisdiction of the Union, with a minimum of 600 hours of credited employment in that six (6) month period. If the Employee does not accumulate 600 hours of credited employment in the initial six (6) month period, the Employee shall become eligible one month following the accumulation of 600 hours of credited employment.

Eligibility for an Employee no longer working or available for employment in the jurisdiction of an Affiliated Union Chapter shall be extended only through the quarter he/she terminates employment in the area.

Self-Payment Participants:

Signatory self-employed proprietors, partners, or shareholders in a Corporation, who work within a Bargaining Unit, may participate in the Fund as a Self-Payment participant as follows:

A. A Contributing Employer who has previously had the approval of the Trustees and is now eligible may continue coverage in the Plan by making “self-payments” monthly, in advance, at the current rate set by the Trustees. Delinquent contributions will void this provision, and an Employer becomes delinquent if payments are not received on time.

B. A new Contributing Employer or newly established Contractor that employs at least two full-time bargaining unit employees and has never been affiliated with the Fund may participate in the program if they make a written request to the Plan Administrator, and receive the approval of the Board of Trustees. This request must be made within three months after becoming affiliated with the Bricklayers and Allied Craftworkers Health and Welfare Fund of Indiana. The Employer will make a “self-payment” monthly, in advance,
at the current rate set by the Trustees. Delinquent contributions will void this provision as set forth in (A) above. Eligibility will start one month following six month’s contributions.

C. Clerical employees of a participating Union, or this Fund, who are employed on a full-time basis, may participate in the program on approval of the Trustees. After approval by the Trustees, the Union will pay an amount set by the Trustees monthly, in advance, for each Employee. Eligibility will start one month following six months’ contributions. No Bank Credits will apply.

**Continuing Eligibility:**

After the Employee has established eligibility, the following rules apply:

A. Employees accumulating sufficient Bank Credits to cover the cost of three (3) months’ coverage during the Qualifying Period shall be eligible for benefits for the corresponding Benefit Period.

B. An Employee may use all or part of any surplus Bank Credits in their Individual Account if there are insufficient Bank Credits in (A).

C. Any surplus Bank Credits not used in the current three (3) month Benefit Period will remain in the Employee’s Individual Account for future cost of coverage.

D. If the Employee participates in another Welfare Fund with which the Plan holds a Reciprocity Agreement, the contributions made on his behalf will be returned to his home fund, if the Employee so indicates, by signing a Reciprocity Transfer Application. No eligibility is established under this plan by transfer of hours.

E. A new Employer may, upon approval by the Trustees, obtain coverage through his Bank Credits for a maximum of six (6) months after he becomes an Employer. He then must make payments as set forth above in order to maintain coverage.

**Self-Payment Provisions:**

The following provisions will apply to all covered Active Employees whose coverage may be terminated because of insufficient Bank Credits in their Individual Accounts on any Qualifying Date (January, April, July, October):

A. An Employee will be allowed to retain coverage by making a self-payment, which is reduced by using available Bank Credits, as long as Bank Credits are available.

B. If there are no Bank Credits available, an Employee will be allowed to retain coverage by self-payment a maximum of six (6) consecutive months.

C. The self-payment amount will be determined by the cost of three (3) months’ premium payment minus any available Bank Credit in the employees Individual Account.
D. The Employee must make his self-payment before the first day of the new Benefit Period to remain eligible.

E. If the Employee makes no self-payment by the first day of the new Benefit Period, he will not be eligible for benefits during that Benefit Period. The Employee will become eligible for benefits on the first day of the next Benefit Period after he has accumulated sufficient Bank Credits to cover the cost of four (4) months’ premium.

F. Coverage for an Employee will terminate if he has insufficient Employer Contributions or Bank Credits, and fails to make a self-payment, if permitted, to continue coverage.

G. To reinstate his coverage once he has let it lapse, the Employee must accumulate four (4) months’ premium to be eligible for the next Benefit Period.

H. In order to use any Bank Credits for eligibility, the Employee must be regularly employed, or eligible for full-time employment, in the jurisdiction of a B.A.C. Chapter affiliated with the Plan or have reciprocal contributions to this Fund. The only exception to this rule is under the retirement rules set forth in this Plan. Eligibility for an Employee, who is no longer available for employment in the jurisdiction of an Affiliated Chapter, shall be extended only through the end of the current Benefit Period. (See COBRA section in this book if you wish to keep your coverage through self-payments.)

I. After an Employee’s coverage has lapsed for any reason, for more than four (4) Benefit Periods, the Employee will forfeit the Bank Credits in his Individual Account. To qualify again for coverage, the Employee must accumulate four (4) months’ cost of coverage in order to be eligible for the next Benefit Period.

J. Receipts from Reciprocal Agreements will be credited to your Individual Account as Bank Credits on the date received. These credits will be applied to the current Qualifying Period, if needed; otherwise, they will remain in your Individual Account for future use.

Note: At the same time you receive a self-payment notice, you will also receive a COBRA Election form from the Plan. You can choose to either self-pay for coverage as indicated above, or you can elect COBRA coverage and pay COBRA premiums for up to 18 months, or the maximum allowed by law. If you choose COBRA coverage, you must pay the entire premium each month, and you cannot use your Individual Account to reduce your payments. **If you elect self-payments, you may NOT be eligible for COBRA coverage again until you reestablish eligibility as explained in the “New Participating Employees” section.**
Retiree Coverage:

An Active Participant may be able to continue coverage under this Plan once they retire, based upon the following provisions, however, **for retirees to continue coverage under the Plan, they must also continue to maintain Union Membership.** Please refer to the Schedule of Benefits for Retirees for the benefits provided to retirees.

A. **Early Retirement:** An Employee who retires from the trade, and is eligible for **and** is receiving benefits from the Local Pension Fund, may continue coverage, provided the Employee has been continuously eligible for coverage the preceding five (5) years. The early retiree may continue eligibility by use of Bank Credits available from his Individual Account or by paying the cost of coverage in each Benefit Period.

B. **Disability Retirement:** An Employee who is on Social Security Disability may continue coverage provided the Employee has been continuously eligible for coverage the preceding five (5) years, and provides a Social Security Disability Award Letter as proof of disability. The Employee may continue his eligibility with Bank Credits available from his Individual Account, and/or a self-payment to cover the full cost of the coverage each Benefit Period. Once the Employee is eligible for Medicare, he will be covered as a Normal Retiree.

C. **Normal Retirement:** An Employee who is at least age 65 and not available for full time employment and who has been continuously eligible in the Plan for the preceding five (5) years, either as an active employee or as an early retiree, shall be entitled to continue coverage, as detailed in the Schedule of Benefits for Retirees who are Medicare Eligible, and provided that the Employee pays the applicable cost of coverage either from Bank Credits, or by self-payment. The spouse of such member may also continue coverage, whether or not the spouse is yet Medicare eligible. The cost of coverage to a member and spouse under the age of 65 shall be the amount payable by an active employee. At the time both the member and spouse are eligible for Medicare, the cost shall be the amount as set by the Trustees.

An Employee who continues working on a regular basis after age 65 will continue to be covered according to the Eligibility Rules for Active Employees.

Bank Credits which are not utilized for the purchase of retiree benefits shall remain with the Fund. If the retiree wishes to return to full time employment, he must notify the Fund in writing. However, once the retiree has lost coverage for whatever reason, he must re-qualify for coverage by being available for full time employment, and by meeting the initial eligibility requirements for New Participating Employees.

**Family Security Benefits**

Any Dependent benefits which are in effect under this Plan at the time of the Employee’s death will be continued after such death while any required contributions for such coverage are continued. The Surviving Dependents will be allowed to use the Employee’s remaining Bank Credits to offset the required self-payments.
**Dependent Eligibility**

Your Dependents are eligible for benefits if you are covered under the Plan, and have submitted completed enrollment forms which include all dependents to be covered. For a definition of Dependent, see page 12.

If both husband and wife are covered under the Plan as Employees, either, but not both, may elect to cover eligible dependents as described above.

**Qualified Medical Child Support Orders (QMCSO)**

A Qualified Medical Child Support Order (QMCSO) is a court order that requires an Employee to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation or a paternity case.

A QMCSO requires the Plan to cover an alternate recipient who might not otherwise be eligible for coverage. This Plan provides benefits to the extent required by the QMCSO and by federal law. The Plan Administrator will notify you and alternate recipients if a QMCSO is received. You may obtain a copy of the Plan’s QMCSO procedures, without charge, by calling the Plan Administrator.

**When Coverage Ends**

Coverage for you and your Dependents will end on the last day of the month during which you no longer meet any of the continued eligibility requirements. In addition, coverage for you and your Dependents will end if:

- You join active military service; or
- The Plan ends.

Coverage for a Dependent also ends on the day when he or she no longer qualifies as a Dependent, as described on page 12.

When you or your Dependents’ coverage ends, you and your Dependent will be provided with a certification of your length of coverage under this Plan. This may help reduce or eliminate any pre-existing condition limitation under a subsequent group medical plan.

If coverage under the Plan ends due to uniformed service, please see “If You Enter Military Service”, below for more information about USERRA Service continuation coverage. Otherwise, if coverage under the Plan ends, you and your Dependents may be eligible to continue coverage under either, but not both, of two options – the Self-Payment option or the COBRA Coverage option.
Non-Work Hours

If you become disabled, join the military or take a leave under the Family and Medical Leave Act (FMLA), your eligibility for coverage may continue while you are not working.

If You Enter Military Service

If you enter the uniformed services of the United States, you may elect to continue your health coverage (medical and prescription drug) as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Or your Benefit Bank will be frozen until you are released from service and are available for work.

Uniformed services include Service in the United States Armed Forces, and their Reserves, the Army National Guard and the Air National Guard, the commissioned corps of the Public Health Services and any other category of persons designated by the President in time of war or emergency. “Service” means the performance of duty on a voluntary or involuntary basis under competent authority and includes active duty, active duty training, initial active duty training, inactive duty training, full-time National Guard duty and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

Your regular coverage will continue until the last day of the month that you enter Service. For the first 30 days of Service, you do not have to pay for your USERRA Health Coverage. After the 30th day of Service, you or your Dependent must make the required self-payment contribution for USERRA Health Coverage. The premium for this coverage is the same amount as the COBRA premium.

Your USERRA Health Coverage will continue until the earlier of:

- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- 24 consecutive months after the USERRA Health Coverage began; or
- The date on which you have had a total of five years of USERRA Health Coverage.

Your Dependents may continue coverage under the Plan during your Service either through USERRA Health Coverage, if you have elected it, or through COBRA Coverage. If you do not elect USERRA Health Coverage, your Dependents can only continue coverage under the Plan through COBRA Coverage. Regular eligibility for you and your Dependents will be reinstated on the day you return to work, provided you reapply for work in accordance with USERRA.

You need to notify the Plan Administrator in writing when you enter the uniformed services. For more information about continuing coverage under USERRA, contact the Plan Administrator.
If You Take A Leave under The Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) enables you to take up to 12 weeks (during any 12-month period) of unpaid leave for the birth or adoption of a child or for your serious illness or to care for a seriously ill spouse, parent or child, if you are eligible. The FMLA requires your Employer to continue making contributions for your health care coverage for the length of a qualified FMLA leave, as if you were still working.

Your Employer can tell you if you are eligible for FMLA Leave. When taking a leave under FMLA, you and your Employer need to inform the Trustees in writing so that your rights to Health Coverage are protected during the leave.

If you return to work within 12 weeks, you will not lose health care coverage. If you do not return to work within 12 weeks, you will then qualify to continue your coverage under COBRA Coverage. You may self-pay for COBRA Coverage for up to 18 additional months, or in some situations 29 months. Contact the Plan Administrator for additional information about FMLA or continuing your coverage under COBRA Coverage.
COBRA Continuation Coverage Option

Under certain circumstances, coverage for you or your eligible Dependents (“Qualified Beneficiaries”) can be temporarily continued, at your expense, after it would normally end due to a “Qualifying Event”. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides you with the right to this continuation coverage. This Plan is automatically amended to conform with any changes made to the COBRA regulations. This section of the booklet serves as your initial notice of your COBRA rights, including when COBRA may be available to you and your qualified Dependents and what you must do to protect your COBRA rights.

