

LABORERS' NATIONAL HEALTH & WELFARE FUND

PLAN DESCRIPTION FOR BENEFIT PLAN 2

January 2019

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LABORERS' NATIONAL HEALTH & WELFARE FUND

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Dental Benefits Administrator: Delta Dental of Pennsylvania (Delta Dental)

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Short Term Disability Insurer: Union Labor Life Insurance Company (Ullico)

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January 2019

TO ALL EMPLOYEES COVERED BY THE LABORERS' NATIONAL HEALTH & WELFARE FUND (BENEFIT PLAN 2):

Congratulations! LIUNA--your Union--and your Employers have entered into collective bargaining agreements requiring the Employers to contribute to the Laborers' National Health & Welfare Fund ("the Fund") so that you, your spouses and your children can earn eligibility for the wide range of valuable benefits provided by the Fund.

We are pleased to present to you this new Plan Description. It contains the governing Rules & Regulations of the Benefit Plan 2 by which you are covered. It describes the benefits provided by the Fund to eligible employees (called "Participants") and eligible family members (sometimes called "Dependents" or "Beneficiaries") under Benefit Plan 2. These benefits include medical benefits, prescription drug benefits, dental benefits, vision benefits, short term disability insurance, life insurance, accidental death and dismemberment, and membership assistance benefits. This Plan Description also describes the rules, terms and conditions under which these benefits are available to you and your family members, including eligibility (coverage) requirements.

A separate document, called the Summary Plan Description ("SPD"), has been provided to you by the Fund and is also available on the Fund's website (www.lnhwf.org). The SPD is a summary of this Plan Description.

This Plan Book reflects the rules, terms and conditions of Benefit Plan 2 as adopted and amended through January 1, 2019, and it supercedes all earlier Benefit Plan 2 booklets, summaries of material modifications, and notices.

Note that the Board of Trustees reserves the right to change the rules, terms and conditions of Benefit Plan 2 at any time, with or without advance notice, or to terminate Benefit Plan 2. This includes the right to set, and to change from time-to-time, the contribution rates required for Benefit Plan 2 coverage and the amount of deductibles, co-payments and other cost-sharing charges.

We encourage you to check the Fund's website (www.lnhwf.org) for updates that could affect your and your family members' standing and coverage, including changes in Benefit Plan 2. We also encourage you to contact the Fund Office if you have any questions regarding the Fund or Benefit Plan 2.

A final comment. We continue to look for ways to improve the benefits offered by the Fund under Benefit Plan 2 and other plans so that the benefits and coverages meet your and your family's needs. We want to make it as easy as we can for you and your family members to obtain good health care, including preventive care and treatment when needed, so that you and they can enjoy healthy, happy and productive lives.

We are also mindful of the need to contain costs for the Fund and for you so that the coverage remains affordable, both in terms of collectively bargained employer contribution rates and cost-sharing by participants and beneficiaries. This means designing the benefit programs so the Fund's resources are used efficiently and in ways that promote good health behaviors and outcomes for you and your loved ones. As the costs of medical care and prescription drug costs in America continue to increase, the challenge of balancing benefits and costs is tougher than ever and requires adjusting the benefit programs from time-to-time.

We wish you and your family the best of health!

THE BOARD OF TRUSTEES

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OVERVIEW OF THE LABORERS' NATIONAL HEALTH & WELFARE FUND

The Laborers' National Health & Welfare Fund ("Fund") is a joint labor-management, non-profit, multiemployer trust fund established in 1988 by agreement between the Laborers' International Union of North America (LIUNA) and various employers for the benefit of employees represented by LIUNA and affiliated Local Unions, primarily in the service contract industry.

Governance & Administration

The Fund is governed by a Board of Trustees ("Board") composed of Union and Employer Trustees. The Board has overall authority and responsibility regarding the structure and operations of the Fund, including the design of the benefit programs offered by the Fund.

The day-to-day administration of the Fund has been assigned by the Board to an "in-house" administrative staff based in offices at 905 16th Street, N.W., Washington, D.C. ("the Fund Office"). The staff is headed by the Fund Administrator (Adam M. Downs) and the Assistant Fund Administrator (Michael J. Davis). Prior to January 1, 2017, the Fund was administered by a third-party administration company.

The Fund Office is assisted in its administrative functions by various service providers including Cigna Health and Life Insurance Company (Cigna, medical claims administration, vision benefits administration, and member assistance program administration), Express Scripts Inc. (prescription drug administration), Delta Dental (dental benefits administration), and Union Labor Life Insurance Company (short term disability and life insurance). The Fund Office is the "go to" place for questions and information regarding the Fund.

The Fund's main website (www.lnhwf.org) can be accessed at any time through the Internet. The website is interactive. Each covered employee, upon becoming eligible for benefits, will be able to set up a personal account on the website through which he or she will be able to obtain individualized information such as employer contributions received, eligibility status and, through hyperlinks to websites maintained by Cigna, Express Scripts, and Delta Dental, the status of benefit claims.

In addition, the website gives eligible employees and contributing employers access to a wide range of information about the Fund.

Benefit Plans

The Fund currently offers two Benefit Plans (Plan 1 and Plan 2). Both Benefit Plans offer comprehensive benefits to eligible employees and their eligible spouses and children. These benefits include hospital care, doctor care, prescription drugs, dental care, vision care, short

term disability, accidental death and disability insurance, life insurance, and member assistance benefits. The main difference between Plan 1 and Plan 2 is the amount of benefits that the Fund pays under each Plan. For example, Plan 2 generally pays a larger share of the cost of medical care, and the patient pays a lesser share.

Plan 1 was closed indefinitely to new groups in 2017, but continues for existing groups.

The Board has full authority to amend, suspend, or terminate Benefit Plan 1, Benefit Plan 2 or any other Benefit Plan of the Fund at any time and for any reason. This includes the authority to limit participation in any Benefit Plan and to terminate or suspend the participation of any employer or employee group to protect the Fund. If the Benefit Plan is amended, a notice in the form of a Summary of Material Modifications will be sent to all participants by the Fund Office.

Both Benefit Plans encourage the use of the Fund's preferred provider networks of hospitals, doctors and dentists. The costs of medical and dental care for both the patient and the Fund are lower when the care is received from an "in-network" provider. Use of an "out-of-network" medical or dental care provider is permitted, but the cost to you will be higher.

Funding & Contributions

All of the medical, prescription drug, and dental benefits are paid directly from the Fund's assets to the care provider or the patient. In other words, the Fund "self-funds" or "self-insures" these benefits, rather than an insurance company. However, the short term disability, accidental death and disability, and life insurance coverages are all insured, and the Fund pays group premiums to the insurance companies for all Fund participants.

The Fund obtains the money with which to pay benefits primarily from two sources: (a) employer contributions; and (b) investments of Fund assets. Collective bargaining agreements between the Union and employers require the employers to contribute to the Fund for each hour for which their covered employees earn wages, including days of paid leave. The contributions are pooled with the Fund's existing assets and invested for the Fund by professional investment managers selected by the Board to earn income and grow the Fund's reserves.

Each year the Board sets the rate of contributions that participating Employers must contribute to maintain coverage under the Fund for their employees for the year. The rates are different for Plan 1 and Plan 2. The Union and each employer negotiate a collective bargaining agreement that: (a) selects coverage under Benefit Plan 1 or Benefit Plan 2 for the employees as a whole; and (b) obligates the employer to contribute to the Fund at the required rate for the selected Benefit Plan and in accordance with the Fund's rules.

The employer contributions to the Fund are tax deductible for the employer and are not included in the employees' taxable income (under current law). Generally no employee contributions are required by the Fund, although there are circumstances under which employee contributions are permitted to maintain or extend coverage.

There are no individual accounts under the Fund. All contributions and investments are pooled and held in trust for the sole purpose of paying promised benefits and reasonable administrative expenses (including premiums for insurance purchased by the Fund).

Benefit Eligibility, Enrollment and Identification Cards

Employees are not automatically entitled to benefits from the Fund merely because they are covered by a collective bargaining agreement requiring their Employer to contribute to the Fund. Each employee must earn eligibility for benefit coverage by working enough hours for which his or her employer contributes to the Fund. Similarly, an employee's spouse and children are not eligible for benefits unless the employee works enough hours for family coverage and the employer pays the required contributions.

The failure of an employer to pay the required contributions can cause the employees and their families to lose eligibility for benefits. The Fund's ability to pay benefits depends on employers paying the required contributions on time each month. If an employee or family member loses eligibility for benefits for any reason, he or she may be entitled to self-pay the required contributions to maintain eligibility under the "COBRA continuation coverage" provisions of the Benefit Plans.

An employer must be accepted into Fund participation by the Fund Office. As noted above, entering into a collective bargaining agreement with the Union does not automatically entitle the employer and its employees to participation in the Fund. The Fund Office is required by the Board to perform a due diligence review to ensure that participation by the employer or group would not cause harm to the Fund and its existing participants.

The Fund Office must also obtain certain information about each of the employees, spouses and children that is needed for proper administration of the Fund for them (including name, gender, date of birth, mailing address, and Social Security Number). Enrollment is the process through which the Fund obtains this information. Each employee, spouse and child must be enrolled with the Fund to have coverage.

Once the employer is accepted into participation by the Fund Office and the employees' enrollment information is received, the Fund will send to each employee and each enrolled spouse and child Identification Cards (medical, prescription drug, and dental).

The Cards can be presented to care providers (e.g. hospitals, doctors, pharmacists, dentists)

when the employee or family member is receiving services. The Cards contains important information about the Fund, conditions of coverage, instructions regarding benefit claims, and contact numbers.

Legal Status & Regulation of the Fund: Non-Grandfathered Plans

The Fund is regulated under several Federal laws, and it is designed and operated to comply with all of those laws. The Employee Retirement Income Security Act ("ERISA") regulates the Fund as an employee welfare benefit plan, a group health plan and a multiemployer plan. The Internal Revenue Code regulates the Fund as a tax-exempt trust and voluntary employee beneficiary association. The Fund is a joint labor-management trust fund structured to comply with the Labor Management Relations (Taft-Hartley) Act. And, the Fund is a *bona fide* fringe benefit program under the Service Contract Act.

The Fund, Benefit Plan 1 and Benefit Plan 2 are "non-grandfathered plans" under the Affordable Care Act (ACA). This is a change from earlier years. Both Benefit Plans comply with the ACA's requirements for non-grandfathered plans, including preventive care benefits without patient cost-sharing, a limit on patient out-of-pocket costs, and an opportunity for external review of claims.