COBRA Coverage is identical to the coverage you had under the Plan. You may continue your medical, dental, prescription drug and vision benefits under the plan, but the Life Insurance and Short Term Disability Benefits cannot be continued.

After a “Qualifying Event”, each person losing Health Coverage will become individually entitled to elect COBRA Coverage. You or your Spouse, if your Spouse is eligible to elect COBRA Coverage, may elect COBRA Coverage for your Dependent Children who are eligible for COBRA Coverage. Each person must pay the full cost of the COBRA Coverage plus a small administrative charge.

If you (the Employee) have a newborn child, adopt a child or have a child placed with you for adoption (for whom you have financial responsibility) while COBRA Coverage is in effect, you may add your child to your COBRA Coverage. You must notify the Plan Administrator, in writing, of the birth or placement to have your child added to your coverage. Alternate recipients receiving benefits under a QMSCO which is received by the Plan Administrator during your Health Coverage are entitled to the same right to elect COBRA Coverage as other eligible Dependent Children. Like all Qualified Beneficiaries with COBRA Coverage, their continued coverage depends on timely and uninterrupted COBRA premiums on their behalf.

18-Month COBRA Continuation Coverage

If coverage ends for one of the following reasons or “Qualifying Events,” you may elect to pay for COBRA Coverage for yourself and your qualified Dependents for up to 18 months:

- Your coverage ends because your employment ends, including retirement, but not including termination due to gross misconduct;
- You are no longer eligible for Plan coverage due to your failure to work the required number of hours in the corresponding work period; or
- Your Employer lays you off.

However, if your qualified Dependents have a second “Qualifying Event” during the initial 18 months of COBRA Coverage, they may pay for COBRA Coverage for a total of 36 months. Second “Qualifying Events” include your:

- Death;
- Divorce; or
- Dependent child no longer qualifying for Dependent coverage under the terms of the Plan.
If the “Qualifying Event” is the end of employment, layoff or a reduction of hours, and you became entitled to Medicare benefits less than 18 months before the “Qualifying Event”, COBRA Coverage for your Dependents can last until up to 36 months after the date of your Medicare entitlement. So, for example, if you become entitled to Medicare 8 months prior to a termination of employment, that results in your losing Health Coverage under the Plan, then your Dependents could receive COBRA Coverage for 28 months (36 months minus 8 months). This COBRA Coverage period is available only if you become entitled to Medicare less than 18 months before your termination, layoff or reduction of hours.

29-Month COBRA Continuation Coverage

If your coverage ends due to one of the above “Qualifying Events” (termination, layoff or reduction of hours) and, at the time of the event, or within the first 60 days of the COBRA Coverage, you or one of your qualified Dependents is totally disabled (as determined by the Social Security Administration), COBRA Coverage for you and all of the family members who are covered under COBRA Coverage is extended for an additional 11 months, for a total of 29 months. This option offers the disabled individual COBRA Coverage until Medicare coverage becomes effective. Coverage for the additional 11 months will be at a higher cost.

If your qualified Dependents have a second “Qualifying Event” during the initial 29 months of coverage, they may pay for a total of 36 months of COBRA Coverage.

36-Month COBRA Continuation Coverage

Your qualified Dependents may elect to purchase COBRA Coverage for up to 36 months if their Plan coverage ends for any of the following “Qualifying Events” or reasons:

- Your death;
- Your divorce or legal separation; or
- Your Dependent Child no longer qualifies for Dependent coverage under the terms of the Plan.

Notice of Qualifying Events

To be eligible for COBRA Coverage, you, your qualified Dependents, or your Employer must provide written notice to the Plan Administrator of the Qualifying Event. The notice must be mailed, emailed, faxed or hand-delivered to the TPA. Who must provide this notice depends on the nature of the Qualifying Event.

You should notify the Plan Administrator of your entitlement to Medicare. Your employer will notify the Plan Administrator of your termination of employment, reduction of hours, or death. However, because employers contributing to multiemployer funds may not be aware of these events, the TPA will rely on its records for determining when eligibility is lost under these circumstances. To help ensure that you do not suffer a gap in coverage, we urge you or your family to notify the TPA of qualifying events as soon as they occur.

To elect COBRA Coverage after a divorce, legal separation or a child ceasing to be a Dependent Child under the Plan, you and/or a family member must inform the Plan Administrator in writing of that event no later than 60 days after that event occurs. That
notice should be sent to the Third Party Administrator whose address is listed in the “Contact Information” section on page 8.

To receive an extension of COBRA Coverage due to a second Qualifying Event, you or a family member must inform the Plan Administrator in writing within 60 days of the death, divorce, legal separation or the date a Child ceases to be a Dependent under the Plan. To receive an extension, this notice must also be received before the end of the first 18 months of COBRA Coverage. Otherwise, you will NOT be eligible for the extension of coverage.

If you and/or your qualified Dependents are seeking an extension due to disability, you or a family member must inform the Plan Administrator in writing, providing Social Security Administration’s determination of disability, within 60 days of the latest of:

- the date of the SSA’s disability determination;
- the date of termination, layoff or reduction of hours; and
- the date of lost coverage of your Dependent due to termination, layoff or reduction of hours.

If the TPA does not receive the notice discussed above within the 60-day period, the Qualified Beneficiary will not be entitled to choose or extend COBRA Coverage.

What is Not a Qualifying Event

If your Employer withdraws from participating in the Plan (for example becomes a non-union contractor) then you do not have the right to buy COBRA Coverage from this Plan, because your Employer’s withdrawal from this Plan is NOT a Qualifying Event.

If you lose your Retiree Coverage because you do not pay your premium, this is not a Qualifying Event.

When COBRA Coverage Ends

COBRA Coverage may end for any of the following reasons:

- You or your Dependent becomes covered under another group medical plan. However, COBRA Coverage will continue if you or a qualified Dependent has an existing health problem for which coverage is excluded under the other group plan;
- The required contribution is not paid on time;
- The Board of Trustees terminates the Health and Welfare Plan;
- You or your Dependent reaches the end of the 18-month, 29-month or 36-month COBRA Coverage period;
  - If the Qualified Beneficiary who was disabled is later determined by Social Security to no longer be disabled, you must notify the Plan Administrator of that decision within 30 days of the decision.
- You become entitled to Medicare; or
- Your Dependents become entitled to Medicare.

When your COBRA Coverage ends, you will be provided with certification of your length of coverage under this Plan. This may help reduce or eliminate any pre-existing limitation under a new group medical plan.
Death Benefit (Active and Retired Employees Only)

In the event of your death, a benefit will be paid to your beneficiary as listed in the “Schedule of Benefits,” if you were eligible for coverage under the Plan at the time of your death. A benefit will be paid upon receipt of proof of your death.

Designating Your Beneficiary

To designate your beneficiary, complete a form supplied by the Fund Office. You may name more than one beneficiary and indicate the percentage of the Death Benefit you want each beneficiary to receive. If you do not specify the percentage for each beneficiary, then your beneficiaries will share the benefit equally. If one of your beneficiaries predeceases you, the benefit will be split equally among your remaining beneficiaries. You can change your beneficiary at any time by submitting a new form to the Fund Office. Beneficiary designations are effective on the date you sign the form.

If there is no named beneficiary still surviving at the time of your death, your Death Benefit is divided equally among the members of the first surviving class listed below:

- Your spouse;
- Your children;
- Your parents;
- Your brothers and sisters; or
- Your estate.

A legal guardian or administrator must be appointed by the court and the legal papers must be submitted to the Fund Office before the Death Benefit may be made to a beneficiary who is a minor child or when multiple beneficiaries are designated.

Filing A Claim

In the event of your death, your beneficiary must contact the Fund Office. The Fund Office will provide a claim form for your beneficiary to complete and return along with a copy of the death certificate.
Accidental Death Benefit (Active Employees Only)

The Accidental Death Benefit is paid to your beneficiary in the event of your death as a result of an Accident. The loss must occur within 90 days after the Accident. This benefit is in addition to any other benefits you may receive from the Plan. The Accidental Death Benefit amount is listed in the “Schedule of Benefits.”

Limitations

The benefits described above do not cover any loss caused by:

- An attempt at suicide or a self-inflicted injury or Illness, including complications thereof;
- An injury incurred during war or act of war while in combat;
- An injury resulting directly or indirectly from a self-inflicted or self-induced chemical substance or barbiturate consumption. Injury sustained due to intoxication by means of alcohol or other drugs will be considered self-inflicted;
- Injury incurred while in an aircraft, except when you are a passenger in a licensed aircraft (other than a chartered aircraft) operated by a licensed pilot on a regularly scheduled passenger flight offered between specified airports by a licensed passenger carrier;
- Death caused directly or indirectly from sky-diving, competitive auto or sport car racing or motorcycle racing; or
- A felonious act or the result of a felonious act committed by you.

Filing A Claim

In the event of a loss under the Accidental Death Benefit, you or your beneficiary must contact the Fund Office. The Fund Office will provide a claim form to complete and return along with any supporting documents.
Short Term Disability Benefit (Active Employees Only)

The Short-Term Disability Benefit is payable if you become Disabled and unable to perform the material duties of your occupation for compensation or profit due to an Injury or Illness not arising from or in the course of any employment, and you meet each of the following conditions:

- You become Disabled while you have Health Coverage in this Plan (not COBRA, USERRA, FMLA or Retiree Coverage),
- You are under the direct care and treatment of a Physician for your Disability,
- You are not working for wage or profit,
- You meet the Plan's claim filing requirements, and
- None of the exclusions or limitations described in this part of the Plan apply.

The Plan Administrator may require you to provide proof from time to time that you are disabled.

Benefit Amount

If you are eligible for the Short Term Disability Benefit, you will receive up to the maximum listed in the “Schedule of Benefits” per week. The Short Term Disability Benefit is paid for the maximum number of weeks specified in the Schedule of Benefits, for any one period of Disability.

Periods of disability separated by less than six (6) weeks’ active work for a signatory contractor shall be considered one period of disability and no employee shall be allowed more than two (2) disability periods in any one (1) calendar year. You must be under the care of a legally qualified medical doctor during the period for which benefits are claimed.

The Short Term Disability Benefit is taxable. The Plan will deduct the amount required by the Internal Revenue Service (IRS) for FICA (Federal Insurance Contributions Act) taxes and income taxes.

When Short Term Disability Benefits Begin

The Short Term Disability Benefit begins on the first day of Disability for Accidental injury, or on the eighth day of Disability for Sickness.

Filing A Short Term Disability Benefit Claim

You must submit a claim form that was completed by you or your Physician. The form may be obtained from the Local Union office, or the Plan Administrator. The completed form should then be submitted to the Fund Administrator for consideration.

Once benefits are approved, Short Term Disability Benefits will be paid no later than the end of each two-week period. If you have questions, contact the Fund Administrator at the phone number listed in the “Contact Information” at the front of this booklet.
Termination of Short Term Disability Benefits

Short Term Disability benefits end when the first of the following events occurs:

- You have received 6 weeks of benefits;
- You die;
- You are no longer Disabled;
- You work for wage or profit;
- You fail to provide any required proof that you are Disabled;
- You stop being under the direct care and treatment of a Physician;
Comprehensive Major Medical Expense Benefit (All Participants)

Your health care benefits cover most reasonable health care expenses that you and your eligible Dependents may incur. The following sections explain the details of the Plan’s benefits, and any deductibles, co-payments and limitations that may apply. The Health Care benefits include the following:

- Comprehensive Major Medical Expense Benefit;
- Wellness Benefit; and
- Prescription Drug Benefit.

Your Comprehensive Major Medical Expense Benefit protects you and your family from potentially catastrophic health care expenses.

Deductible

The deductible is the amount of covered medical charges that you and each of your eligible Dependents must pay each calendar year before the Plan begins to pay benefits. Deductible amounts are listed in the “Schedule of Benefits.”

The individual deductible applies to each member in your family every calendar year. In addition, if you or a member of your family incurs an expense that is used to satisfy the deductible during October, November or December, that amount will be used to satisfy the deductible for the following calendar year as well.

Co-payments do not count toward satisfaction of the Deductible.

Benefits Payable (Co-insurance)

Once you pay the annual Deductible, the Plan pays a percentage (as specified in the “Schedule of Benefits”) of Covered Charges up to the Reasonable and Customary Charges or In-Network allowable amount. The percentage the Plan pays varies depending on whether you use an In-Network or Out-of-Network provider. In addition, some maximums apply to certain coverages.

Out-of-Pocket Maximum

You must pay the remainder of the Covered Charge after the Plan pays the co-insurance amount as listed in the “Schedule of Benefits”, until the individual Out-of-Pocket Maximum for Covered Charges is reached. The individual Deductible for each person is not included in the individual Out-of-Pocket Maximum. If you reach the annual Out-of-Pocket Maximum, the Plan pays 100% of Covered Charges for the rest of the calendar year, except for certain benefits that will not be paid at 100% even though the Out-of-Pocket Maximum has been met: Home Health Care, Spinal Adjustment, Prescription Drugs, Vision Benefits, Hospice Care.

Note: Charges for Co-payments, pre-certification penalties, charges that exceed the maximum benefits as listed in the “Schedule of Benefits” and payment for non-covered charges do NOT apply toward your Deductibles or Out-of-Pocket Maximums.
Annual Maximum

This Plan will pay up to the Annual Maximum Benefit, as specified in the Schedule of Benefits, for any one person during a calendar year for all Medical, Wellness, Vision, and Prescription Drug services. This is your Annual Maximum Benefit.

Preferred Provider Organization (IN-NETWORK)

To help control medical costs, the Health and Welfare Plan has an agreement with a Preferred Provider Organization regarding In-Network Providers (In-Network Providers). In-Network Providers refer to a group of Hospitals and providers that agree to provide services at fees that are generally lower than those normally charged by other Hospitals or providers.

To minimize your out-of-pocket costs, contact the Preferred Provider Organization for information on which Hospitals and providers belong to the Network. When you use In-Network Hospitals and providers rather than Out-of-Network Hospitals and providers, you can reduce costs for both you and the Plan. You may use any provider you wish, but the Plan pays a higher percentage of your Covered Charges when you use a provider in the Network. As referred to in this section, an “Out-of-Network” provider does not have an agreement in effect with the Preferred Provider Organization. When you use In-Network Providers, you do not need to file claims. The In-Network Provider Organization files the claims for you. It is the Participant’s responsibility to call the Preferred Provider Organization prior to each hospitalization or doctor visit to determine whether the facility and/or provider is a member of the Network. If you need a listing of In-Network Providers, contact the In-Network Provider Organization. A listing of In-Network Providers will be furnished to you free of charge. If you have a question about In-Network Providers, see the section titled “Contact Information”.

EXCEPTIONS TO OUT-OF-NETWORK LEVEL OF BENEFITS

The following listing of exceptions represents services and supplies rendered by an Out-of-Network Provider where eligible expenses shall be payable at the Network Provider level of benefits:

- emergency treatment rendered at an Out-of-Network facility;
- Out-of-Network anesthesiologist if the operating surgeon is a Network Provider;
- radiologist or pathologist services for interpretation of x-rays and laboratory tests rendered by an Out-of-Network Provider when the facility rendering such services is a Network Provider;
- emergency room Physician services rendered by an Out-of-Network Provider when the facility rendering such services is a Network Provider;
- diagnostic laboratory and pathology tests performed by an Out-of-Network Provider when referred by a Network Provider;
- assistant surgeon services rendered by an Out-of-Network Provider when the facility rendering such services is a Network Provider;
• while confined to a Network Provider hospital, a consultation from an Out-of-Network Provider requested by the Network Physician;

• medically necessary services and supplies which are not available through any Network Provider in the geographical area;

• eligible expenses incurred by a covered Spouse or Dependent Child when residing outside the service area of the Preferred Provider Organization;

• eligible expenses incurred by Participant when residing more than thirty (30) miles from an area serviced by the Preferred Provider Organization;

• when the Participant incurs non-emergency eligible expenses while traveling outside the area serviced by the Preferred Provider Organization, unless the primary purpose of the travel is the receipt of medical care; and

• medically necessary services and supplies which are not available through the Participant’s Network Provider because the Network Provider is out of the office shall be considered if a letter is obtained from the office of the out of the office Physician.

Utilization Review

The Plan also has a utilization review agreement with a Utilization Review Company, “UR” Company, to certify Hospital admissions. The Participant must call the UR Company, as listed in the Contact Information, to certify your Hospital stay (in most cases your provider will call on your behalf). If you or your doctor do not, and the Plan determines that either the Hospitalization or surgery is not Medically Necessary or that the surgery is Experimental or Investigational, no benefits will be paid.

Elective Hospital admissions should be certified before admission. An elective admission is one in which your condition permits adequate time to schedule the hospitalization.

Urgent Hospital admissions and emergency Hospital admissions are reviewed after admission. You or someone else should call the UR Company, as listed in the Contact Information, within two (2) working days or as soon as reasonably possible of an urgent or emergency Hospital admission. An urgent admission is one in which you require immediate attention for the care and treatment of your physical or mental condition. Generally, you are admitted to the first available and suitable accommodation. An emergency Hospital admission is one in which the sudden onset of a severe medical condition requires immediate Hospital admission to prevent the patient from:

- Putting their health in permanent jeopardy;
- Incurring other serious medical consequences;
- Having a serious impairment of bodily functions; or
- Incurring serious permanent dysfunction of any bodily organ.

Extended Hospital Confinements are reviewed when the UR Company contacts the Hospital on the expected date of discharge. If a longer Hospitalization is anticipated, the attending Physician will be called to discuss the continued length of stay.
Second Surgical Opinions are Covered Charges, and the Plan will pay for the cost just as it pays for other benefits.

**Note:** Certification does NOT guarantee that benefits will be paid. You still must be eligible for Health Coverage at the time the services are provided, and the services for which you are actually charged must be Covered Charges, and Out-of-Network charges billed must be Reasonable and Customary. To verify your eligibility and whether a certain procedure is a Covered Charge, you should call the Third Party Administrator. Should the UR Company deny certification of your hospitalization or surgical procedure, you can appeal the decision by sending a notice of appeal to the Plan Administrator within 180 days after you received the notice of denial. Your appeal will be treated as a claim for benefits, and will be subject to the same appeal procedures as other claims.

**Medical Case Management**

Medical Case Management is a cost management program administered to provide a timely, coordinated referral to alternative care facilities to a Participant who suffers a catastrophic Sickness or Injury while covered under this Plan.

The following are examples of diagnoses that might constitute a catastrophic Sickness or Injury:

- High Risk Pregnancy
- Neonatal High Risk Infant
- Cerebral Vascular Accident (CVA or Stroke)
- Multiple Sclerosis
- Amyotrophic Lateral Sclerosis (ALS)
- Cancers/Tumor Malignancy
- Severe Cardio/Pulmonary Disease
- Leukemia
- Major Head Trauma and Brain Injury Secondary to Illness
- Spinal Cord Injury
- Amputation
- Multiple Fractures
- Severe Burns
- AIDS
- Transplant
- Any claim expected to exceed $25,000

When the case manager is notified of one of the above diagnoses (or any other diagnosis for which Medical Case Management might be appropriate), the case manager will contact the Participant to discuss current medical treatment and facilitate future medical care. The case manager will also consult with the attending Physician to develop a written plan of treatment outlining all medical services and supplies to be utilized, as well as the most appropriate treatment setting. The treatment plan may be modified intermittently as the Participant’s condition changes, with the mutual agreement of the case manager, the patient, and the attending Physician.
All services and supplies authorized by the treatment plan will be considered covered expenses, whether or not they are otherwise covered under the Plan. The benefit level for alternative treatment settings may be the same as the Hospital benefit level, in the absence of the Medical Case Management program. For all other services and supplies, the benefit level will be the same as the benefit for outpatient medical treatment, in the absence of the program.

Any deviation from the treatment plan without the case manager’s prior approval will negate the treatment plan, and all charges will be subject to the regular provisions of this Plan.
Covered Charges

Covered charges are the Reasonable and Customary Charges for the following Medically Necessary services and supplies received for the treatment of a non-occupational Injury or Illness when ordered and prescribed by a legally qualified Physician:

1. Hospital services and supplies for:
   a. Room and board charges up to the Hospital’s:  
      - Regular daily semi-private rate; or  
      - Charges for a private room, when semi-private is not available.  
   b. Drugs, medicines and other Hospital services and supplies for medical care and treatment exclusive of professional services, while hospitalized.  
   c. Out-Patient Hospital charges including charges incurred for:  
      - Out-Patient surgical procedures; and  
      - Emergency treatment for an Injury or Illness.

Group health plans and health issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery or less than ninety-six (96) hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

*This Plan only covers maternity benefits for female Employees and the Spouse of male Employees.*

2. Urgent Care at an Urgent Care Center.

3. Medical care and treatment performed by a legally qualified Physician.

4. Charges made by a Physician for medical services, including active services as an assistant Surgeon.

5. Services of all licensed medical professionals who are acting within the scope of their license.

6. Charges made by a Physician or Surgeon for the performance of an operation or the repair of a dislocation or fracture. When more than one surgery is performed at the same time, Covered Charges for the services of the Physician for each procedure that is clearly identified and defined as a separate procedure will not exceed:

   - 100% of the Reasonable and Customary Charges for the first or primary operation;  
   - 50% of the Reasonable and Customary Charges for the second operation; and  
   - 25% of the Reasonable and Customary Charges for any additional operations.
7. Charges for the services of an anesthesiologist or professional anesthetist.

8. Charges made by a registered nurse (RN) or licensed practical nurse (LPN/LVN) other than one who ordinarily resides in your home or who is a member of your or your eligible Dependent’s Immediate Family.

9. Charges by a local ambulance service for Medically Necessary ground transportation to the nearest facility.

Ambulance services for transportation from one facility to another when the first facility is not fully equipped to properly treat the patient’s condition.

Charges for air ambulance transportation to the nearest medical facility, for treatment of a serious medical Illness or Injury, when ground transportation cannot be utilized due to terrain, distance, or severity of the patient’s condition.

**Charges for ambulance services for convenience or non-emergency care shall not be an eligible expense.**

10. Diagnostic X-ray and laboratory services.

11. Whole blood or blood plasma and the cost of its administration, except that replaced by or for the patient. The handling charge for storing the patient’s blood prior to surgery is also covered.

12. Radium, radioactive isotopes and X-ray therapy.

13. Prescription drugs and medications which require a written prescription. Expenses will be payable as indicated in the Schedule of Benefits.

14. Out-Patient cardiac rehabilitation following surgery.

15. Pulmonary rehabilitation when prescribed by the patient’s primary Physician.

16. Voluntary sterilization including tubal ligation and vasectomy, and birth control including insertion and/or removal of an IUD and injection of Norplant, Depo-Provera and Lunelle. *Note: Benefits will be payable for expenses incurred by Dependent Children only when Medically Necessary.*

17. Wellness Benefits, including, but not limited to:

- Routine physical examinations and all related services, including well-baby visits.
- Pediatric Vaccines administered to Dependent Children from birth through eighteen (18) years of age. Pediatric vaccines are those vaccines on a list established by the Advisory Committee on Immunization Practices as referenced by Section 1928 of Title 19 of the Social Security Act or another list of vaccines as mandated by other Federal laws that are applicable to this Plan.
- Flu and pneumonia shots each calendar year
18. Treatment and surgery by a Physician, either in an office or Hospital, for the repair of
damage to the jaw and sound natural teeth, if the damage is the direct result of an
Injury (but did not result from chewing) and if the dental services are completed within
twelve (12) months after the Injury.


20. Manual manipulation of the spine to correct distortion, misalignment or subluxation of
or in the vertebral column, including diagnostic services, up to the calendar year
maximum listed in the “Schedule of Benefits” by a licensed chiropractor acting within
the scope of his license. Chiropractic Care does not include:
   a. Allergy therapy;
   b. Diet or hair analysis;
   c. Nutritional or food supplements not requiring a Physician’s prescription;
   d. Pillows, supports or similar devices; or
   e. Booklets.

21. Speech therapy, except for treatment of a learning disorder, language disorder,
remedial reading or special education or a condition which is the result of a
developmental delay.

22. Surgical dressing, casts, splints, braces, crutches, surgical supplies, colostomy bags,
ileostomy supplies, catheters, cervical collars, head halters and other traction
apparatus.