NOTE TO READER: *This Plan Description, like the Summary Plan Description, is addressed to “you” and “your”. It assumes that “you” are an Employee and that, once you become eligible for coverage under the Plan, you are a Participant in the Fund covered by Plan 2.*

**SECTION 1:
ELIGIBILITY FOR PLAN COVERAGE & ENROLLMENT IN THE PLAN**

1.1: Eligibility

- (a) Benefits are payable under this Plan only for Participants, Spouses of Participants and Children of Participants who are eligible for coverage and who have enrolled with the Plan, and only to the extent that the service or event for which benefits are claimed occurs while the Participant, Spouse or Child is eligible for coverage. Individuals who are eligible and enrolled are entitled to the Plan's Medical Benefits, Prescription Drug Benefits, Dental Benefits, Vision Benefits, Short Term Disability Benefits, Accidental Death & Disability Insurance, Life Insurance, and Member Assistance Program Benefits to the extent they meet the terms and conditions of those benefit programs.

- (b) Generally, you can become eligible and remain eligible for coverage only if your Employer is accepted into participation in the Fund and Plan by the Fund Office, and the Employer makes timely contributions to the Fund at the required contribution rate. Employer contributions must be made for each hour you work or are paid, or for each month you work or are paid, depending on the terms of the employer's collective bargaining agreement.

- (c) For Single Coverage (Employee Only) based on hourly rate contributions:
 - (1) Initial Eligibility: Generally, you will become eligible for Single Coverage as of the first day of the second calendar month following three consecutive calendar months during which contributions are made to the Fund on your behalf for at least 210 hours. You must also enroll in the Fund and Plan to be eligible.

 - (2) Continuation of Eligibility: Once you earn initial eligibility, you will remain eligible for Single Coverage for each calendar month thereafter so long as contributions for at least 210 hours were made on your behalf for the preceding three consecutive calendar month period.

If the Fund does not receive this minimum amount of contributions, you may lose coverage.

- (3) Banked Hours: If fewer than 210 hours of Employer contributions have been received by the Fund for you during any continuing eligibility base period, your eligibility for Single Coverage will be continued nonetheless if you had enough “excess hours” of contributions over the preceding six calendar months to make up the shortfall.
 - (4) Regaining Eligibility: If you lose eligibility for Single Coverage due to insufficient contribution hours during any three consecutive calendar month period, you will regain eligibility if your Employer makes at least 210 hours of contributions during a subsequent three calendar month period. Once the Fund receives sufficient contributions, your eligibility for Single Coverage will be renewed as of the first day of the second month following the continuing eligibility base period (three consecutive calendar months). The Fund Administrator may require you to re-enroll in the Plan.
- (d) For Family Coverage based on hourly rate contributions:
- (1) Initial Eligibility: Generally, you will become eligible for Single Coverage as of the first day of the second calendar month following three consecutive calendar months during which contributions are made to the Fund on your behalf for at least 360 hours. You and your Spouse and each of your Children must also enroll in the Plan to be eligible.
 - (2) Continuation of Eligibility: Once you earn initial eligibility, you will remain eligible for Single Coverage for each calendar month thereafter so long as contributions for at least 360 hours were made on your behalf for the preceding three consecutive calendar month period.
- If the Fund does not receive this minimum amount of contributions, you may lose coverage. If you lose Family Coverage, you may qualify for Single Coverage if the Fund has received the minimum contributions for Single Coverage.
- (3) Banked Hours: If fewer than 360 hours of Employer contributions have been received by the Fund for you during any continuing eligibility base period, your eligibility for Family Coverage will be continued nonetheless if you had enough “excess hours” of contributions over the preceding six calendar months to make up the shortfall.
 - (4) Self-Paying A Shortfall: If you are going to lose Family Coverage because Employer contributions for less than 360 hours were made for you during a three-month continuing eligibility period, you may self-pay up to 40 hours of contributions to the Fund during the eligibility period to purchase a continuation of your Family Coverage. You cannot self-pay for more than 40 hours in an

eligibility period. In other words, if your Employer made at least 320 hours of contributions for you in the eligibility period, you can pay the difference to the Fund so that you have the 360 hours to keep your Family Coverage.

- (5) Regaining Eligibility: If you lose eligibility for Single Coverage due to insufficient contribution hours during any three consecutive calendar month period, you will regain eligibility if your Employer makes at least 360 hours of contributions during a subsequent three calendar month period. Once the Fund receives sufficient contributions, your eligibility for Family Coverage will be renewed as of the first day of the second month following the continuing eligibility base period. The Fund Administrator may require you to again enroll in the Plan.
 - (6) Eligible Family Members: See Section 13 of this Plan Description for rules defining who is a Spouse and a Child for purposes of the Plan.
- (e) For Family Coverage based on monthly rate contributions:
- (1) Initial Eligibility: Generally, you will become eligible for Family Coverage after the Fund receives two consecutive months of contributions for you. Your coverage will be effective as of the first day of the next month (that is, the third month). You and your Spouse and each of your Children must also enroll in the Plan to be eligible.
 - (2) Continuation of Eligibility: Once you earn initial eligibility, you will remain eligible for Family Coverage for each calendar month thereafter so long as the Fund continues to receive the required monthly contributions from your Employer.
 - (3) Regaining Eligibility: If you lose eligibility for Family Coverage because your Employer has failed to make the required monthly rate contributions, your eligibility for Family Coverage will be renewed if your Employer resumes making the required monthly rate contributions. If the Employer resumes making the required contributions, your eligibility will be renewed as of the first day of the second month following the month for which the Employer resumes making the required contributions.
 - (4) Eligible Family Members: See Section 13 of the Plan Description for rules defining who is a Spouse and a Child for purposes of the Plan.

1.2: Enrollment

- (a) Enrollment in the Fund and Plan is a necessary condition of eligibility for coverage for

you and, if you have Family Coverage, for your Spouse and each of your Children. To enroll in the Fund and Plan, you must complete and submit to the Fund Administrator an Enrollment Form and, if you have Family Coverage, you must also submit the following documents:

- > Copy of your and your Spouse's marriage certificate.
 - > Copy of the birth certificate for each Child.
 - > If your Spouse's or Child's name is different than yours, you must submit a copy of your most recent federal income tax return.
 - > Such additional documentation as the Fund Administrator deems necessary to determine if a person claimed to be a Spouse or Child can qualify for coverage.
- (b) If the enrollment information you submitted to the Fund changes, you must notify the Fund Administrator as soon as possible. Submission to the Fund Administrator of a new enrollment form will be necessary to make the changes in enrollment information. Failure to submit a new enrollment form could affect your or your Spouse's or Child's eligibility (for example, a newborn child will not be eligible until enrolled). In particular, you must notify the Fund Administrator of:
- > changes in your mailing address or the mailing address of your Spouse or a Child;
 - > the birth or adoption of a Child;
 - > a Child attaining age 26;
 - > a divorce;
 - > the death of a Spouse or Child.
- (c) If a State court or agency has issued an order requiring you to provide health plan coverage for your Child (a Qualified Medical Child Support Order), you should submit it to the Fund Office as soon as possible.
- (d) There is no enrollment period or window nor an "open season". Accordingly, no special enrollment rights are required.

1.3: Identification Cards

Once you are enrolled, you will be sent three Identification Cards by Cigna, Express Scripts and Delta Dental. These Identification Cards obtain information on how you or your health care provider (hospital, doctor, pharmacist, etc.) can contact Cigna, Express Scripts and Delta Dental for questions about your medical, prescription drug, dental, vision and member assistance program benefits. The Identification Cards also contain

information about the Fund and Plan that your health care provider needs. You should bring your Identification Cards whenever you visit a doctor, pharmacy, dentist, hospital, urgent care facility, or other health care provider.

Cards will also be sent to you for your Spouse and each Child, if you have Family Coverage.

1.4: Loss Of Coverage

- (a) You and, if you have Family Coverage, your Spouse or Children may lose coverage under the Plan and Fund if any of the following events occurs:
 - > Your Employer fails to make contributions for the minimum number of hours or months required for eligibility.
 - > Your Employer's participation in the Fund terminates. This may happen if the Employer's collective bargaining agreement expires, the Employer goes out of business, the Employer is expelled from the Fund, or other reasons.
 - > Your Spouse ceases to be your Spouse or your Child attains age 26.

- (b) If you, your Spouse or Child lose coverage under the Plan, you may be able to continue your or their coverage for a limited period on a self-paid basis under the "COBRA" provisions of the Plan.

- (c) If you take Family and Medical Leave Act leave from covered employment, your coverage under the Plan may continue. As a matter of law, your Employer is required to continue making contributions on your behalf as if you were working your normal schedule for so long as the leave is in effect. See 29 CFR 825.211.

Upon your return to Active Service following a leave of absence that qualifies under the any canceled insurance (health, life or disability) will be reinstated as of the date of your return. You will not be required to satisfy any eligibility or benefit waiting period to the extent that they had been satisfied prior to the start of such leave of absence.

- (d) If you take military leave from covered employment, your and your Family's coverage under the Plan may continue as provided by Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA").
 - (1) If your leave is for 30 days or less, your Employer is required to continue making contributions on your behalf as if you were working your normal schedule for so long as the leave is in effect. Your eligibility would be based on the hours of contributions received, under the regular rules.

- (2) If your leave is for 31 or more days, you may elect to continue coverage for yourself and your Family on a self-pay basis for a period of 24 months or the length of your service, whichever is the shorter period. You should contact the Fund Office to discuss arrangements for maintaining coverage during your military service.
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**SECTION 2:
MEDICAL BENEFITS COVERAGE,
INCLUDING HOSPITAL & DOCTOR SERVICES**

2.1: 24 Hour Health Information Line

The Plan provides you free telephone access, 24-hours a day, to a Health Information Line run by Cigna. If you have a medical or health concern or question, you can call the Health Information Line at any time and speak with a nurse. The nurse can answer the question or guide you to where to get the help you need. The Health Information Line telephone number is 1-800-244-6224 (1-800-Cigna24).

2.2: Medical Telehealth

- (a) The Plan, through Cigna, offers 24-hour / 7 days-a-week access by telephone or video access to a Physician for minor conditions that do not require emergency or urgent care treatment. The Physician may be able to diagnose your condition and prescribe medications. This can save you a doctor's office visit for conditions like sore throats, fever, allergies, colds and flu.
- (b) The Plan pays 100% of the cost of a Cigna Medical Telehealth call by you (or by your Spouse or Child, if you have Family Coverage) up to the Maximum Reimbursable Charge.
- (c) To use the Cigna Medical Telehealth benefit, you must pre-register by contacting either or both of the following providers (on-line or by telephone):
 - > AmwellforCigna.com or 1-855-667-9722
 - > MDLIVEforCigna.com or 1-888-726-3171

2.3: Covered Medical Expenses: Generally

- (a) "Covered Medical Expenses" means the cost charged for medical services, treatment, equipment or supplies that are covered by the Plan and are not excluded from coverage. Generally, the Plan covers a certain percentage of the Covered Medical Expenses that you or your Eligible Dependents (if you have Family Coverage) incur, if and to the extent that:

- (1) the services, treatment, equipment or supplies are Medically Necessary, as determined by the Board of Trustees, the Fund Administrator or their designee (including Cigna), or are preventive care services;
- (2) the costs charged for the services, treatment and supplies do not exceed the Maximum Reimbursable Charge;
- (3) you have satisfied the applicable Deductible(s);
- (4) you satisfy any other Plan conditions applicable to benefits for the particular Covered Medical Expense; and
- (5) you pay the required Co-Payment, if any, for the Covered Medical Expense.