23. Charges for the initial purchase of a prosthesis for a wholly or partially missing body
part, such as, but not limited to, artificial limbs and eyes. Eligible expenses shall
include the replacement if needed due to growth and development of the patient. An
eligible prosthesis must be the result of an Injury, Illness, or physical condition
occurring while eligible for coverage under this Plan or the plan this Plan replaces.
Charges for dental prosthesis shall not be an eligible expense.

24. Custom-molded orthotics up to the maximum in the Schedule of Benefits including:
   a. Charges for the purchase and fitting of braces, splints and other appliances used
to support or restrain a weak or deformed body part;
   b. Charges for orthopedic braces (including corrective shoes if attached to the brace),
crutches and prosthetic devices and appliances including the initial purchase, fitting
and placement of fitted devices which replace body parts or perform body functions
necessary for the alleviation of or correction of conditions arising out of an
Accident, Injury or Illness; and
   c. Charges for the repair of any of the covered items described above

Covered Charges do NOT include, and the Plan will NOT pay benefits for:
   o Appliances for palliative treatment of the foot, such as, but not limited to,
     heel lifts, foot pads and arch supports;
   o Corrective or orthopedic shoes not attached to a brace; and
   o Loss, theft or damage.
25. Federal law requires plans that provide medical and surgical benefits for mastectomies to pay for the following, when requested by the patient in consultation with her Physician:
   a. Reconstruction of the breast on which the mastectomy has been performed;
   b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
   c. Prostheses and physical complications of all stages of mastectomy, including lymph edemas.

26. Charges for the rental or purchase of durable medical equipment, whichever is economically justified, which is:
   a. Medically Necessary and prescribed by the attending Physician;
   b. for therapeutic use or specifically used for treatment of an Injury or Illness;
   c. suitable for use in the home; and
   d. exclusively for the use of the individual being treated.

   Eligible expenses will include charges for the replacement of purchased durable medical equipment if due to growth and development of the patient. Routine maintenance of the equipment is not an eligible expense.

27. Allergy testing and injections when related to the diagnosis and therapeutic treatment for allergies.

28. Home Health Care, when referred to and provided by a licensed home health care agency following a covered Hospital confinement, up to the calendar year maximum visits listed in the “Schedule of Benefits,” for the following:
   a. Evaluation by a registered nurse or Physician of the need for a home health care plan;
   b. Care by a home health care aide for the patient only, when supervised by a registered nurse (RN), licensed practical nurse (LPN) or medical social worker;
   c. Physical, respiratory and/or speech therapy;
   d. Medical supplies (including oxygen);
   e. Durable medical equipment;
   f. Drugs and medicines;
   g. Laboratory services;
   h. Special meals prescribed by a Physician, licensed nutritionist or dietician.

   Skilled Nursing Care Facility within thirty (30) days of release from a Hospital confinement of at least 5 days, for the following covered charges:
   a. Room and board, up to a maximum of the charge for a semiprivate room in the Hospital to which the patient was confined just before the Skilled Nursing Care Facility;
   b. General nursing care; and
   c. Medical services and supplies.

   Each eight (8) hours of service by a home health care aide equals one (1) visit. Each visit by any other member of the home health care agency team equals one (1) visit.
The following Home Health Care Charges are NOT Covered Charges:

a. Services or supplies that are not a part of a treatment plan worked out in advance by the patient’s Physician and a licensed home health care agency;
b. Services provided by a person who usually lives with the patient or by a member of the patient’s Immediate Family;
c. Services of a social worker;
d. Transportation;
e. Charges for care, which are not skilled care, but which is primarily for the personal comfort or convenience of the patient, the provider or any other person (“Custodial Care”);
f. Services in excess of the visit limitations set out above in the Skilled Nursing and Home Health Care Services section;
g. The part or all of any nursing care that does not require the education, training and technical skills of an RN or LPN, such as transportation, meal preparation, charting of vital signs and companionship;
h. Inpatient private duty nursing care;
i. Care provided solely for skilled observation;
j. Service provided solely to administer medicines, except where applicable law requires that such medicines be administered by an RN or LPN; and/or
k. Care which is not Medically Necessary.

Deductibles and Co-insurance for Home Health Care charges are the same as for any Medical Covered Charges. Coverage of Home Health Care charges does not prevent any person from visiting their Physician or any other health care provider.

29. Organ and Tissue Transplant Benefits

Human organ and tissue transplant benefits are provided according to the terms and conditions set forth in a separate Organ & Tissue Transplant Policy (Transplant Policy) that has been issued to the health plan. Transplant related benefits will be provided to each covered person during the transplant benefit period specified in the Transplant Policy. Once the transplant benefit period has elapsed, all transplant-related benefits will revert back to this health plan, subject to its terms and conditions.

Transplant related benefits are only available to individuals that:
A. Are eligible for medical benefits under this health plan; and
B. Meet all the terms and conditions outlined in the Transplant Policy; and
C. Have fulfilled the pre-existing condition waiting period (if applicable) as defined in the Transplant Policy.

Covered persons that are subject to a pre-existing condition waiting period under the Transplant Policy will receive transplant benefits according to the terms and conditions of this health plan until the pre-existing condition waiting period has elapsed.

Organ transplant or tissue replacements, which are not covered by the separate Organ & Tissue Transplant Policy are covered by the following provisions:

The following procedures are covered:

a. Cornea transplants;
b. Kidney transplants;
c. Heart transplants;
d. Heart and lung transplants;
e. Bone marrow transplants;
f. Liver transplants;
g. Skin;
h. Pancreas;
i. Lung.

The Plan will also cover any other types of human organ transplants that become accepted as non experimental procedures, as generally accepted by the medical profession. Covered Charges include charges to obtain the organ or tissue which is going to be transplanted.

Covered Charges do NOT include, and the Plan will NOT pay benefits for:
- Any Experimental or Investigational transplant or transplant procedure, even if it is listed as a covered transplant.

30. The following treatment for a mental/nervous condition or for substance abuse:
   a. Services ordered and prescribed by a legally qualified Physician only. Court ordered or school ordered care is not covered;
   b. Duly constituted Hospital confinement or partial hospitalization (day treatment);
   or
   c. Diagnosis and treatment by a licensed psychiatrist, clinical psychologist or licensed social worker. If care is provided by a clinical psychologist or licensed social worker, the care must be prescribed and supervised by a psychiatrist or other MD or DO.

31. Less Costly Care. In the sole discretion of the Trustees, benefits may be provided for treatment and services which are not Covered Charges, but which are less costly than Covered Charges.

32. Abortion. Induced termination of a pregnancy for all covered females, by any acceptable means, only when Medically Necessary, or due to pregnancy caused by rape.

33. Chemotherapy. A regimen comprised of a single agent or a combination of anti-cancer agents clinically recognized for treatment of a specific type of cancer, including modifications and combinations appropriate to the history of the cancer or according to protocol specifying the combination of drugs, doses, and schedules for administration of the drugs.

Drug Requirements

- Use that is included as an indication on the drug’s label as approved by the FDA;
- The Plan shall refer to the Centers for Medicare & Medicaid services (CMS) authoritative compendia, including the NCCN Drugs and Biologics Compendium and Thomson Micromedex, in the determination of medically accepted drugs and biologicals used off-label in an anti-cancer chemotherapy regimen. Subject to a medical opinion, if no other FDA or Off-Label approved treatment is feasible and as
a result the Participant faces a life or death medical condition, the Plan retains
discretionary authority to cover the services or treatments.

- Use of drugs to treat toxicities or side effects of the cancer treatment regimen when
  the drug is administered in relation to chemotherapy, including off-label uses
  supported by medical literature.

OncoSentrics (Cancer Management Program)

The Plan has an agreement with Biologics to support members who have a cancer
diagnosis by assisting the member and member’s oncologist during the course of
cancer treatment. OncoSentrics begins at the point of diagnosis, collecting a patient’s
entire plan of treatment, including all drug formulations, and conducting a proactive
and ongoing clinical review to ensure the plan of treatment is supported by evidence-
based guidelines.

It is important the member’s treating oncologist call Biologics at (800) 983-1590
prior to chemotherapy administration. Oncology Nurse Specialists are also
available to assist members with questions.

34. Hospice Care Expenses.

Services:
- Hospice room and board while the terminally ill person (diagnosed by the attending
  Physician as having six months or less to live) is an inpatient in a Hospice;
- Outpatient and other customary Hospice services provided by a Hospice or
  Hospice team; and
- Counseling services provided by a member of the Hospice team.
- Bereavement Counseling

Requirements:
These services and supplies are eligible only if the Hospice operates as an integral
part of a Hospice Care Agency and the Hospice team includes at least a doctor and a
registered graduate nurse. Each service or supply must be:

- Provided under a Hospice Care Agency program that meets standards set by the
  Plan. If such a program is required by federal or state law to be licensed, certified,
  or registered, it must meet that requirement;
- Provided while the terminally ill person is in a Hospice Care Program; and
- Ordered by the doctor directing the Hospice Care Program.

35. Facility charges for procedures performed in an Ambulatory Surgical Center and
associated services and supplies.

36. Physical/Occupational Therapy. Medically Necessary services, as certified by a
Physician, rendered by a certified or licensed physical therapist or registered
occupational therapist. Therapy rendered by a licensed therapist to restore the loss or
impairment of motor functions resulting from illness, disease or injury. Coverage ends
once maximum medical recovery has been achieved and further treatment is primarily
for maintenance purposes. Only therapy designed to restore motor functions needed for activities of daily living (such as walking, eating, dressing, etc.) is covered.

37. Services and supplies provided under case management for the continuing care needs of catastrophic and chronic high-cost medical care cases. The case manager from the utilization review company will work in conjunction with the attending Physician, the patient and patient’s family to find less costly medical services and supplies, even though such alternatives are not specifically stated as covered charges by the Plan. This does not, however, cover charges that are considered Experimental or Investigational as explained on page 14 or are provided as a convenience to the patient, the patient’s family or health care provider. Coverage for alternate care is subject to the same overall Plan benefit maximum, Co-payment and Deductible requirements that apply to the medical care being replaced.

Although the case manager may suggest to the Physician less costly alternate means of medical care, the final decision on patient care and treatment is the responsibility of the patient, the patient’s family and the attending Physician. If the case manager, patient, patient’s family and Physician agree to a less costly alternative means of medical care, the Plan will reimburse at that rate. **Out-of-Network provider expenses negotiated by a case manager are eligible under the Plan at the PPO provider level.**

38. Sleep Apnea: expenses for diagnosis and treatment of Sleep Apnea are a covered expense.
Charges Not Covered

The Comprehensive Major Medical Expense Benefit does not cover and will not pay benefits for any charge incurred for the following:

1. Confinement, treatment or service that results from an Accidental Injury or Illness that arises out of or occurs in the course of any occupation or employment for wage or profit, or any Accidental Injury or Illness for which you are entitled to any benefits under any Workers’ Compensation or Occupational Disease Law. The Plan can withhold benefits for any Injury that may be questionable or compensable under Workers’ Compensation or Occupational Disease Law until you have made a reasonable effort to exhaust your claim to benefits under Workers’ Compensation or Occupational Disease Law, up to and including the Industrial Board.

2. Confinement, treatment or service that results from or is made worse by a war or any act of war (declared or undeclared) or military or naval service of any country.

3. Confinement, treatment or service that results from or is made worse by the commission of an assault or felony, except for conditions resulting from being a victim of an act of domestic violence.

4. Confinement, treatment or service that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicare or Medicaid provisions of Federal law).

5. Confinement, treatment or service for educational or training problems, learning disorders, marital counseling or social counseling except that services for diabetic education and nutritionist counseling which are incurred in connection with a diagnosed diabetic condition are Covered Charges.

6. Confinement, treatment, service or materials for organ or tissue transplants, except as expressly provided in this Plan.

7. Confinement, treatment or service related to chiropractic care or manual manipulation, except as expressly provided in the Plan.

8. Treatment, service or Hospital confinement that is not Medically Necessary for the diagnosis/treatment and In-Patient care where the condition does not require Hospitalization.

9. Charges in excess of the Reasonable and Customary Charges, this applies to out-of-network claims only.

10. Confinement, treatment, or service for which the Participant has no financial liability or legal obligation to pay, or that would be provided at no charge in the absence of coverage under this Plan, or for which the provider has waived the charges.