Covered Medical Expenses may also include all charges made by an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies.

The percentage of a Covered Medical Expense not paid by the Fund is called "Co-Insurance".

- (b) You are responsible for any portion of the cost that is not paid by the Fund or that is not discounted under the Plan's rules.
- (c) Provider Networks:
 - (1) Note that the cost to you of medical care will normally be lower if you receive the services from an "In-Network" provider. "In-Network" means a doctor, hospital or other care provider that participates in the Cigna Health and Life Insurance Company network of preferred providers.
 - (2) You do not need to register with any In-Network providers in advance of needing their services. If and when you need an In-Network provider's services, present your Plan Member Identification Card to the provider who will check with the Fund Administrator to confirm your eligibility for coverage.
 - (3) A list of network providers is available to you without charge by visiting Cigna's website (www.myCigna.com), or by calling the phone number on your Identification Card. This information may change frequently, so the you should check the website for updates when you need to find a provider.

- (4) You can receive medical care services from a hospital, doctor or other care medical care provider who is not in the Cigna network ("Out-Of-Network"), but the cost of those services to you are normally higher and you may have to submit a claim form to have the Fund pay its share of the cost. Your Deductibles and Co-Payments are higher for Out-Of-Network providers. Providers usually have claim forms available.

2.4: Your Share Of Medical Expenses: Deductibles

- (a) A Deductible is the portion of your Covered Medical Expenses that you must pay before the Fund pays for any portion of those expenses. However, not all Medical Expenses are subject to a Deductible (for example, preventive care services are not subject to a Deductible). Only Covered Medical Expenses can be used to satisfy a Deductible requirement. Under the Plan there are two types of Deductibles: Annual Deductibles and Special Deductibles.
- (b) Annual Deductibles:
 - (1) There are two Annual Deductibles: an Individual Deductible and a Family Deductible.
 - (2) The Annual Individual Deductible is the amount of Covered Medical Expenses that any one Covered Individual (you, your Spouse or Child) must pay during a calendar year before the Plan pays any portion of the Covered Medical Expenses for that Covered Individual. The Annual Individual Deductible is \$200 of In-Network Covered Medical Expenses, and \$400 of Out-of-Network Covered Medical Expenses.
 - (3) The Annual Family Deductible is the amount of Covered Medical Expenses that a family of two or more Covered Individuals (you and one or more Eligible Dependents) must collectively pay during a calendar year before the Plan pays any portion of the Covered Medical Expenses for any of those Covered Individuals. The amount of this Annual Family Deductible is \$400 of In-Network Covered Medical Expenses, and \$800 of Out-of-Network Covered Medical Expenses.
 - (4) Once the Annual Family Deductible for the year has been satisfied, the Annual Individual Deductible for the year will be deemed as satisfied for all Covered Individuals in your family.
 - (5) If you do not satisfy the Annual Individual Deductible or Family Deductible in a calendar year, the Covered Medical Expenses incurred by you and your

Dependents during the last three months of the year will be applied towards your Annual Deductibles for the next calendar year.

- (6) Benefits are provided for some specified Covered Medical Expenses even if the Annual Deductible has not been satisfied. If a Deductible does not apply to a particular benefit, the Schedule of Covered Medical Expenses will say so.

- (c) **Special Deductible:** Is a Deductible that applies to certain types of benefits. The Special Deductible must be paid before the Plan will pay any portion of the cost for a benefit to which a Special Deductible applies. If a Special Deductible applies to a benefit, the benefit's description in the Schedule of Covered Medical Expenses will say so.

2.5: Your Share Of Medical Expenses: Co-Payments & Co-Insurance

In addition to a Deductible, if any, you are responsible for paying:

- (a) Co-Payments are normally paid directly to an In-Network provider.

- (b) Any applicable Co-Payment, including any additional Co-Payment imposed for failure to use the Plan's utilization management program when required to do so. Co-Payments are normally paid directly to the provider.

- (c) The percentage of Covered Medical Expenses, if any, not paid by the Fund.

- (d) The full cost of medical expenses not covered by the Plan because they are excluded medical expenses ("Exclusions");

- (e) Charges for Covered Medical Expenses that exceed the Maximum Reimbursable Charge for such expenses (excess cost); and

- (f) Covered Medical Expenses that exceed any benefit-specific limitations on benefits in the Plan.

2.6: Maximum Limit On Your Share Of Covered Medical Expenses (Out-Of-Pocket Maximum)

- (a) There is a maximum limit on how much you and your family will have to pay in any year for covered medical care and prescription drugs. This annual limit, called the Out-Of-

Pocket Maximum, applies to the total amount of Deductibles, Co-Payments and Co-Insurance you are required to pay. After this limit is reached, the Fund will pay the remaining allowable costs of covered medical and hospital care for the rest of the calendar year. This annual limit is called the Out-Of-Pocket Maximum.

- (b) The annual In-Network, Out-Of-Pocket Maximum for Covered Medical Expenses (not including prescription drug expenses) is \$5,350 per individual and \$10,700 per family.
- (c) The annual Out-Of-Network, Out-Of-Pocket Maximum for Covered Medical Expenses is \$10,000 per individual and \$20,000 per family. Prescription drug costs do not count towards the Out-Of-Network, Out-Of-Pocket Maximum.
- (d) Any changes in the Out-Of-Pocket Maximums will be posted on the Fund's website (www.Inhwf.org).

2.7: The Plan's Share Of Covered Medical Expenses

- (a) After you pay any Deductible and Co-Payment that is due, the Plan will pay a portion of the cost of the Covered Medical Expenses, unless excluded from coverage or limited by other Plan rules. The portion payable by the Plan is a percentage of the Maximum Reimbursable Charge for each Covered Medical Expense or, if Out-of-Network the charge negotiated by Cigna with the provider.
- (b) The portion payable by the Plan generally depends on whether the Covered Medical Expenses are for In-Network or Out-Of-Network services. An Out-of-Network health care provider may charge you the difference between its normal charges and the amount payable by the Plan. In-Network providers are not allowed to do so.
- (c) Expenses are considered Covered Medical Expenses only to the extent that they are recommended (or prescribed where required) by a Physician and are Medically Necessary for the care and treatment of an Injury or Sickness (as determined by Cigna, the Fund Administrator, the Board of Trustees or their designee) or are Preventive Care Services.
- (d) Covered Medical Expenses, and the portion (percentage) payable by the Plan for each Covered Medical Expense, are as follows, subject to the limitations, conditions and exclusions contained in this Plan Description:
 - (1) **Preventive Care Services**
Comprehensive coverage. See Section 2.11 of this Plan Description.
In-Network: 100% (No Deductible)

Out-of-Network: 60%

(2) **Doctors Office Visits (Primary Care)**

All services including lab services, radiology services, office surgical services, Medical Pharmaceuticals. No limit on number of visits.

In-Network: 100% (after \$10 Co-Payment)

Out-of-Network: 60%

(3) **Doctors Office Visits (Specialist)**

All services including lab services, radiology services, office surgical services, Medical Pharmaceuticals. No limit on number of visits.

In-Network: 90% (after \$25 Co-Payment)

Out-of-Network: 60%

(4) **Hospital Services (In-Patient)**

Hospital room, special care unit care, hospital primary and specialty care physician services, lab services, radiology services, Medical Pharmaceuticals.

In-Network: 90%

Out-of-Network: 60%

(5) **Hospital Services (Out-Patient, including Free-Standing Surgical Facility)**

All services including lab services, radiology services, Hospital primary and specialty care Physician services, Medical Pharmaceuticals.

In-Network: 90%

Out-of-Network: 60%

(6) **Urgent Care Facility Services**

All services including X-rays, lab services, Medical Pharmaceuticals. Also includes advanced imaging with pre-approval from Cigna (which provider will obtain if In-Network)

In-Network: 100% (after \$50 Co-Payment)

Out-of-Network: 100% (after \$50 Co-Payment)

(7) **Hospital Emergency Room Services**

All services including X-rays, labs, advanced imaging if billed by the Hospital as part of visit.

In-Network: 100% (after \$150 Co-Payment, forgiven if the patient is admitted)

Out-of-Network: 100% (after \$150 Co-Payment, forgiven if the patient is admitted)

(8) **Ambulance Services**

Limited to licensed ambulance services to and from nearest Hospital where needed

medical care can be provided.

In-Network: 90%

Out-of-Network: 90%

(9) **Other Health Care Facilities** (In-Patient)

Includes Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility. All services. Limited to Calendar Year Maximum of 60 days.

In-Network: 90%

Out-of-Network: 60%

(10) **Short Term Rehabilitative Therapy** (Out-Patient)

Includes Occupational Therapy, Physical Therapy, Cognitive Therapy, Pulmonary Rehabilitation Services. All services. Limited to Calendar Year Maximum of 28 visits.

In-Network: 100% after \$10 Co-Payment per visit.

Out-of-Network: 60%

(11) **Cardiac Rehabilitation**

All services. Limited to Calendar Year Maximum of 36 visits.

In-Network: 100% after \$10 Co-Payment per visit.

Out-of-Network: 60%

(12) **Chiropractic Services**

Limited to Calendar Year Maximum of 30 visits.

In-Network: 100% after \$10 Co-Payment per visit.

Out-of-Network: 60%

(13) **Home Health Care Services**

Includes private duty nursing if approved by Cigna as Medically Necessary, Medical Pharmaceuticals. Limited to Calendar Year Maximum of 40 days of care.

In-Network: 90%

Out-of-Network: 60%

(14) **Hospice Services** (In-Patient & Out-Patient)

Includes Bereavement Counseling by a Mental Health Professional

In-Network: 90%

Out-of-Network: 90%

(15) **Maternity Care Services**

For a global maternity fee by an OB/GYN including prenatal, delivery, and postnatal visits:

In-Network: 90%

Out-of-Network: 60%

For the Delivery Facility (Hospital or Birthing Center):

In-Network: 90%

Out-of-Network: 60%

Breast Feeding Equipment & Supplies (including rental of breast pump):

In-Network: 100%

Out-of-Network: Not covered

(16) **Abortion Services**

In-Network: If performed in doctor's office, 100% after \$10 Co-Payment for Primary Care / \$25 for Specialist.

Inpatient/Outpatient: plan deductible, then 90%

Out-of-Network: 60%

(17) **Family Planning Services**

Includes prescribed female contraceptive devices, female and male sterilization surgeries (but not reversals).