11. Experimental or Investigative Treatments or Procedures, services, supplies, devices and drugs.
12. Confinement, treatment, or service for Cosmetic Surgery; unless the surgery is necessary for (a) repair or alleviation of damage resulting from an Accident; (b) because of infection or Sickness; or (c) because of congenital disease, developmental condition or anomaly of a covered Dependent child which has resulted in a functional defect. A treatment will be considered cosmetic for either of the following reasons: (a) the primary purpose is to beautify or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to illness, Injury or congenital abnormality.

13. Charges for telephone consultations, missed appointments or fees sometimes added for filling out a claim form or charges made for non-compliance with a cost containment program.

14. Personal services or supplies.

15. Personal convenience items such as special air conditioners, humidifiers, air filters, pillows, mattresses, physical fitness equipment and other such devices, whether or not ordered by a Physician.

16. Dental Services and materials, except as described under Covered Charges.

17. Eye examinations for the correction of vision or the fitting of glasses, except as described in the Vision Benefit section.

18. Vision equipment (frames or lenses), except as described in the Vision Benefit section.

19. Confinement, treatment, service, or materials for Kerato-Refractive Eye Surgery.

20. Hearing tests, hearing aids, or the fitting of hearing aids.

21. Appliances for palliative treatment of the foot including, but not limited to, heel lifts, foot pads and arch supports or corrective or orthopedic shoes not attached to a brace.

22. Wigs or hair prostheses, except for wigs during or after chemotherapy.

23. Any expense or charge for the restoration or promotion of conception including, but not limited to, reversal of voluntary sterilization, fertility tests, hormone therapy, artificial insemination, in vitro fertilization and embryo transfer.

24. Confinement, treatment or service to children of Dependent Children, and confinement, treatment or service that results from pregnancy or childbirth or any complications of pregnancy or childbirth of a Dependent daughter.

25. Service provided by a member of the patient’s Immediate Family.

26. Over-the-counter Nonprescription drugs, vitamins, nutritional supplements or special diets (whether they require a Physician’s prescription or not).
27. Any expense or charge incurred for treatment relating to weight loss or dietary control, including the care and treatment of obesity whether or not it is, in any case a part of the treatment plan for another Sickness.

28. Rest cures, domiciliary care, convalescent care or custodial care, which is care provided primarily for convenience, or to assist the patient in the activities of daily living, or custodial in nature when the constant attention of trained medical personnel is not required (except Hospice Care as specified).

29. Hospital confinements primarily for observation and/or diagnostic studies that could have been performed on an out-patient basis.

30. Travel expenses

31. Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

32. Medications or prosthesis for sexual dysfunction, inadequacies or enhancements except as provided under the Covered Charges.

33. Treatment by any method of jaw joint problems, including temporomandibular joint syndrome or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the joint except as provided under the Covered Charges.

34. Orthoptics, macular degeneration or surgery to correct nearsightedness or farsightedness

35. Abortion, except as specified under Covered Charges.

36. Vocational rehabilitation.

37. Medical care that is provided when a Dependent who has primary coverage under a Health Maintenance Organization (HMO) or similar organization fails to use the Health Maintenance Organization (HMO) or similar organization.

38. Charges made for “stand by” medical personnel where no service is actually rendered.

39. Expense or charges incurred for exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this plan.

40. Expenses or charges related to Marriage Counseling.

41. Any loss due to an intentionally self-inflicted Injury. (Under HIPAA, benefits for injuries generally covered under a plan cannot be excluded merely because they were self-inflicted or were sustained in connection with a suicide or attempted suicide if the injuries resulted from a medical condition such as depression.)
42. Speech Therapy for remedial or educational purposes or for initial development of natural speech. This would apply to children who have not established a natural speech pattern for reasons that do not relate to a congenital defect. In these cases, speech therapy would be considered educational in nature and not eligible for coverage. Speech therapy would **not** meet coverage criteria for the following conditions: chronic voice strain, congenital deafness, delayed speech, developmental or learning disorders, environmental or cultural speech habits, hoarseness, infantile articulation, lisping, mental retardation, resonance, stuttering, and voice defects of pitch, loudness, and quality.

43. Third, or subsequent, surgical opinions.

44. Charges for vitamins, minerals, non-prescription food and/or food supplements, and non-prescription dietary drugs, except as specified on page 8.

45. Acupuncture or acupressure treatment.

46. Care and treatment of an injury or sickness that results from engagement in a hazardous activity. An activity is hazardous if it is an unusual activity which is characterized by a constant threat or danger or risk of bodily harm. Examples of hazardous activities are skydiving, auto racing, hang gliding, operating an ATV or motorcycle without a helmet for anyone under the age of 18, or bungee jumping.

47. Charges incurred outside of the United States, when the reason for being out of the country is primarily for treatment of an illness or injury.

48. Charges not listed as Covered Charges.

**Note:** This list is not meant to be all inclusive. Any exclusion/limitation stated does not necessarily include all charges that are not expressly excluded or limited. Only those charges listed as covered can be assumed payable.
Wellness Benefit (All Participants)

The Wellness Benefit will pay up to the maximum listed in the “Schedule of Benefits” per calendar year, for you and each of your eligible Dependents. This benefit is meant to cover medical care and treatment not provided under the Comprehensive Major Medical Expense Benefit. This benefit covers charges such as:

1. Routine physicals, including those for school or camp;
2. Immunizations;
3. Inoculations;
4. Mammograms, limited to 1 baseline mammography screening for covered females age 35 to 39; and one mammography screening per calendar year for covered females age 40 and over;
5. Gynecological exams;
6. Prostate exams;
7. Fecal occult blood test;
8. Colonoscopies;
9. Well-baby care;
10. Any related tests, lab work and x-rays;
11. Flu and Pneumonia shots.

IN-NETWORK or OUT-OF NETWORK
The Plan will pay 100% of your expenses up to the maximum listed in the “Schedule of Benefits.” Any In-Network expense above the maximum for Wellness Benefits is covered by the Plan, subject to deductible and coinsurance.

Charges will only be considered under the Wellness Benefit when there is no diagnosis of Illness or Injury indicated with the service provided; therefore, the Participant must advise the Physician he is seeking wellness services and the billing must be coded as a wellness visit.
Prescription Drug Benefit (All Participants not Medicare Primary)

The Prescription Drug Benefit is administered by the provider listed in the “Contact Information” section. Two programs are available under the Prescription Drug Benefit – the Retail Card Program and the Mail Order Program.

Covered Charges

Both parts of the program cover prescriptions for the following:

1. All federal legend drugs;
2. Compound medications;
3. Insulin on prescription;
4. Insulin needles, syringes, and lancets on prescription;
5. Blood glucose testing supplies/materials; and

To find out if a drug is covered, contact the Third Party Administrator.

Charges Not Covered

The following are excluded from coverage under this Prescription Drug Benefit, unless specifically listed under Covered Charges above:

1. Drugs or medicines that are not Medically Necessary;
2. Drugs or medicines dispensed by a Hospital, Skilled Nursing Care Facility, rest home, or other institution in which the patient is confined;
3. Drugs or medicines delivered or administered by the Physician who prescribes them;
4. Drugs or medicines prescribed or dispensed by a person in the patient’s Immediate Family;
5. Administration of any drug or medicine, except that the administration of certain contraceptives are Covered Charges;
6. Fertility drugs or agents including, but not limited to oral and injectable drugs, Crinone Jel and HCG;
7. Impotence treatment including Caverject, Muse, Edex, Yohimbine and Viagra;
8. Growth hormones;
9. Over-the-counter (OTC) items;
10. Amphetamines, anorexiants and/or laxatives including, but not limited to Miralax;
11. Cosmetic and health and beauty aids;
12. Dermatological drugs used for cosmetic purposes including, but not limited to, Renova, Propecia Tablets, Vaniqua, Rogaine and Accutane;
13. Non-prescription smoking cessation products including, but not limited to, Zyban, Nicotine Spray (nasal) and Nicotine Inhalers, except that Nicotine Gum and Nicotine Patch are Covered Charges;
14. Vitamins and minerals, pediatric vitamins with fluoride tabs and drops, POTABA, non-prescription vitamin D, non-prescription multi-vitamins, multi-vitamins with iron, folic acid (1mg), Niacin, Niaspan, Hemantics (iron preparation), except that prenatal
15. Dietary supplements;
16. Therapeutic devices or appliances, including hypodermic needles, reusable needles, disposable needles and reusable or disposable syringes, except hypodermic needles and syringes used to treat diabetes are Covered Charges under the Prescription Drug Benefit in the Plan;
17. Support garments and other non-medical substances, regardless of their use;
18. Immunization agents, biological sera, blood, blood plasma;
19. Devices or appliances (such items may be available under the Comprehensive Major Medical Expense Benefit);
20. Drugs labeled “Caution – limited by federal law to investigational use” or Experimental drugs even though a charge is made to the individual;
21. DESI drugs;
22. Prescriptions or refills in excess of the number directed by the Physician or any refill dispensed more than one year after the prescription date;
23. Drugs or medications for which the Participant has no financial liability or legal obligation to pay, or that would be provided at no charge in the absence of Health Coverage under this Plan;
24. Drugs or medicines that are paid for or furnished by the United States Government or one of its agencies (except as required under Medicare or Medicaid provisions or Federal law);
25. Drugs or medicines provided as the result of an Illness or Injury that is due to or made worse by war or act of war;
26. Confinement, treatment or service that results from or is made worse by engaging in illegal activities, except that drugs or medicines provided to a Participant for conditions resulting from being a victim of an act of domestic violence are Covered Charges;
27. Drugs or medicines for which the cost is recoverable under Workers' Compensation or Occupational Disease law, or any state or governmental agency, or any other drug or medical service for which no charge is made;
28. Drugs or medicines provided as the result of an Illness or Injury arising out of or in the course of any occupation or employment for wage or profit;

Note: Benefits may be provided for drugs and supplies which are not Covered Charges, if they are effective and less costly than Covered Charges.

Benefits Payable

You pay a Co-pay as specified in the “Schedule of Benefits” for your covered prescriptions and the Plan pays the rest.

If a non-participating pharmacy is used, the Covered Person will have to pay the full price charged, and a claim form must be submitted for reimbursement. The Covered Person will be reimbursed subject to the Reasonable and Customary charge for participating pharmacies and the applicable benefit as stated in the Prescription Drug Schedule of Benefits.
Mandatory Generic Drugs

If a participant will not accept generic drugs, or if his doctor orders a brand name drug, and a generic drug is available, the Fund will only cover the cost of the generic drug. The participant will be responsible for the difference in costs, plus the co-payment.

Retail Card Program

The Retail Card Program offers benefits for short-term prescriptions. When you become eligible for benefits under the Prescription Drug Benefit, you will receive a prescription drug card. You may obtain up to a thirty (30) day supply of your prescription through the Retail Card Program.

The Plan recommends you obtain all drugs through a Network pharmacy. You may obtain a listing of Network pharmacies, at no charge, by contacting the Prescription Drug Provider Network listed in the “Contact Information” section. If you obtain a prescription outside the Network, you must meet your Deductible, pay the pharmacy in full for the drug and file a claim with the Third Party Administrator for reimbursement.

Present your prescription drug card and your prescription to your pharmacist. When you use a Network pharmacy, you pay only the Co-payment listed in the “Schedule of Benefits.”

The pharmacist will fill your prescription with a Brand Name Drug only if your Doctor specifies “May Not Substitute” or “Dispense as Written (DAW)” on the prescription form or otherwise specifically indicates that the Brand Name Drug is Medically Necessary. In all other instances, your prescription will be filled with a Generic Drug, if available in that form.

You will receive the quantity prescribed by your Physician, up to a thirty (30) day supply. No forms, receipts or submission of claims are necessary if you use an In-Network pharmacy. The pharmacist will submit the claim. You simply pay the necessary Co-payment when you fill your prescription. The Co-payment is not reimbursable under the Comprehensive Major Medical Expense Benefit and does not count toward your individual out-of-pocket maximum explained on page 9. If you obtain a prescription outside the prescription drug network, you must file a claim with the Third Party Administrator.