In-Network: 100%

Out-of-Network: 60%

(18) **Organ Transplants**

Lifesource Center: 100% + travel expenses reimbursement up to \$10,000

In-Network: 90%

Out-of-Network: Not covered

(19) **Prosthetic Appliance & Devices** (Internal & External)

As needed for permanent or temporary alleviation or correction of an Injury, Sickness or congenital defect. Limited to most appropriate and cost-effective alternative as determined by Cigna's Utilization Review Physician.

In-Network: 90% after payment of a Special Deductible of \$200

Out-of-Network: 60% after payment of a Special Deductible of \$200

(20) **Hearing Aids**

Limited to two (2) hearing aids per individual within 36 months.

In-Network: 100%
Out-of-Network: Not covered

(21) **Mental Health Services**

All In-Patient services, including Acute and Residential Treatment, and all Out-Patient services.

In-Network: 90% inpatient/100% after \$10 Co-Payment for office visits.

Out-of-Network: 60%

(22) **Substance Abuse**

All In-Patient services, including Acute and Residential Treatment, and Out-Patient services.

In-Network: 90% inpatient/100% after \$10 Co-Payment for office visits.

Out-of-Network: 60%

(23) **Clinical Trials**

See Section 2.14 regarding when the Plan will pay your routine costs if you are enrolled in a qualifying clinical trial.

(24) **Genetic Testing**

See Section 2.17 regarding the Plan's coverage of genetic testing.

In-Network: 90%

Out-of-Network: 60%

(25) **Out-patient Lab Services and Radiology**

In-Network: 100% after \$10 Co-payment

Out-of-Network: 60%

(26) **Acupuncture Treatment**

Limited to Calendar Year Maximum of 28 visits.

In-Network: 100% after \$20 Co-Payment

Out-of-Network: 50%

(27) **Any Other Medical Services Required By Law**

In-Network: 90%

Out-of-Network: 60%

(e) Detailed information, rules and restrictions regarding some of the Covered Medical Expenses are described in later subsections of this Section 2.

2.8: Expenses Excluded From Medical Coverage: Plan Pays No Share

The Plan generally will not pay any portion of the costs you incur for certain types of situations, services, treatments, supplies and equipment. These are called Exclusions. They are all excluded from the Plan's Medical Benefits Coverage, although they may be covered by other benefit coverage offered by the Plan (e.g. Dental Benefits, Prescription Drug, Vision Benefits). In addition to exclusions described elsewhere in this Plan Description, the following Exclusions apply to medical benefits.

(a) General Exclusions From Medical Coverage

- Applied Kinesiology
- Artificial Aids (e.g., arch supports, corrective orthopedic shoes, wigs)
- Artificial Insemination
- Augmentative Communication Devices
- Cosmetic Surgery or Therapy
- Cranial Therapy
- Custodial Care
- Dance Therapy
- Dental Care / Dental Implants
- Experimental / Investigational / Unproven Services, Treatments and Devices
- Extracorporeal Shock Wave Lithotripsy
- GIFT
- In Vitro / ZIFT
- Infertility: Drugs / Office Visit / Surgical Treatment
- Self-Administered Injectables
- In-Patient Private Duty Nursing
- Lasik Surgery
- Massage Therapy
- Nutritional Evaluation and counseling (unless part of the medical management of a documented organic disease)
- Personal or Comfort Items
- Procedures for Sex Determination
- Prolotherapy
- Reversals of Voluntary Sterilization
- Rolfing
- Routine Foot Care

Third Party Requests for Health Exams
TMJ Treatments
Treatment of Obesity
Treatment of Sexual Dysfunction

(b) Exclusions Regarding Mental Health and Substance Use Disorder Services

Counseling for activities of an educational nature
Counseling for borderline intellectual functioning
Counseling for occupational problems
Counseling related to consciousness raising, and vocational, or religious counseling
Custodial care including geriatric day care
Developmental disorders (Treatment for Autism is not excluded)
IQ testing
Occupational / recreational therapy programs
Psychological testing on children requested by school
Treatment of disorders that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain

2.9: When Certification Or Prior Authorization Is Required Before You Obtain Certain Services:

- (a) The Plan has Utilization Review Programs designed to minimize unnecessary costs for the Fund and you, while enabling you and your family to receive necessary and appropriate medical services, treatment, equipment and supplies. These Programs include requirements for Certification or Prior Authorization from the Fund Administrator's designee (Cigna) before Hospital admissions and receiving some other services.

In-Network providers are responsible for obtaining prior approval when required.

You are responsible for obtaining any required prior authorization if you use an Out-Of-Network provider. You can obtain a Certification of Prior Authorization by contacting Cigna's Review Organization at the toll-free telephone number on the back of your Member Identification Card. You can also obtain the telephone number on the Fund's website. This prior approval process enables Cigna to confirm that the Hospital admission, length of stay, tests and other procedures are Medically Necessary and covered by the Plan.

If your request for a Certification or Prior Authorization is denied, in whole or in part, you can appeal the denial. See the "How To Claim Benefits & Appeal Denials Of Benefits", below.

(b) Out-Of-Network Hospital: Pre-Admission Certification Requirement

You must request a Pre-Admission Certification ("PAC") before any *non-emergency* treatment in an Out-of-Network Hospital for you (or your Spouse or Child, if you have Family Coverage):

- > as a registered bed patient (except for 48/96 hour maternity stays);
- > for a Partial Hospitalization for the treatment of a Mental Health or Substance Abuse Disorder; or
- > for Mental Health or Substance Abuse Disorder Residential Treatment Services.

In the case of an *emergency* admission to a Hospital, you must request an Admission Certification within 48 hours after admission to an Out-Of-Network Hospital.

In the case of an admission in an Out-Of-Network Hospital due to pregnancy, you should contact Cigna by the end of the third month of pregnancy.

Failure to obtain a timely Certification may result in loss of some or all benefits for the Hospital admission. The Plan Description lists the benefits that you may lose, including non-coverage for the first \$750 of Hospital charges.

(c) Out-Of-Network Hospital: In-Patient Continued Stay Review Requirement

If you are admitted to an Out-Of-Network Hospital and certified for a specific length of stay there, but need to stay longer, you should request a Continued Stay Review before the end of the certified length of stay.

Failure to obtain a timely Continued Stay Review and authorization to extend the Hospital stay, you may result in loss of some or all benefits if you stay longer than authorized. The Plan Description lists the benefits that you may lose, including non-coverage of the Hospital charges for the unauthorized days.

(d) Out-Of-Network Out-Patient Procedures: Certification Requirement

Before you (or your Spouse or Child, if you have Family Coverage) obtain non-emergency Out-Patient diagnostic testing or an Out-Patient procedure at a Free-Standing Surgical Facility, Other Health Care Facility, or a Physician's office, you must contact Cigna's Review Organization and request a Certification of the testing or procedure. The request should be made at least four working days (Monday - Friday) in advance of the testing or procedure.

The testing and procedures covered by this requirement include, but are not limited to, Advanced Radiological Imaging (for example: CT scan, MRI, MRA, PET scan) and a Hysterectomy. Before undergoing any Out-Patient testing or procedure, you should contact Cigna's Review Organization (toll-free telephone number on the back of your Member Identification Card) and ask whether the testing or procedure requires Certification.

Failure to obtain a timely Certification may result in loss of some or all benefits for the testing or procedure. The Plan Description lists the benefits that you may lose, including non-coverage for the first \$750 of charges for the testing or procedure.

(e) In-Network Hospital Admission & Procedures: Prior Authorization Requirement

In-Network Hospitals, Physicians and other providers are required to obtain Prior Authorization from Cigna's Review Organization before providing some services for you (and your Spouse or Child if you have Family Coverage) to confirm coverage under the Plan. Obtaining the Prior Authorization for In-Network services is the responsibility of the In-Network Hospital, Physician or other provider.

The services requiring Prior Authorization include the following:

- > In-Patient Hospital services (except 48/96 hour maternity stays);
- > In-Patient services at any Other Health Care Facility;
- > Residential treatment;
- > Outpatient Facility Services;
- > Partial Hospitalization;
- > Advanced Radiological Imaging;
- > Non-Emergency ambulance;
- > certain Medical Pharmaceuticals; and
- > transplant services.

2.10: Emergency Hospitalization

You do not have to obtain prior authorization before seeking emergency services in a Hospital Emergency Room. The same Co-Payment for an Emergency Room visit applies to both In-Network and Out-Of-Network facilities (\$150). The Co-Payment is waived if the patient is admitted to the Hospital.

Emergency services for patients with an emergency medical condition include a medical screening examination and treatment to stabilize the patient. An "Emergency Medical Condition" is defined in Section 13: Definition Of Terms.

2.11: Preventive Care Services

(a) Covered Preventive Care Services include:

- (1) an annual physical examination by a Primary Care Physician (for you);
- (2) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- (3) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved, including the following Prevention including the following (doses, recommended ages, and recommended populations vary):
 - > Hepatitis A
 - > Hepatitis B
 - > Herpes Zoster (Shingles)
 - > Inactivated Poliovirus (IPV)
 - > Human Papillomavirus
 - > Influenza (Flu)
 - > Rotavirus
 - > Measles, Mumps, Rubella
 - > Meningococcal
 - > Pneumococcal
 - > Tetanus-Diphtheria / Tetanus-Diphtheria Acellular Pertussis (Tdap)
 - > Diphtheria / Tetanus-Acellular Pertussis (Dtap)
 - > Varicella (Chicken Pox)

- (4) for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
 - (5) for women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration;
 - (6) gender specific testing including Mammograms, PAP Smear tests, and PSA tests; and
 - (7) additional related services such as urinalysis, EKG and other laboratory tests are also covered.
- (b) For the sake of clarity, Covered Preventive Care Services for women include the following services. If you, your Spouse or Dependent receive these services from an In-Network provider, there will be no cost-sharing (Deductible, Co-Payment or Co-Insurance) if the services are medically necessary or appropriate for the patient and are otherwise covered by the Plan.
- (1) "Well-woman" preventive care visit (annually for adult women to obtain the USPSTF recommended preventive services that are age and developmentally appropriate including pre-conception and pre-natal care).
 - (2) Screening for breast cancer / mammography (women age 40 or above, every 1-2 years).
 - (3) BRAC (breast cancer) risk assessment and genetic counseling / testing (for women who have family history of breast, ovarian, tubal or peritoneal cancer or otherwise indicated).
 - (4) Breast cancer preventive counseling / medications (for women at increased risk).
 - (5) Screening for cervical cancer.
 - (6) Screening for gestational diabetes (women 24 weeks pregnant and those at high risk of developing gestational diabetes)

- (7) Screening for iron deficiency anemia.
- (8) Screening for gonorrhea, syphilis, and chlamydia.
- (9) Screening / testing for human papillomavirus (HPV) (beginning at age 30 and no more frequently than every 3 years).
- (10) Screening and counseling for human immune deficiency virus (HIV).
- (11) Counseling for all sexually transmitted infections (STI).
- (12) Screening and counseling for interpersonal and domestic violence.
- (13) Folic Acid supplements (for women who may become pregnant).
- (14) Screening for Hepatitis B.
- (15) Screening for osteoporosis / bone density (for women age 65 or older or at increased risk).
- (16) Contraception education and counseling.
- (17) Surgical sterilization (excluding hysterectomy solely for sterilization).
- (18) Contraception methods / devices by prescription (only generic oral contraception); OTC methods / devices (female condoms, sponges, spermicides, emergency contraception).
- (19) Screening for Rh incompatibility.
- (20) Breastfeeding support, supplies and counseling from trained providers.
- (21) Screening for tobacco use and tobacco cessation interventions, with expanded counseling for pregnant tobacco users.
- (22) Urinary tract, bacteriuria or other infection screening (for pregnant women).