Mail Order Program

You may order through the mail up to a ninety (90) day supply of any covered maintenance medication that your Physician prescribes for you or your eligible Dependent. Maintenance medications are medications you or your Dependents take for long periods of time for such chronic conditions as high blood pressure, heart condition, diabetes, asthma and arthritis.

If your Physician prescribes a long-term medication that you need right away, ask the Physician to write two prescriptions – one prescription for fourteen (14) days to be filled at a Network pharmacy using the Retail Card Program, and a second prescription for up to ninety (90) days, with refills allowed, for the remainder of the medication to be submitted to the Mail Order Program.

If your Physician wants you to take a medication on a trial basis, you should ask the Physician to write two prescriptions – one prescription for a short period of time for you to fill immediately at a Network pharmacy using the Retail Card Program, and a second
prescription for up to ninety (90) days, with refills allowed, for you to fill through the mail if the medication works for you.

When you use the Mail Order Program, you pay the generic or brand name prescription Co-payment for each prescription as listed in the “Schedule of Benefits.”

The pharmacist will fill your prescription with a Brand Name Drug only if your Doctor specified “May Not Substitute” or “Dispense as Written (DAW)” on the prescription form. In all other instances, your prescription will be filled with a Generic Drug, if available in that form.

Follow these steps to obtain prescriptions through the mail:

■ Request a form from the Local Union office or the Third Party Administrator.
■ Fill out all required information on the patient profile/registration form.
■ Enclose the Physician’s prescription including:
  a. Patient’s name;
  b. Patient’s address;
  c. Patient’s social security number;
  d. Number of pills to be provided;
  e. Time period over which the pills will be taken (cannot be more than ninety (90) days);
  f. Number of refills allowed (cannot be more than a year’s worth of medication; and
  g. Physician’s signature.
■ Enclose your original prescription and Co-payment and mail to the address listed in the Contact Information.

To find out the amount of payment to send with your order, call the telephone number listed in the “Contact Information” section.

For refills, a new order form and envelope will be included with each delivery, or call the telephone number in the “Contact Information” section.

You should allow 14 days for an order to be completed and shipped. Your order will either be sent to you by First Class U.S. Mail, or by UPS or Federal Express if the drug must be refrigerated.
Vision Benefits

The Plan will pay for necessary Vision services specified in this section, subject to all of the provisions of this Summary Plan Description. Please refer to the Schedule of Benefits for the benefit limits, and benefit percentages that apply to Vision Benefits.

Summary of Vision Benefits

If a Participant receives any necessary Vision services upon the recommendation of an optometrist or ophthalmologist, the Plan will pay for complete vision examinations (including refraction), frames, lenses, and contact lenses as specified in the Schedule of Benefits.

Exclusions From Vision Coverage

The following exclusions apply to this Plan, in addition to the other exclusions as listed in the section, Charges not Covered, beginning on page 46, except that if any exclusion is contrary to any law to which this Plan is subject, the provision is hereby automatically changed to meet the law’s minimum requirement.

1. Diagnostic Services. Diagnostic services and drugs or medications that are not part of the vision exam.
2. Education or Training.
3. Employer Sponsored Services. Services or supplies received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustees, or similar person or group.
4. Frame or Lens Replacement. Broken, lost or stolen lenses or frames.
5. Medical Treatment. Medical or surgical treatment of the eyes.
6. Not Necessary Service or Supply. Services or supplies which are not necessary.
7. Not Specified. Any charge not specifically listed as a covered expense.
8. Orthoptics. Orthoptics, visual training or subnormal vision aids.
10. Safety Glasses. Safety glasses or goggles.
11. Specialty lenses. Sunglasses whether plain or prescription, any tinted lenses, photosensitive lenses, ultraviolet coating, anti-reflective coating and scratch-resistant coatings.
Bank Credit Reimbursement Program

Eligible participants may be reimbursed monies they have paid "out of pocket" for deductibles, co-pays, and co-insurance, for eligible medical, dental, vision and prescription drug claims from their Bank Credits. In order to be eligible for this benefit, the participant must have the prescribed amount in his/her Individual Account. The following rules apply to the Reimbursement Program:

A. A participant will be eligible for reimbursement of any amounts that have been applied to the calendar year deductibles, co-pays and/or co-insurance, for covered medical, dental, vision and prescription drug services. However, an eligible participant must have at least eighteen (18) months of eligibility at the then current cost of coverage, in his or her Individual Account when the reimbursement is calculated, in order to utilize his or her Bank Credits.

B. A participant may utilize the Bank Credits in his/her Individual Account, but the amount of the Individual Account may not drop below the cost of providing eighteen (18) months of coverage. The participant must submit an Authorization Form to the Fund Office, authorizing the Fund Office to utilize the Bank Credits for the Bank Credit Reimbursement Program.

C. Reimbursement will be made quarterly, approximately one month following the determination of eligibility for coverage and calculation of the Individual Account bank balance.

D. If, after this calculation, funds are available for reimbursement, the Administrator will provide a Bank Credit Reimbursement form to you for completion. The forms will be provided in October and April of each year to those individuals that qualify. Once completed, the form must be submitted to the administration office by the 1st of the month following the date the form is provided to you.

E. Bank Credit Reimbursement claims for each calendar year must be filed no later than the end of the calendar year following the year in which the expenses were incurred. You may request reimbursement of claims from January of the previous year to the time of the reimbursement request.

F. The maximum payable from Bank Credits in any calendar year is $1,000. The $1,000 maximum applies, as a combined maximum, to all deductibles, copays, and coinsurance reimbursed under this program per covered participant and eligible dependents (i.e. $1,000 annually per covered family).

G. In no event will reimbursement be made for any services not eligible for coverage by the Plan, including medical, dental, vision, and prescription drug services. Therefore, services that were originally excluded from coverage would not qualify for reimbursement.

H. In no event will a payment of less than $5 be issued.
Coordination of Benefits

Under the Plan, your benefits may be coordinated if another group plan or source is obligated to make benefit payments for you or your Dependents.

“Another group plan or source” refers to any plan providing benefits or services for or by reason of actual expenses, which benefits or services are provided by:

- Group insurance, whether insured or self-insured;
- Group programs and practices offered on a group basis or other group prepayment coverage;
- Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, employee benefits organization plans;
- Any coverage under governmental programs including Medicare, Medicaid, Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Deficit Reduction Act (DEFRA) and any coverage required by statute;
- Motor vehicle insurance including, but not limited to, first-party medical expense provisions of an automobile policy; or
- Group insurance or other coverage for a group of individuals, including student coverage obtained through an educational institution or educational agency.

The following plans are not coordinated with this Plan, and are neither Primary nor Secondary Plans:

- A student accident policy; or
- A state medical assistance program where eligibility is based on financial need.

How Benefits Are Paid

Benefit coordination insures that you receive maximum benefits and that benefits are not paid for more than 100% of the Allowable Expenses incurred.

When health care coverage is available to a Participant from more than one plan, the Primary Plan pays benefits first. Your Primary Plan determines benefits as if that plan was the only coverage available. Then the Secondary Plan pays according to its coordination of benefits rules. When secondary, this Plan pays the difference between your Allowable Expenses and what your Primary Plan paid. If 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.

If this Plan is Secondary, it stays Secondary even if the Primary Plan refuses to or is unable to pay the benefits it owes. If this Plan is Secondary, and the Primary Plan denies or reduces benefits because you did not follow the certification rules of the Primary Plan or because you did not use an authorized provider of the Primary Plan, this Plan will not pay more than it would have paid had the denial or reduction of the Primary Plan not occurred.
If you are covered or a Dependent is covered by another plan or source, in addition to this Plan, the order of benefit payment will be determined according to the guidelines outlined below.

Order of Benefit Payment

For coordination with other plans, the following rules apply:

1. A plan without coordination of benefits rules will be primary and will pay benefits before this Plan.
2. A plan that covers a person other than as a dependent is primary and pays benefits before a plan that covers the person as a dependent.
3. The plan which covers a person as an employee who is neither laid-off nor retired, or as that employee’s dependent, pays first. The plan which covers that person as a laid-off or retired employee, or as that employee’s dependent, pays second. If the other plan does not have this rule, and the plans do not agree on the order of benefits, this rule does not apply.
4. For a person who has coverage under continuation of coverage required under federal or state law (for example, COBRA), the plan which covers the person as an active employee or that person’s dependent pays first. The plan which covers the person under the required continuation of coverage pays second.
5. For claims on behalf of dependent children whose parents are not divorced or legally separated or for claims on behalf of dependent children whose parents share custody and a court decree does not specify financial responsibility for medical expenses, the plan which covers the parent whose birthday (month and day) falls first in the calendar year is primary and will pay benefits first (Birthday Rule). If both parents have the same birthday, the plan covering the parent for the longer period of time will be primary and pay benefits first. However, if the other plan does not have the Birthday Rule, but instead has a rule based on the gender of the parent, and as a result the plans do not agree on the order of benefits, the rule of the other plan controls which plan pays first.
6. For claims on behalf of dependent children whose parents are divorced or legally separated, the following rules apply:
   a. If there is a court decree that establishes financial responsibility for medical expenses, the plan covering the parent who has such financial responsibility will be primary.
   b. If there is no court decree and the parent with custody has not remarried, the plan that covers the parent with custody will be primary.
   c. If there is no such court decree and the parent with custody has remarried, the order of benefit coordination will be as follows:
      ■ The plan, if any, of the parent with custody is primary and pays benefits first;
      ■ The plan, if any, of the step-parent with custody pays benefits second;
      ■ The plan, if any, of the parent without custody pays benefits third; and
      ■ The plan, if any, of the step-parent without custody pays benefits fourth.
7. If none of the above rules applies, the plan that has covered the claimant for the longer period of time will be primary and pay benefits first.
Implementation Rules

To implement the coordination of benefits rules, the Trustees, without consent of any person, will have the right to:

- Release or obtain information considered necessary;
- Authorize payment directly to another group plan or source that paid claims that should have been paid by this Plan; and
- Recover payments from the person to or for whom the benefits were paid in excess of the amount that should have been paid by this Plan.

Any person claiming benefits under this Plan must furnish to the Trustees such information as may be reasonably necessary to implement these rules. The Trustees are under no obligation to furnish any benefits under this Plan until such information has been received.

Whenever payments have been made under any other plan that should have been paid by this Plan, the Trustees have the right, in their sole discretion, to pay the other plan any amount determined to be warranted. Such payments will be deemed benefits paid under this Plan and the Plan will be fully discharged from liability for such charges.

Coordination of Benefits With Medicare

The Plan has primary responsibility for claims of active Employees over age 65 and their Dependents. If you are entitled to Medicare solely because of an end stage renal disease (ESRD), this Plan has primary responsibility for your claims for the first 30 months and Medicare is secondary. After 30 months, Medicare has primary responsibility and this Plan is secondary. If you retire before the end of the 30-month period, Medicare will become primary and, as a retired Employee entitled to Medicare, you will be covered under this Plan, and it will be secondary if you elect and pay for Retiree Coverage. Medicare has primary responsibility for claims for retired Employees over age 65 and entitled to Medicare. Medicare also has primary responsibility for an eligible Employee who is disabled and entitled to Medicare because he or she has received Social Security Disability Income for 24 consecutive months.

THIS PLAN IS SECONDARY TO MEDICARE TO THE FULLEST EXTENT ALLOWED BY FEDERAL LAW. WHEN THIS PLAN IS SECONDARY TO MEDICARE, IT REDUCES BENEFITS BASED ON WHAT MEDICARE WOULD PAY UNDER PART A AND PART B, EVEN IF THE COVERED PERSON IS NOT ENROLLED IN PART A OR PART B.

For claims incurred on or after June 1, 1991, the Bricklayers and Allied Craftworkers Health and Welfare Fund of Indiana elects treatment under clause (iii) of 42 U.S.C. §1395y(b) (1) (A), and consistent with this election, the Fund office be and is hereby authorized and directed to pay claims secondary to Medicare benefits in those cases where such secondary payment is permitted.
Subrogation or Reimbursement

Participants in this Plan agree to the following as a condition precedent to participating in and receiving benefits under this Plan:

1. Participants shall reimburse the Plan for all medical, drug, dental, vision, or disability benefits paid to them or on their behalf, when any recovery is obtained from any source, including a person, corporation, entity, automobile insurer (including medical expense, uninsured and underinsured coverage), malpractice insurer, or other insurer or fund. The Plan shall have a lien against any money you recover to the extent of benefits paid by the Plan, along with any costs or fees incurred by the Plan in asserting its rights under this section, and shall have the right to first reimbursement out of any recovery obtained from any source for the Injury or condition for which the Participant claims an entitlement to benefits under the Plan.