- (c) For the sake of clarity, Covered Preventive Care Services for your Children include the following services. If these services are received from an In-Network provider, there will be no cost-sharing (Deductible, Co-Payment or Co-Insurance) if the services are medically necessary or appropriate for the patient and are otherwise covered by the Plan.
- (1) "Well-baby" and "well-child" visits.
 - (2) Sensory screening (visual, hearing).
 - (3) Developmental screening and surveillance.
 - (4) Autism screening.
 - (5) Psychological / behavioral assessment.
 - (6) Alcohol and drug use assessment.
 - (7) Tobacco use education, counseling, intervention.
 - (8) Hematocrit / Hemoglobin screening
 - (9) Lead screening.
 - (10) Tuberculin testing.
 - (11) Dyslipidemia screening (cholesterol).
 - (12) Cervical Dyslasia screening.
 - (13) Oral health risk assessment.
 - (14) Chemoprevention of dental caries.
 - (15) Anticipatory guidance.
 - (16) Screening and counseling for obesity.

- (17) Screening for Phenylketonuria (PKU).
- (18) Screening for HIV.
- (19) Screening for congenital hypothyroidism (newborns).
- (20) Prophylactic medication for gonorrhea (newborns).
- (21) Screening for hemoglobinopathies / sickle cell (newborns).
- (22) Behavioral counseling to prevent skin cancer.
- (23) Screening for depression.
- (24) Immunization vaccines as recommended by the Centers for Disease Control and Prevention.
- (25) Cervical Dysplasia screening.
- (26) Iron supplements (for children ages 6 to 12 months at risk for anemia).
- (27) Sexually Transmitted Infection (STI) prevention counseling and screening (for adolescents at higher risk).

2.12: Designation of Primary Care Provider

Under the Plan, there is no requirement to designate a primary care provider. However, should you wish to choose a primary care provider, you have the right to designate any In-Network primary care provider who is available to accept you. This includes the right to designate a participating pediatrician as your child's primary care provider, and the right to designate a participating obstetrical or gynecological physician as your primary care provider.

2.13: Direct Access To Obstetrical and Gynecological Care

You do not need prior authorization from the Fund Administrator or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from an In-Network health care professional who specializes in such care. The health care professional, however, may be required to comply with certain procedures, including obtaining proper authorization for certain services, following a pre-approved treatment plan, or

procedures for making referrals.

For a list of the participating In-Network specialists in obstetrics and gynecology, contact Cigna by going on Cigna's website (myCigna.com) calling the Customer Services telephone number on the back of your Identification Card.

2.14: Women's Health and Cancer Rights Act Notice

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

- > All stages of reconstruction of the breast on which the mastectomy was performed.
- > Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- > Protheses.
- > Treatment of physical complications of the mastectomy, including lymphadema.

These benefits will be provided subject to the same Deductibles, Co-Payments, Co-Insurance and Out-of-Pocket Cost limits applicable to other medical and surgical benefits provided under this Plan. If you would like more information on WHCRA benefits, contact the Fund Administrator.

2.15: Newborns' and Mothers' Health Protection Act Notice / Maternity Hospital Stay

The Plan is designed to comply with the federal Newborns' and Mothers' Health Protection Act. Under this Federal law, group health plans like the Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

2.16: Clinical Trial Costs

- (a) If you, your Spouse or your Child are eligible to participate in a Qualified Clinical Trial with respect to medical treatment of cancer or another life-threatening disease or condition, the Fund will:

- (1) not deny you participation in the trial;
 - (2) not deny, limit or impose additional conditions on the Plan's coverage of routine patient costs for items, services or drugs otherwise covered by the Plan that are furnished in connection with participation in the trial;
 - (3) not discriminate against you because of your participation in the trial; and
 - (4) cover routine patient care costs related to the Qualified Clinical Trial.
- (b) The Plan will deem you eligible to participate in the trial if:
- (1) you are eligible to participate in the Qualified Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and
 - (2) your health care provider is an In-Network provider under the Plan and that provider has concluded that your participation in the trial would be medically appropriate; or
 - (3) you provide medical and scientific information establishing that your participation in the trial would be medically appropriate for you.
- (c) For purposes of clinical trials, the term "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- (d) The Qualified Clinical Trial must meet the following requirements:
- (1) be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
 - (2) be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
 - (3) involve a drug trial that is exempt from having such an investigational new drug application.
- (e) Routine patient care costs are costs associated with the provision of health care items

and services including drugs, items, devices and services otherwise covered by this Plan for an individual who is not enrolled in a clinical trial and, in addition:

- (1) services required solely for the provision of the investigational drug, item, device or service;
 - (2) services required for the clinically appropriate monitoring of the investigational drug, device, item or service;
 - (3) services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service; and
 - (4) reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.
- (f) Routine patient care costs do not include:
- (1) the investigational drug, item, device, or service, itself; or
 - (2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- (g) Qualified Clinical Trial conducted by non-participating (Non-Network) providers will be covered at the In-Network benefit level if:
- (1) there are not In-Network providers participating in the Qualified Clinical Trial that are willing to accept the individual as a patient, or
 - (2) the Qualified Clinical Trial is conducted outside the individual's State of residence.

2.16: Case Management & Special Programs

(a) Cigna Case Management Program

Cigna has a program under which a Case Manager can be assigned to assist you (or your Spouse or Child, if you have Family Coverage) if you become a patient to make sure that you are receiving appropriate care in the most effective setting possible (at home, as an Out-Patient, or as an In-Patient at a Hospital or other facility). Case Managers are Registered Nurses or other health care professionals with appropriate

training for your particular condition. Your Physicians remain responsible for your care, but a Case Manager can assist you.

You (or, if you have Family Coverage, your Spouse or Child) or your Physician can request Case Manager services by calling the toll-free telephone number on the back of your Member Identification card. Also, Case Manager services can be requested as part of a Utilization Review Program or by Cigna.

Cigna's description of the Case Management program and its rules is as follows:

- (1) Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting.

The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an Out-patient, or an In-patient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

- (2) Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.
- (3) You, your dependent or an attending Physician can request Case Management services by calling the toll-free number shown on your ID card during normal business hours, Monday through Friday. In addition, your fund, a claim office or a utilization review program (see the PAC/CSR section of your certificate) may refer an individual for Case Management. The Review Organization assesses each case to determine whether Case Management is appropriate.
- (4) You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no

penalty or benefit reduction is imposed if you do not wish to participate in Case Management.

- (5) Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
 - (6) The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
 - (7) The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
 - (8) Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.
 - (9) While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.
- (b) Special Managed Care Programs
- (1) The Board of Trustees may, from time to time, adopt, authorize or terminate special programs offered by Cigna or other service providers designed to help you and your Family manage care for a health condition, particularly chronic conditions and diseases, and for pregnancy. The object of such programs is to improve health outcomes and minimize unnecessary costs. These programs may be voluntary or mandatory. Such a program may offer you or your Family financial incentives for participation in the program. Payment of a financial incentive will be considered a benefit under this Plan.
 - (2) Notice regarding the availability of such programs will be sent to Participants and posted on the Fund's website (www.lnhwf.org).
 - (3) Special programs adopted by the Board include the following:
 - > Cigna "Healthy Pregnancies Healthy Babies" program.

2.17: Care Management & Coordinated Care

Cigna has collaborative care arrangements with some In-Network providers committed to improving quality care, patient satisfaction and affordability. These arrangements are intended to encourage Physicians and other providers to be proactive in their care for you. The aim is to improve your health and well-being by keeping in contact with you and coordinating your medical care. Reimbursement by the Plan is 100% for services provided by an In-Network collaborative care provider.

2.18: Genetic Testing

- (a) Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:
 - (1) a person has symptoms or signs of a genetically-linked inheritable disease; or
 - (2) it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
 - (3) the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.
- (b) Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.
- (c) Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per calendar year for both pre- and post-genetic testing. The visit limit does not apply to genetic counseling related to treatment of mental health and/or substance use disorders.

2.19: Orthognathic Surgery

- (a) Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone can not correct, provided:
 - (1) the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
 - (2) the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease; or

- (3) the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.
- (b) Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review Physician.

2.20: Cardiac Rehabilitation

- (a) Phase II cardiac rehabilitation provided on an Out-patient basis following diagnosis of a qualifying cardiac condition when Medically Necessary. Phase II is a Hospital-based outpatient program following an inpatient Hospital discharge. The Phase II program must be Physician directed with active treatment and EKG monitoring.
- (b) Phase III and Phase IV cardiac rehabilitation is not covered. Phase III follows Phase II and is generally conducted at a recreational facility primarily to maintain the patient's status achieved through Phases I and II. Phase IV is an advancement of Phase III which includes more active participation and weight training.

2.21: Home Health Services

- (a) Charges incurred for Home Health Services are Covered Medical Expenses when you: require skilled care; are unable to obtain the required care as an ambulatory outpatient; and do not require confinement in a Hospital or Other Health Care Facility.
- (b) Home Health Services are provided only if Cigna has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for nonskilled care and/or custodial services (e.g., bathing, eating, toileting), Home Health Services will be provided for you only during times when there is a family member or care giver present in the home to meet your nonskilled care and/or custodial services needs.
- (c) Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals.
- (d) A visit is defined as a period of 2 hours or less. Home Health Services are subject to a maximum of 16 hours in total per day.
- (e) Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health Services are covered.
- (f) Home Health Services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Health Care Professional.

- (g) Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations. Physical, occupational, and other Short-Term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Short-term Rehabilitative Therapy Maximum.

2.22: Hospice Care Services

- (a) Charges incurred for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program are Covered Medical Expenses:
 - (1) by a Hospice Facility for Bed and Board and Services and Supplies;
 - (2) by a Hospice Facility for services provided on an outpatient basis;
 - (3) by a Physician for professional services;
 - (4) by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
 - (5) for pain relief treatment, including drugs, medicines and medical supplies;
 - (6) by an Other Health Care Facility for:
 - > part-time or intermittent nursing care by or under the supervision of a Nurse;
 - > part-time or intermittent services of an Other Health Care Professional;
 - (7) physical, occupational and speech therapy;
 - (8) medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.
- (b) The following charges for Hospice Care Services are not included as Covered Medical Expenses:
 - (1) for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
 - (2) for any period when you or your Dependent are/is not under the care of a Physician;

- (3) for services or supplies not listed in the Hospice Care Program;
- (4) for any curative or life-prolonging procedures;
- (5) to the extent that any other benefits are payable for those expenses under the policy;
- (6) for services or supplies that are primarily to aid you or your Dependent in daily living.

2.23: Mental Health and Substance Use Disorder Services

- (a) **Mental Health Services** are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.
- (b) **Substance Use Disorder** is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Use Disorder.
- (c) **In-patient Mental Health Services**

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Mental Health Residential Treatment Services.

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when

she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

(d) **Out-patient Mental Health Services**

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group or Mental Health Partial Hospitalization or Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

Mental Health Partial Hospitalization Services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Mental Health program in accordance with the laws of the appropriate legally authorized agency.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program in accordance with the laws of the appropriate, legally authorized agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

(e) **In-patient Substance Use Disorder Rehabilitation Services**

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Use Disorder Services include Residential Treatment services.

(f) **Substance Use Disorder Residential Treatment Services**

Services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Use Disorder conditions.

(g) **Substance Use Disorder Residential Treatment Center**

Means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Use Disorder; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Use Disorder Residential Treatment Center when she/he is a registered bed patient in a Substance Use Disorder Residential Treatment Center upon the recommendation of a Physician.

(h) **Out-patient Substance Use Disorder Rehabilitation Services**

Services provided for the diagnosis and treatment of Substance Use Disorder or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Use Disorder Partial Hospitalization or Intensive Outpatient Therapy Program.

Substance Use Disorder Partial Hospitalization Services are rendered no less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency.

A Substance Use Disorder Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week.

(i) **Substance Use Disorder Detoxification Services**

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Cigna will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

(j) **Exclusions From Mental Health And Substance Use Disorder Services**

The following are specifically excluded from Mental Health and Substance Use Disorder

Services:

- (1) treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain;
- (2) developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders;
- (3) counseling for activities of an educational nature;
- (4) counseling for borderline intellectual functioning;
- (5) counseling for occupational problems;
- (6) counseling related to consciousness raising;
- (7) vocational or religious counseling;
- (8) I.Q. testing;
- (9) custodial care, including but not limited to geriatric day care;
- (10) psychological testing on children requested by or for a school system; and
- (11) occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

2.24: Durable Medical Equipment

- (a) Covered Medical Expenses include charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by Cigna for use outside a Hospital or Other Health Care Facility.
- (b) Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

- (c) Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs, and dialysis machines.

- (d) Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:
 - (1) Bed Related Items: bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses.

 - (2) Bath Related Items: bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.

 - (3) Chairs, Lifts and Standing Devices: computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs.

 - (d) Fixtures to Real Property: ceiling lifts and wheelchair ramps.

 - (e) Car/Van Modifications.

 - (f) Air Quality Items: room humidifiers, vaporizers, air purifiers and electrostatic machines.

 - (g) Blood/Injection Related Items: blood pressure cuffs, centrifuges, nova pens and needleless injectors.

 - (h) Other Equipment: heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

2.25: Internal Prosthetic / Medical Appliances

Covered Medical Expenses include charges incurred for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

2.26: External Prosthetic Appliances And Devices

- (a) Covered Medical Expenses include charges incurred or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect. Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician.
- (b) External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; and splints.

2.27: Prostheses / Prosthetic Appliances And Devices

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Covered Medical Expenses include charges for prostheses/prosthetic appliances and devices including, but are not limited to:

- (a) basic limb prostheses;
- (b) terminal devices such as hands or hooks;
- (c) speech prostheses; and
- (d) breast prostheses.

2.28: Orthoses and Orthotic Devices

- (a) Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Covered Medical Expenses include custom foot orthoses and other orthoses as follows:

- (1) Nonfoot orthoses – only the following nonfoot orthoses are covered:
 - > rigid and semirigid custom fabricated orthoses;
 - > semirigid prefabricated and flexible orthoses; and
 - > rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.

- (2) Custom foot orthoses – custom foot orthoses are only covered as follows:
 - > for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
 - > when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
 - > when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
 - > for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

- (b) The following are specifically excluded orthoses and orthotic devices:
 - (1) prefabricated foot orthoses;
 - (2) cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
 - (3) orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
 - (4) orthoses primarily used for cosmetic rather than functional reasons; and

- (5) orthoses primarily for improved athletic performance or sports participation.

2.29: Braces And Splints

- (a) A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part. Generally, braces are Covered Medical Expenses, except that the following braces are excluded from coverage: Copes scoliosis braces.
- (b) A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts. Splints are generally Covered Medical Expenses, except as provided herein below. Coverage for replacement of external prosthetic appliances and devices is limited as follows:
 - (1) Replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
 - (2) Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
 - (3) Coverage for replacement is limited as follows:
 - > no more than once every 24 months for persons 19 years of age and older;
 - > no more than once every 12 months for persons 18 years of age and under; and
 - > replacement due to a surgical alteration or revision of the site.
- (c) The following are specifically excluded external prosthetic appliances and devices:
 - (1) external and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
 - (2) myoelectric prostheses peripheral nerve stimulators.

2.30: Short-Term Rehabilitative Therapy

- (a) Short-term Rehabilitative Therapy is a Covered Medical Expense if it is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting. The following limitation applies to Short-term Rehabilitative Therapy: occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Illness or Injury or Sickness.
- (b) Short-term Rehabilitative Therapy services that are not Covered Medical Expenses include, but are not limited to:
 - (1) sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
 - (2) treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury; and
 - (3) maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status.
- (c) Multiple outpatient services provided on the same day constitute one day.
- (d) A separate Copayment will apply to the services provided by each provider.
- (e) Services that are provided by a chiropractic Physician are not covered. These services include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

2.31: Chiropractic Care Services

- (a) Charges made for diagnostic and treatment services utilized in an office setting by chiropractic Physicians as Covered Medical Expenses under the terms of this subsection. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function. For these services you have direct access to qualified chiropractic Physicians.

- (b) The following limitation applies to Chiropractic Care Services:
 - (1) occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.
- (c) Chiropractic Care Services that are not Covered Medical Expenses include but are not limited to:
 - (1) services of a chiropractor which are not within his scope of practice, as defined by state law;
 - (2) charges for care not provided in an office setting;
 - (3) maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status;
 - (4) vitamin therapy.

2.32: Breast Reconstructive and Breast Prosthesis

Charges incurred for reconstructive surgery following a mastectomy are Covered Medical Expenses. Benefits include: surgical services for reconstruction of the breast on which surgery was performed; surgical services for reconstruction of the nondiseased breast to produce symmetrical appearance; postoperative breast prostheses; and mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

2.33: Reconstructive Surgery

Covered Medical Expenses include charges incurred for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, noncosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

2.34: Transplant Services And Transplant Travel Services

- (a) Covered Medical Services generally include charges incurred for human organ and

tissue Transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories. This coverage is subject to the conditions and limitations described in this subsection.

- (b) Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral.
- (c) All Transplant services, other than cornea, are covered at 100% when received at Cigna LIFESOURCE Transplant Network® facilities. Cornea transplants are not covered at Cigna LIFESOURCE Transplant Network® facilities. Transplant services, including cornea, received at participating facilities specifically contracted with Cigna for those Transplant services, other than Cigna LIFESOURCE Transplant Network® facilities, are payable at the In-Network level. Transplant services received at any other facilities, including Non-Participating Providers and Participating Providers not specifically contracted with Cigna for Transplant services, are not covered.
- (d) Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation (refer to Transplant Travel Services), hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.
- (e) Charges made for non-taxable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for transportation and lodging are available to you only if you are the recipient of a preapproved organ/tissue transplant from a designated Cigna LIFESOURCE Transplant Network® facility. The term recipient is defined to include a person receiving authorized transplant related services during any of the following: evaluation, candidacy, transplant event, or post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); and lodging while at, or traveling to and from the transplant site.
- (f) In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age. The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed

coach class rates.

- (g) These benefits are only available when the covered person is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above. Charges for the expenses of a donor companion are not covered. No benefits are available when the covered person is a donor.

2.35: Medical Pharmaceuticals

- (a) Covered Medical Expenses generally include charges incurred for Medical Pharmaceuticals that are administered in an Inpatient setting, Outpatient setting, Physician's office, or in a covered person's home.
- (b) Benefits under this subsection are provided only for Medical Pharmaceuticals which, due to their characteristics (as determined by Cigna), are required to be administered, or the administration of which must be directly supervised, by a qualified Physician. Benefits payable under this section include Medical Pharmaceuticals whose administration may initially, or typically, require Physician oversight but may be self-administered under certain conditions specified in the product's FDA labeling.
- (c) Certain Medical Pharmaceuticals are subject to prior authorization requirements or other coverage conditions. Additionally, certain Medical Pharmaceuticals are subject to step therapy requirements. This means that in order to receive benefits for such Medical Pharmaceuticals, you are required to try a different Medical Pharmaceutical and/or Prescription Drug Product first.
- (d) The Cigna Business Decision Team determines whether utilization management requirements or other coverage conditions should apply to a Medical Pharmaceutical by considering a number of factors, including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of Medical Pharmaceuticals as well as whether utilization management requirements should apply. Economic factors may include, but are not limited to, the Medical Pharmaceutical's cost including, but not limited to, assessments on the cost effectiveness of the Medical Pharmaceuticals and available rebates. When considering a Medical Pharmaceutical for a coverage status, the Business Decision Team reviews clinical and economic factors regarding enrollees as a general population across its book-of-business. Regardless of its eligibility for coverage under your plan, whether a particular Prescription Drug Product is appropriate for you or any of your Dependents is a determination that is made by you (or your Dependent) and the prescribing Physician.
- (e) The coverage criteria for a Medical Pharmaceutical may change periodically for various reasons. For example, a Medical Pharmaceutical may be removed from the market, a new Medical Pharmaceutical in the same therapeutic class as a Medical Pharmaceutical may become available, or other market events may occur. Market events that may affect the coverage status of a Medical Pharmaceutical include, but are not limited to, an increase in the cost of a Medical Pharmaceutical.

2.36: Experimental / Investigational / Unproven Services, Treatments and Devices

- (a) Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:
- (1) not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
 - (2) not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
 - (3) the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this Plan; or
 - (4) the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this Plan.
- (b) In determining whether drug or Biologic therapies are experimental, investigational and unproven, the utilization review Physician may review, without limitation, U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature.