2. Participants shall subrogate the Plan for any and all claims, causes of action, or rights that they presently have or which may arise against any source (as delineated in paragraph (1) immediately preceding), which source has or may have caused, contributed to, or aggravated the Injury or condition for which the Participant claims an entitlement to benefits under this Plan. The Plan’s right to subrogation shall take first priority in the disbursement of any funds received from any source, even if you do not receive full compensation for your damages, and the make-whole doctrine shall not apply.

The Plan may pend the payment of any and all claims until a completed reimbursement agreement is received from the Participant seeking payment of benefits from the Plan. If circumstances warrant, the Plan may pend the payment of any and all claims until liability is legally determined, and may offset the claim payments due by the amount you recover from another source.

In the event that a Participant settles with, recovers from, or is reimbursed from any source, the Participant agrees to hold any and all recoveries in trust for the benefit of the Plan, and to reimburse the Plan for all past, present, and future benefits paid on his or her behalf as a result of the Injuries or conditions giving rise to reimbursement.

Should the Participant choose not to pursue recovery from any source that may be liable, including, but not limited to, benefits which may be due you through medical motorist coverage or uninsured or underinsured motorist coverage, the Plan is authorized to pursue, sue, compromise or settle any such claims in the Participant's name and/or on his or her behalf, and the Plan is authorized to execute any and all documents necessary to pursue said claims. The Participant agrees to fully cooperate with the Plan in the prosecution of any such claims and to do nothing that would interfere with or reduce those rights.

The Plan is not responsible for any attorney fees and costs incurred by the Participant in collecting from the responsible party, and the common fund doctrine shall not apply. Moreover, the Participant shall reimburse the Plan for any costs and attorney fees incurred by the Plan, if the Plan must file suit against the Participant to enforce its subrogation / reimbursement rights under this section. The plan is entitled to the full right of recovery regardless of any admission of liability, by any person, and regardless whether a settlement identifies medical expenses. The Plan has a right to recover benefits from any and all
settlements or judgments, even those designated as “pain and suffering” and “non-economic damages”.

The Plan Administrator has the sole authority, discretion, and responsibility to make all decisions related to exercise and enforcement of its subrogation and recovery rights under this provision.
Claim Submissions and Appeals

Claims Submission

Written proof of claims must be given to the Plan Administrator no later than 18 months from the date the expense was incurred. However, when a Covered Person’s coverage terminates for any reason, written proof of the claim must be given to the Plan Administrator within 90 days of the date of termination of coverage, provided the Plan remains in force. However, upon termination of the Plan, final claims must be received within 30 days of termination.

The Plan shall have the right (at its own expense) to require a claimant to undergo a physical examination, when and as often as may be reasonable.

Payment of any medical claim will be made to the Participant only when using an Out-of-Network Provider. If the Participant dies before all benefits have been paid, the remaining benefits may be paid to any relative of the Participant or to any person or corporation appearing to the Plan to be entitled to payment. The Plan will fully discharge its liability by such payment.

Claim Appeal Process

These provisions govern all claims and appeals except for those claims made on the basis of an insurance contract governing insured benefits, which will be determined solely by the insurance company. A claimant (i.e., Participant) may authorize a representative to act on his behalf, provided any such authorization must be in writing and pursuant to any procedures adopted by the Trustees.

Time Limits on Decision of Claims

The following rules govern the time limits of claims decisions:

A) Health, Dental and Vision Claims

The Plan Administrator shall notify the claimant of the Plan's benefit decision on a claim within 30 days of the date the claim is filed, regardless of whether all necessary information was included with the claim. Within that 30-day period, the claimant will receive notice of the decision or a notice that explains the circumstances requiring a delay in the decision, and sets a date, no later than 15 days after the ending of the initial 30-day benefit determination period, by which the claimant can expect to receive a decision.

If, during the review, additional information is required from the claimant, the claimant will be so notified within the required time period for notice of a decision. The claimant will have at least 45 days to provide such information. A written notice of the decision will be issued following the date the claimant provides the required information or the expiration of the time period for providing such information.

B) Short Term Disability Benefit Claims

If a claim for Short Term Disability Benefits is denied in whole or in part, the claimant will be informed of the denial within 45 days of the date the initial claim was received, regardless of whether all necessary information was included with the claim.

1. Extension

Special circumstances may require more time to review a claim. If so, written notice will be provided within the 45-day period explaining the reason for the delay and setting a date upon which the notice will be issued, no later than 30 days after the end of the initial 45-day benefit determination period. If special circumstances again require more time to review a claim, a
second 30-day extension may be taken subject to written notice within the initial 30-day extension, subject to the same rules.

2. Additional Information
   If, during the review, additional information is required from the claimant, the claimant will be so notified within the required time periods for notice of a decision or extension detailed above. The claimant will have at least 45 days to provide such information. A written notice of any denial will be issued within 30 days following the date the claimant provides the information or the expiration of the time period for providing such information, unless special circumstances require a second 30-day extension, subject to the same rules.

Content of Claim Denial Notice

If a claimant’s claim is partially or wholly denied, he will receive notice from the Fund Office stating the specific reason(s) for the denial including specific reference to the pertinent provision of the Plan documents on which the denial is based, describing and explaining any additional material or information required of the claimant in order to make the claimant’s claim valid, explaining what steps must be taken to have the claim denial reviewed, and explaining that the initial decision shall be a final decision unless the decision is appealed as hereinafter set forth. The notice will inform the claimant if the denial is based on a determination of medical necessity or experimental treatment or similar exclusion, and provide the scientific or clinical judgment for the determination or offer a copy free of charge upon request. The notice will also inform the claimant of the right to bring a civil action under ERISA following denial on appeal and inform the claimant if an internal rule, guideline, protocol or other similar criterion was relied upon and offer a copy free of charge upon request.

Appeal of Denied Claim

If a claimant wants to have the denied claim reviewed, the claimant must send a written request for a review of the claim denial to the Fund no later than 180 days after the date the notice of denial is mailed to the claimant. Any claimant filing a timely request for review may submit additional materials for consideration on review including a written explanation of the issues and comments on the issue.

Review of Denied Claim

The following rules govern the review of denied claims.

A) Full and Fair Review
   The Board of Trustees or its authorized Committee will review the denied claim according to the terms and conditions of the Plan. The review will consider all comments, documents, records and other information submitted by the claimant, regardless of whether the information was submitted or considered in the initial determination. The review will not defer to the decision on the initial claim. The claimant will have the right to access and copy all documents, records and other information relevant to the claim (information relied upon, submitted, considered or generated in the review or demonstrating compliance with the claims processing requirements). If the decision requires medical judgment, the Board of Trustees or Committee will consult an appropriate health professional who is not the same health professional or subordinate to any health professional who reviewed the initial claim.

B) Time of Decision
   The following rules govern the time limits of claim reviews:

   1. Health, Dental and Vision Claims
      The Trustees or its authorized Committee will meet quarterly to render a determination on appeals of Post-Service Claims received since the prior meeting, provided any appeal filed within the 30-day period preceding a meeting will be decided at the next following meeting. If
special circumstances require a delay in the decision, the decision will be rendered no later than the third meeting following receipt of the appeal, and the Fund Manager will notify the claimant of the reasons for the delay prior to any extension. The claimant will be informed of the decision within five days of the date the decision is made.

2. Short Term Disability Benefits
The Trustees or its authorized Committee will meet quarterly to render a determination on appeals of Accident and Sickness Weekly Income Benefits received since the prior meeting, provided any appeal filed within the 30-day period preceding a meeting will be decided at the next following quarterly meeting. If special circumstances require a delay in the decision, the decision will be rendered no later than the third quarterly meeting following receipt of the appeal, and the claimant will be notified of the reasons for the delay prior to any extension. The claimant will be notified of the decision within five days of the date the decision is made.

Content of Reviewed Claim Denial Notice
Written notice of denial will explain the specific reason(s) for the denial and include specific reference to the pertinent provision of the Plan documents on which the denial is based. The notice will inform the claimant if the denial is based on a determination of Medical Necessity or experimental treatment or similar exclusion, and provide the scientific or clinical judgment for the determination or offer a copy free of charge upon request. The notice will also inform the claimant of the right to bring a civil action under ERISA following denial on appeal and inform the claimant if an internal rule, guideline, protocol or other similar criterion was relied upon and offer a copy free of charge upon request.

Further Action
In the event a claim for benefits has been denied, no lawsuit or other action against the Plan or its Trustees may be filed until the matter has been submitted for review in accordance with the claims appeal provisions set forth in this Section. Further, in the event a claim has been submitted for review in accordance with such procedures and the claim has again been denied, no lawsuit or other action against the Plan or its Trustees may be filed after one (1) year from the date the participant or beneficiary has been given written notice of the Trustees’ decision on his appeal.

If this limitation is less than that required by law, such limitation is hereby extended to conform to the minimum period permitted by law.

Discretion of Trustees
The Trustees or persons to whom such authority has been delegated by the Trustees, such as a claims review committee, have sole authority to make final determinations regarding any application for benefits and the interpretation of the Plan of Benefits, the Trust Agreement and any other regulations, procedures or administrative rules adopted by the Trustees. Decisions of the Trustees (or, where appropriate, decisions of those acting for the Trustees) in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. Benefits under this Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them. If a decision of the Trustees or those acting for the Trustees is challenged in court, it is the intention of the parties to the Trust that such decision is to be upheld unless it is determined to be arbitrary or capricious.
Effective Date of Notice: September 1, 2013

The Welfare Fund is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

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

The term “Protected Health Information” (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic) and includes “genetic information.” PHI is protected for 50 years after the death of a participant or beneficiary after which it is no longer PHI.

Section 1. Notice of PHI uses and Disclosures

Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan’s compliance with the privacy regulations.

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

The Plan and its business associates will use PHI without your consent, authorization or opportunity to agree or object to carry out treatment, payment and health care operations. The Plan also will disclose PHI to the Plan Sponsor (Trustees of the Welfare Fund) for purposes related to treatment, payment and health care operations. The Plan Sponsor has amended its plan documents to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations.)

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

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

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

Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you. Your written authorization is also required before the Plan could sell PHI or use it for marketing.

Use and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

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

Uses and disclosures for which consent, authorization or opportunity to object is not required

Use and disclosure of your PHI is allowed without your consent, authorization or request under the following circumstances:

1. When required by law.
2. When permitted for purposes or public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
3. When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor’s parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor’s PHI.
4. To a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigation; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers;) and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud.)
5. When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One such condition is that satisfactory assurances be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.
6. When required for law enforcement purposes (for example, to report certain types of wounds.)
7. To organ procurement organizations for cadaveric organ, eye, or tissue donation purposes.
8. If you are in the Armed Forces and your PHI is needed by military command authorities. The Fund may also disclose your PHI for the conduct of national security and intelligence activities and for other specialized government functions such as protective services for the President, Medical suitability determinations, correctional institutions and other law enforcement custodial situations.
9. For law enforcement purposes, including the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual’s agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely
affected by waiting to obtain the individual’s agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan’s best judgment.

10. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

11. For medical research subject to conditions.

12. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

13. When authorized by and to the extent necessary to comply with workers’ compensation or other similar programs established by law.

14. To disclose proof of immunization to schools in States that have school entry or similar laws, subject to the agreement of a minor child’s parent or guardian.

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

Section 2. Rights of Individuals

Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is only required to grant a requested restriction if (1) the disclosure is to a health plan for purposes of carrying out payment or health care operations and is not for purposes of carrying out treatment; and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the Privacy Officer, Bricklayers and Allied Craftworkers Health & Welfare Fund of Indiana, PO Box 50440, Indianapolis, IN 46250.

Right to Inspect and Copy PHI

You have the right to inspect and obtain a copy of your PHI contained in a “designated record set,” for as long as the Plan maintains the PHI. If the Plan uses or maintains your PHI in an electronic health record, you have a right to obtain a copy of this information in an electronic format.