2.37: Qualified Medical Child Support Order (QMCSO)

- (a) Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify the Fund Administrator and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the QMCSO being issued.

- (b) Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

- (1) the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
 - (2) the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
 - (3) the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
 - (4) the order states the period to which it applies; and
 - (5) if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.
- (c) The QMCSO may not require the Fund to provide coverage for any type or form of benefit or option not otherwise provided under the Fund's terms and conditions, except that an order may require the Fund to comply with State laws regarding health care coverage.

2.38: Benefit Claims and Appeals

- (a) In-Network: If you or your eligible Dependent receives medical services from an In-Network hospital, doctor or other provider, the provider will submit an electronic claim for benefits to Cigna on your behalf. The In-Network provider may also request pre-authorizations from Cigna and submit urgent claims, pre-service claims and concurrent care claims to Cigna. You pay the provider your Co-Payment, if one is owed for the services.
- (b) Out-of-Network: If you or your eligible Dependent receives medical services from a Hospital, Physician or other provider that is not In-Network, you or your provider will have to submit an approved claim form to Cigna. Your provider can submit the claim form to Cigna for you, if the provider is willing and able to do so. The form may also be submitted to Cigna by your Authorized Representative on your behalf. An approved medical claim form can be obtained on the Cigna website listed on your Identification Card or by calling the Customer Service telephone number on your Identification Card. It is important that you or your provider include your Identification Number and Group Number on the claim form.
- (c) Time Limit For Claims: A claim is timely if submitted to Cigna within 180 days after the medical treatment, services, supplies or equipment to which the claim relates were received by the patient. A claim received after that 180-day period may be denied as untimely and no benefits paid.

- (d) Processing Claim: Upon receipt of a benefit claim, Cigna will check with the Fund Administrator to confirm the patient's eligibility for benefits. Cigna will then process the claim to determine what amount, if any, is payable by the Fund under the terms and conditions of the Plan. Cigna will pay directly to the provider the amount of benefits due under the Plan if you have assigned your benefits to the provider. If you have not assigned your benefits under the Plan to the provider, Cigna will pay directly to you the benefits payable under the Plan and you will be responsible for paying the provider. A Cigna or other Fund representative may contact you or your provider for additional information needed to properly process your claim. The provider may bill you directly for payment of the cost of the services to the extent not payable under the Plan.

A written or electronic Explanation of Benefits ("EOB") will be sent by Cigna to the provider and to you regarding the claim. The EOB will show the amount of the provider's charges, the amount payable by the Fund, the amount payable by you, and other information. If the claim is denied in whole or in part, the EOB will also include a reason for the denial and explain that you have a right to appeal the denial.

If you have a question regarding an EOB, you can contact a Cigna Customer Service Representative by calling the toll-free telephone number on your Member Identification Card or the EOB. Cigna will review or investigate your question as soon as possible, but in any case within 30 days. If you are not satisfied with Cigna's response, you can start the appeals procedure, described below.

- (5) Appealing A Denial Of Benefits: If your claim for medical benefits is denial, in whole or in part, by Cigna, you have a right to appeal. See "How To Claims Benefits & Appeal Denials Of Benefits", Section 9.

2.39: General Incorporation Of Cigna Agreement

Any benefit, limitation, exclusion, or rule relating to medical services not specifically addressed in this Plan Description, but addressed in a written agreement between the Fund and Cigna, will be determined under the agreement.

2.40: Nondiscrimination & Assistance

- (a) The Fund and its service providers, including Cigna, comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. They do not exclude people or treat them differently because of race, color, national origin, age, disability or sex.
- (b) The Fund, through Cigna, provides free aids and services to people with disabilities to communicate effectively with it and the Fund, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).

**SECTION 3:
PRESCRIPTION DRUG COVERAGE**

3.1: Prescription Drug Benefits Covered

- (a) The Plan pays benefits for Covered Prescription Drug Expenses incurred by you and, if you have Family Coverage, your Eligible Dependents, except to the extent excluded. The Plan pays no benefits for drug expenses that are not Covered Prescription Drug Expenses or that are excluded from coverage under this Plan.
- (b) Covered Prescription Drug Expenses are all Federal Legend Drugs, State Restricted Drugs, and injectable insulin that are obtainable only with a Physician's prescription and dispensed by a licensed Pharmacist. The drugs must be prescribed for you or your Eligible Dependent by a Physician for treatment of an Illness or Injury, and must be Medically Necessary.
- (c) The Plan uses a "formulary", which is a list of generic and brand name prescription drugs that are considered safe and effective for patients and that can be obtained through it at a lower cost. A drug that is listed in the Plan's formulary is called a formulary drug. A drug that is not listed in the formulary is called a non-formulary drug. You may be required to pay a higher Co-Payment, or even the full cost, for drugs that are not on the formulary. The formulary may be obtained by contacting the Pharmacy Benefit Manager, Express Scripts, Inc. ("ESI") through its website (www.express-scripts.com) or calling the number on your ID card.

3.2: Exclusions: Drugs & Items For Which The Plan Pays No Benefits

No prescription drug benefits are payable under the Plan for the following exclusions, although coverage may be provided for some items under another Plan benefit program (e.g. Medical Benefits):

- > Any charge for the administration or injection of a drug or insulin
- > Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original order
- > Any charge where the Reasonable and Customary Charge is less than the Covered Individual's Co-Payment
- > Any charge above the Reasonable and Customary Charge or the advertised or posted price, whichever is less
- > Bee sting kits
- > Blood or plasma.
- > Compounded medications that are themselves not FDA-approved (see Compound Drugs Cost Management Program, below)
- > Contraceptives, oral or other, whether medication or device, regardless of intended use
- > Diagnostic drugs
- > Drugs which are lawfully obtainable without a prescription, except injectable insulin
- > Drugs used to treat obesity and anorexia or assist weight reduction
- > Drugs used for cosmetic purposes

- > Drugs received without charge under governmental programs or workers' compensation
- > Drugs which are not Medically Necessary
- > Fertility drugs (injectables or oral)
- > Growth hormones
- > Immunization agents (except to the extent required by the Affordable Care Act)
- > Injectables, except injectable insulin
- > Investigational or Experimental drugs, even though a charge is made to the individual
- > Levonorgestrel (Norplant)
- > Medication which is to be taken by or administered to a Covered Individual, in whole or in part, while he or she is a patient in a Hospital or other Health Care Facility which operates on its premises a facility for dispensing pharmaceuticals
- > Minoxidel, Rhogaine, Rhogam and similar drugs
- > Non-federal legend drugs and non-state restricted drugs, other than injectable insulin
- > Serums
- > Sexual dysfunction drugs, including Yohimbine and similar drugs
- > Therapeutic devices or appliances, including hypodermic needles, syringes, support garments, elastic stockings and other non-medical items regardless of their intended use.
- > Tretinoin and Retin-A for persons age 25 or older
- > Vitamins, whether Federal Legend or not, except pre-natal vitamins.

3.3: Limitations on Supplies of and Access to Drugs

The amounts of prescribed drugs that may be provided by a Pharmacy at one filling are limited as follows:

- > Retail Pharmacy: 30-day supply or 100 units, whichever is less.
- > Mail Service Pharmacy: 90-day supply

Coverage of certain drugs may be limited, conditioned or excluded under utilization and cost containment programs adopted by the Board and administered by Express Scripts to save you and the Fund unnecessary drug costs. See "Cost Containment and Utilization Management Programs" below.

3.4: Generic Drug Use

Many drugs are available in both a brand name and generic form. A generic drug is a drug known by its chemical name. A brand name drug is a drug known by the trade name used for marketing the drug. The quality, strength and purity of generic drugs are regulated by the U.S. Food and Drug Administration. Generic drugs contain the same active ingredients and are equivalent in strength and dosage as the brand name form of the drug.

You and your Eligible Dependents are encouraged to ask your Physician to prescribe the generic form of the drugs you need, if possible. You will usually be required to pay a higher Co-Payment for brand name drugs than for generic drugs. Use of generic forms of drugs can be less costly for you and for the Fund.

If there is a generic form of a drug available, it will be dispensed by the Pharmacist if your

Physician does not indicate that the brand name form of the drug is required.

3.5: Mail Service Pharmacy: Mandatory for Maintenance Medications

If you or your Eligible Dependent are taking a prescribed drug on an ongoing basis (“maintenance medication”), you are required to use the Plan’s Mail Service Pharmacy. Maintenance medications are often used to treat chronic conditions such as high blood pressure, cholesterol problems, diabetes, arthritis, depression, thyroid conditions, osteoporosis, heart disease and asthma.

The Mail Service Pharmacy may also be used for covered prescriptions other than maintenance medications. If you use the Mail Service Pharmacy, you may be charged a lower Co-Payment than if you use a Retail Pharmacy to fill your prescriptions. Mail service prescriptions may be filled for longer periods (up to a 90-day supply compared to a 30-day supply at a Retail Pharmacy), requiring fewer re-fills (and fewer Co-Payments). If you use the Mail Service Pharmacy to fill prescriptions, you will not have to submit any benefit claims forms. You need only to pay the applicable Co-Payment to the Pharmacy.

3.6: Participating Retail Pharmacies

The Fund, through Express Scripts, has a network of Participating Retail Pharmacies that will accept the Plan’s coverage. No claim forms are required if your or your Eligible Dependent’s prescription is filled at a Participating Retail Pharmacy. You need only to pay the applicable Co-Payment to the Pharmacy. Note that a prescription fill or re-fill at a Retail Pharmacy is limited to up to a 30-day supply. In contrast, a prescription may be filled or re-filled through the Mail Service Pharmacy for up to a 90-day supply.

You can obtain a list of the Participating Retail Pharmacies on the Express Scripts website (www.express-scripts.com) or by calling the Express Scripts customer service telephone number on your Identification Card.

3.7: Your Share Of The Cost: Co-Payments

A Co-Payment, for purposes of the Prescription Drug Program, is the amount (dollar amount or percentage of cost) that you or your Eligible Dependent must pay for each prescription filled or re-filled for a Covered Prescription Drug Expense. The Plan pays for the rest of the drug’s cost. The Co-Payment amounts are different according to whether the prescription is for a generic or brand name drug, whether you used the Mail Service Pharmacy or a Retail Pharmacy, and whether the prescribed drug is a formulary or non-formulary drug.