“Protected Health Information” (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written electronic) and includes genetic information.

“Designated Record Set” includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

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

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the Privacy Officer, Bricklayers and Allied Craftworkers Health & Welfare Fund of Indiana, PO Box 50440, Indianapolis, IN 46250.
If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the US Department of Health and Human Services.

**Right to Amend PHI**

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

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

Requests for amendment of PHI in a designated record set should be made to the Privacy Officer, Bricklayers and Allied Craftworkers Health & Welfare Fund of Indiana, PO Box 50440, Indianapolis, IN 46250.

You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set.

**The Right to Receive an Accounting of PHI Disclosures**

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: 1) to carry out treatment, payment or health care operations; 2) to individuals about their own PHI; or 3) prior to the compliance date. However, electronic health records disclosed for purposes of payment or health care operations are subject to your right to an accounting for disclosures made up to three years before the date of your request.

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

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

**The Right to Receive a Paper Copy of This Notice Upon Request**

To obtain a paper copy of this notice contact the Privacy Officer, Bricklayers and Allied Craftworkers Health & Welfare Fund of Indiana, PO Box 50440, Indianapolis, IN 46250.

**A Note About Personal Representatives**

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

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

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

**Section 3. The Plan’s Duties**

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices. If your PHI is improperly accessed, acquired, used, or disclosed, the Plan will notify you, as required by law. That notification may include a description of what happened, the information involved, and the steps you can take to protect yourself.

This notice is effective beginning September 1, 2013 and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI.
received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this notice will be provided in writing to all past and present participants and beneficiaries for whom the Plan still maintains PHI.

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

Minimum Necessary Standard

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

However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to the Secretary of the US Department of Health and Human Services;
- uses or disclosures that are required by law; and
- uses or disclosures that are required for the Plan’s compliance with legal regulations.

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

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

Section 4. Your Right to File a Complaint with the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the Privacy Officer, Bricklayers and Allied Craftworkers Health & Welfare Fund of Indiana, PO Box 50440, Indianapolis, IN 46250.

You may file a complaint with the Secretary of the US Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, DC 20201. The Plan will not retaliate against you for filing a complaint.

Section 5. Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Privacy Officer, Bricklayers and Allied Craftworkers Health & Welfare Fund of Indiana, PO Box 50440, Indianapolis, IN 46250.

Conclusion

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

The Trustees may change the amount charged to dollar banks or as self-payment for the cost of Employee and Dependent Health Coverage. The Trustees may determine the minimum required contributions for participation in the Plan from time to time and will so-advise the Union.

Physical Examination and Autopsy

The Trustees have the right and opportunity, at the Plan’s expense, to have a Physician they designate examine the eligible Participant whose Injury or Illness is the basis of a claim for Plan benefits, as often as they may reasonably require while the claim is pending. The Trustees also have the right to request an autopsy in case of death where it is not forbidden by law.

Limits of Liability

No Participant shall have any claim arising under this Plan against the Trustees, the Plan, the Plan Administrator, the Plan’s service providers or any other person except for the amount of regular Plan benefits due under this Plan.

This Plan’s use of any preferred provider network does not constitute a recommendation or endorsement of any Hospital, Physician or other provider. No person shall have any claim against the Trustees, the Plan, the Plan Administrator or their service providers, appointees or agents arising out of injuries caused by any provider.

This Plan does not create a contract of employment between any Employer and any Employee, nor does it affect the status of any person as an Employee-at-will.
Gender

Except as the context may specifically require otherwise, use of the masculine gender will be understood to include both masculine and feminine genders. Similarly, words used in the singular or plural shall be construed as including the plural or singular, respectively, as circumstances and context may require.

Assignment

Assignment of benefits may be made only to providers, and only with the Plan’s consent. An assignment is not binding unless the Plan receives and acknowledges in writing the original or copy of the assignment before payment of the benefit. The Plan does not guarantee the legal validity or effect of such assignment.

Amendment and Termination

While the Trustees fully intend to continue the Plan, they reserve the right in their sole discretion to amend or, if necessary, discontinue the Plan. The provisions of the Plan may be amended from time to time in accordance with the Trust Agreement as amended. Amendments may include increases, modifications, reductions or the elimination, in whole or in part, of certain benefits. The effective date of any amendment shall be the date it is signed or any other date the amendment specifies.

The Trustees also have the right within their sole discretion to terminate all benefits in the Plan or suspend all benefits in this Plan at any time in accordance with the Trust Agreement as amended. The termination or suspension shall be effective on the date it is signed, or any other date the termination resolution specifies. The Plan will pay no benefits for expenses incurred after the effective date of the termination.

If the Trustees amend or terminate the Plan, they will notify you in writing of the changes that are made to your coverage. Except as described in this provision, no act or spoken or written statement of any Trustee or other person shall have the effect of amending the Plan, creating coverage of a person or a service, or of waiving any of the Plan’s provisions or requirements.

Plan Documents

The Trustees have established this Plan pursuant to the Bricklayers and Allied Craftworkers Health and Welfare Fund of Indiana Trust Agreement, and collective bargaining agreements between the Union and contractors. This book describes the benefits available under the Plan. While the Trustees believe that the descriptions in this book are accurate, if there is a discrepancy between this book and the Trust Agreement, the terms of the Trust Agreement will control.

The Trustees have the right to interpret and construe the terms and provisions of this Plan and to determine eligibility for benefits. The Trustees have the right to resolve any conflicts or ambiguities in the Plan and the right to determine any issues of fact or law which may bear on the Plan’s obligation to pay benefits.
Plan Information

Plan Name: Bricklayers and Allied Craftworkers Health and Welfare Fund of Indiana

Board Of Trustees: A Board of Trustees is responsible for the operation of this Plan. The Board of Trustees consists of an equal number of Employer representatives and Union representatives. If you wish to contact the Board of Trustees, you may use the address and the telephone number below:

Board of Trustees
Bricklayers and Allied Craftworkers Health and Welfare Fund of Indiana
c/o HealthSCOPE Benefits
9045 E. 59th Street
Indianapolis, IN 46216
(317) 554-9000

Plan Sponsor and Administrator: The Board of Trustees is the Plan Sponsor and Plan Administrator.

Claims Administrator: HealthSCOPE Benefits, pursuant to a contract with the Board of Trustees.

Fund Administrator: HealthSCOPE Benefits, pursuant to a contract with the Board of Trustees.

Trust Identification Number: 35-0945245

Plan Number: 502

Agent for Service of Legal Process: Service of Legal Process may be made on the Board of Trustees or any individual Trustee at the above address.

Source of Contributions: Except for certain large claims, the benefits described in this booklet are provided solely through Employer and Employee contributions. The amount of Employer and Employee contributions and the Employees on whose behalf contributions are made are determined by the provisions of the Plan and the collective bargaining agreements and the amount of monies necessary to provide the coverage required by the Plan.
Collective Bargaining Agreement

The Plan is maintained in accordance with collective bargaining agreements between the Employers and the Local Union. Other agreements may be in effect from time to time. The agreements specify the contributions required.

The Plan Administrator will provide you, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of Employees working under a collective bargaining agreement.

Trust

The Trust consists of a trust account in which all contributions and assets of the Plan are accumulated under the provisions of the collective bargaining agreement and the Trust Agreement. Plan assets are held in the Trust for the purpose of providing benefits to covered Participants and defraying reasonable administrative expenses. All of the benefits in this Plan are paid from the Trust and are provided on a self-funded basis, except to the extent the Board of Trustees purchases insurance to pay covered charges.

The Plan’s assets are managed by professional asset managers selected by the Board of Trustees.

Plan Year

The records of the Plan are kept separately for each Plan Year. The Plan Year begins on July 1 and ends on June 30.

Type Of Plan

This Plan is maintained for the purpose of providing disability, medical, vision, life and accidental death and disability benefits. The Plan benefits are summarized in the “Schedule of Benefits” of this booklet.

Eligibility

The Plan’s requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility or denial or loss of any benefits are fully described in this booklet.

Claim Procedures

The general procedures to follow for filing a claim for benefits are explained in this booklet. If all or any part of your claim is denied, you may appeal that decision.
BRICKLAYERS AND ALLIED CRAFTSMEN
HEALTH AND WELFARE FUND OF INDIANA
c/o HealthSCOPE Benefits
9045 East 59th Street
Indianapolis, IN 46216
(317) 554-9000

Plan Administrator
The Plan Administrator is the Board of Trustees. However, HealthSCOPE Benefits administers the Plan pursuant to a contract with the Board of Trustees.

Board of Trustees

**Employer Trustees**

- Eston Hathaway
  - Hagerman Construction Corp.
  - 7930 Castleway Drive
  - Indianapolis, IN 46250

- Donald Purdy
  - Purdy Masonry
  - 7601 Indianapolis Road
  - Zionsville, IN 46077

- Steven Russell
  - S & R Masonry
  - RR 4, Box 572
  - Linton, IN 47441

- Gregory A. Waltz
  - 778 West 750 South
  - Trafalger, IN 46181

- Paul Nysewander
  - Indiana Mason Contractors Assoc
  - PO Box 1079
  - Plainfield, IN 46168

**Employee Trustees**

- Ted Champ
  - Business Manager
  - 2041 N Broadway
  - Anderson, IN 46012

- Dave Murray
  - BAC Local 4 IN KY
  - 620 N. East Street
  - Indianapolis, IN 46202

- Steve Hunter
  - Secretary/Treasurer
  - 31 ½ South 13th Street
  - Terre Haute, IN 47807

- Ed Helton
  - 31 ½ South 13th Street
  - Terre Haute, IN 47807

- Tim Spaulding
  - BAC Local 4 IN KY
  - 620 N East Street
  - Indianapolis, IN 46202

- David Brinegar
  - 1802 West 17th ST
  - Bloomington, IN 47404
Statement of ERISA Rights

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants are entitled to the following rights.

Receive Information About Your Plan And Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and Union halls, all documents governing the Plan. These include insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated Plan document/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 Eligible Employee with a copy of this summary annual report.

Continue Group Health Plan Coverage

You also have the right to:

- Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Coverage rights.
- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when:
  - You lose coverage under the plan;
  - You become entitled to elect COBRA Coverage; or
  - Your COBRA Coverage ceases.
You must request the certificate of creditable coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.
Actions By Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the 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 the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits, 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.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

For more information about your rights and responsibilities under ERISA:
- Call 1-866-444-3272;
- Visit www.dol.gov/ebsa; or
- Send electronic inquiries to www.askebsa.gov.
All of the benefits of this Plan are made available to you and your eligible Dependents by the Trustees as a privilege and not as a right. You and your eligible Dependents do not acquire any vested right to Plan benefits either before or after your retirement.

The Trustees reserve the right to amend, modify or discontinue all or part of the Plan whenever, in their judgment, conditions so warrant. Participants will be notified in writing of any Plan changes.

Subject to the stated purposes of the Plan and the provisions of the Trust Agreement, the Trustees have full and exclusive authority to determine all questions of coverage and eligibility, methods of providing or arranging for benefits and all other related matters. They have full power to construe the provisions of this Summary Plan Description, the terms used herein and the bylaws and regulations issued thereunder. Any such determination and any such construction adopted by the Trustees in good faith will be binding upon all of the parties hereto and beneficiaries hereof. No matters respecting the foregoing or any difference arising thereunder or any matter involved in or arising under the Trust Agreement or this Summary Plan Description will be subject to the grievance or arbitration procedure established in any collective bargaining agreement between the Employers.

It is the intent of the drafters of this Summary Plan Description that the Trustees possess the maximum discretion to determine eligibility for benefits and to construe the terms of the Trust Agreement and/or Plan document and Summary Plan Description governing benefits. It is also the intent of the drafters of the Trust Agreement and Plan document and Summary Plan Description, by adopting the discretionary power specified above, that the decisions of the Trustees as to determinations of eligibility and the granting or denial of benefits and the construing of terms of the Trust Agreement and Plan, be given judicial deference and be reviewed pursuant to an “arbitrary and capricious” standard of review, as enunciated by the United States Supreme Court in Firestone Tire and Rubber Company et al. v. Richard Bruch.