Co-Payment Amount	Type of Drug / Type of Pharmacy
\$5.....	Generic / Retail Pharmacy
20% of cost..... (\$10 min., \$35 max.)	Brand, Formulary / Retail Pharmacy
30% of cost..... (\$10 min., \$50 max.)	Brand, Non-Formulary / Retail Pharmacy

\$10.....	Generic / Mail Service Pharmacy
20% of cost..... (\$20 min., \$70 max.)	Brand, Formulary / Mail Service Pharmacy
30% of cost..... (\$20 min., \$100 max.)	Brand, Non-Formulary / Mail Service Pharmacy

3.8: Maximum Limit On Your Annual Costs (Out-Of-Pocket Maximum)

- (a) There is a maximum limit on how much you and your Family (if you have Family Coverage) will have to pay in any year for Covered Prescription Drug Expenses. This annual limit, called the Out-Of-Pocket Maximum, applies to the total amount of Deductibles and Co-Payments you are required to pay. After this limit is reached, the Fund will pay your remaining allowable Covered Prescription Drug Expenses for the rest of the calendar year. The annual In-Network, Out-Of-Pocket Maximum for covered medical expenses and prescription drug expenses is \$2,000 per individual and \$4,000 per family. Prescription drug costs do not count towards the Out-Of-Network, Out-Of-Pocket Maximum.
- (b) Any manufacturer-funded Co-Payment assistance will not apply to the Out-Of-Pocket limits.

3.9: Filing Claims for Drug Benefits & Appeals

- (a) If you or your Eligible Dependent use the Mail Service Pharmacy or a Participating Retail Pharmacy to fill prescriptions, you will not have to submit any claim forms to receive benefits. You need only to pay the applicable Co-Payment to the Pharmacy.
- (b) If your prescription is filled at a Pharmacy that is not the Mail Service Pharmacy or a Participating Retail Pharmacy, you will have to pay the full cost of the prescription to the Pharmacy and submit a claim form to Express Scripts for reimbursement of that part of the cost payable by the Plan. You can obtain a claim form through Express Script's website directly or through the hyperlink to Express Scripts on the Fund's website.
- (c) If your claim for benefits is denied, in whole or in part, you have a right to appeal to the Fund's Board of Trustees. See "How To Claim Benefits & Appeal Denials Of Benefits", Section 9.

3.10: Cost Containment and Utilization Management Programs: Prescription Drugs

- (a) The Plan's prescription drug benefits are subject to cost containment and utilization management programs administered by the Pharmacy Benefit Manager (Express Scripts or "ESI") and adopted by the Fund's Board of Trustees from time-to-time. Such programs may condition, limit or exclude coverage of certain drugs, or result in you having to pay a greater share or all of the cost of a drug. These programs are intended to reduce the risk that you will be exposed to an unsafe or inappropriate drug, to control costs for the Fund and you, and to foster the proper usage of a drug.

(b) As of January 1, 2019, the Plan's cost containment, utilization management and patient safety programs include the following:

(1) Advanced Utilization Management Program

ESI is authorized to proactively intervene to contain costs and promote patient safety by active management of your and your family members' prescription drug usage including imposition of prior authorization requirements, step therapy requirements (use of a less expensive drug first before stepping up to a more expensive drug), and quantity control.

(2) Exclusive Specialty Drug Program

You and your family members are required to obtain specialty drugs through ESI's Accredo specialty Pharmacy by mail order.

(3) Compound Drugs Cost Management Program

As of July 15, 2015, the Fund no longer covers prescriptions for compounded medications that are not themselves FDA-approved and contain certain ingredients specified by ESI (ingredients commonly used for compounding abuses). The Fund will continue to cover prescriptions for FDA-approved drugs.

(4) Cholesterol Drug Management Program (PCSK9 Inhibitors)

The Fund will cover drugs PCSK9 Inhibitors to control cholesterol subject to a utilization management program administered by ESI called the "Cholesterol Care Value ("CCV") Program. The Fund will cover and pay benefits for PCSK9 Inhibitors only through the CCV Program. The Program is designed to cover PCSK9 Inhibitors only after traditional cholesterol-lowering therapy has been tried and failed with respect to the patient. Important features of the CCV include the following:

- (i) To be covered by the Fund, all prescriptions for PCSK9 Inhibitors will have to be submitted to the ESI Mail Order Pharmacy (Accredo) by the eligible participant or dependent. The Fund will not cover prescriptions for PCSK9 Inhibitors filled at a retail pharmacy (neighborhood pharmacy, for example).
- (ii) Before filling the prescription, Accredo will contact the patient to determine whether he or she has unsuccessfully tried traditional cholesterol drug therapy and whether the prescription is appropriate for the patient under clinical standards. Accredo will also provide information about the medication and directions for its proper use.
- (iii) Accredo will dispense a PCSK9 Inhibitor initially in three 30-day supplies to determine the patient's tolerance for the drug. Thereafter, if the patient's tolerance for the drug has been shown, Accredo will dispense the drug to the patient in 90-day supplies.

(5) Cholesterol Drug Management Program for Non-PCSK9 Inhibitor Drugs

Effective January 1, 2016, the Fund will generally cover prescriptions for any cholesterol-lowering drug only if the prescriptions are submitted to ESI Mail Order Pharmacy (Accredo) by the eligible participant or dependent. Accredo will dispense the drug in 90-day supplies.

The Fund will not cover cholesterol-lowering drug prescriptions filled at a retail pharmacy, with the following exception. Exception: If you wish to continue filling your cholesterol drug prescriptions at a retail pharmacy, you can elect to “opt-out” of the Mail Order Pharmacy requirement before January 1, 2016. If you do not “opt-out” before January 1, 2016, you will have to pay 100% of the discounted price of the drug if you use a retail pharmacy rather than the Mail Order Pharmacy after January 1, 2016.

If you were using a prescription cholesterol-lowering drug as of July 2015, ESI sent you a letter later this year to explain the program and tell you how to choose to “opt-out”.

(6) Market Events Protection Program

ESI alerts the Board of Trustees to developments in the marketplace for prescription drugs that will result in the Fund and its Participants incurring unnecessary drug costs, and takes or proposes to the Board actions that may be taken to avoid or mitigate the wasteful costs. Such actions may include excluding coverage of certain drugs, limiting coverage to preferred substitute medications, requiring step therapy, covering only one form of the drug, and implementation of a preferred Pharmacy requirement. Developments triggering the program may include sharp increases in the prices of certain drugs, generic drugs becoming available as patents expire for brand names, and unwarranted price discrepancies between drugs for the same medical condition.

(7) Opioid Drug Management Program

ESI may take proactive measures to prevent opioid abuse involving you and your family members. Such actions include limiting the prescribed supply (e.g. 7-day supply limit regardless of the prescribed supply), restricting coverage of long-acting opioids, and interaction with the prescribing Physician or your Pharmacist.

(8) Inflammatory Conditions Care Value Program

There are many drugs that treat inflammatory conditions, such as psoriasis, rheumatoid arthritis, and Crohn’s disease, on the market. ESI is authorized to designate a particular drug for each such condition as the preferred drug to be covered by the Plan, based on quality and cost effectiveness. The preferred drugs can be dispensed on through ESI’s specialty Pharmacy, Accredo. Prior authorization, ongoing utilization management, and step therapy may also be required.

(9) Oncology (Cancer) Care Value Program

ESI is authorized to designate a particular drug for each cancer condition as the preferred drug to be covered by the Plan, based on quality and cost effectiveness. The preferred drugs can be dispensed only through ESI's specialty Pharmacy, Accredo, for mail delivery. Prior authorization, ongoing utilization management, and step therapy may also be required.

(10) Diabetes Care Value Program

ESI is authorized to designate particular diabetes drugs as the preferred drugs to be covered by the Plan, based on quality and cost effectiveness. The preferred drugs can be dispensed only through ESI's specialty Pharmacy, Accredo, for mail delivery. Prior authorization, ongoing utilization management, and step therapy may also be required.

(11) Hepatitis Care Value Program

ESI is authorized to designate particular hepatitis drugs as the preferred drugs to be covered by the Plan, based on quality and cost effectiveness. The preferred drugs can be dispensed only through ESI's specialty Pharmacy, Accredo, for mail delivery. Prior authorization, ongoing utilization management, and step therapy may also be required.

(12) Multiple Sclerosis Care Value Program

ESI is authorized to designate particular drugs to treat multiple sclerosis as the preferred drugs to be covered by the Plan, based on quality and cost effectiveness. The preferred drugs can be dispensed only through ESI's specialty Pharmacy, Accredo, for mail delivery. Prior authorization, ongoing utilization management, and step therapy may also be required.

(13) Coordination of Co-Payments With Cost-Sharing Programs Offered By Drug Manufacturers

ESI is authorized to take action to prevent cost-sharing and subsidy programs offered by drug manufacturers to patients from undermining cost management programs under the Plan.

Any manufacturer-funded Co-Payment assistance will not apply to the Out-Of-Pocket limits.

- (c) The Board of Trustees may amend or terminate these programs, and may adopt additional cost containment and utilization management programs, from time-to-time. Any such changes will be announced on the Fund's website (www.lnhwf.org).

3.11: General Incorporation Of ESI Contract

With regard to matters not expressly addressed in this Section, the terms and conditions of the Fund's contract with ESI, as amended from time to time, are incorporated into this Plan Description by reference.

**SECTION 4:
DENTAL CARE COVERAGE**

4.1: Dental Benefits Coverage Generally

The Plan provides Dental Benefits Coverage through a dental “preferred provider organization” (“PPO”) administered by Delta Dental of Pennsylvania (“Delta Dental”). The PPO is a network of Dentists, including Specialists, located throughout the United States. These “In-Network” Dentists have contracts with Delta Dental requiring them to provide covered dental services at discounted prices and to meet quality of care standards. In-Network Dentists also submit claims for benefits directly to Delta Dental.

You can obtain a list of In-Network Dentists, including Specialists, through Delta Dental's website (www.deltadentalins.com), or you can call Delta Dental’s customer service telephone number on your Identification Card or 1-800-932-0783. (Group ID 19221).

You can use a Dentist who is not In-Network with Delta Dental. However, the Plan provides lower benefits for covered dental services that you or your Eligible Dependents (if you have Family Coverage) receive from a Dentist who is not a member of Delta Dental's Network (“Out-of-Network” Dentist). This means that you will pay more if you use an Out-of-Network Dentist. Also, you will have to submit a claim form for benefits to Delta Dental.

4.2: Dental Benefits: In-Network

The Plan will pay a certain percentage of the In-Network dentist’s discounted charges for treatments and services covered by the Plan (“In-Network”), up to the Annual Maximum Limit (if applicable). The rest of the charges will be the patient’s responsibility, in addition to any applicable Deductible. The percentage of the In-Network Dentist’s charges that the Plan will pay, and any applicable Deductible, is set in the following chart.

Note that the percentages are based on the PPO Allowed Amount, which is the lesser of the Dentist’s submitted fee or the PPO Maximum Plan Allowance. In-Network Dentists have agreed to accept the PPO Maximum Plan Allowance as full payment for each service.

Diagnostic Services.....100% paid by the Plan (Maximum waived)
Includes periodic exams (2 x per calendar year),
bitewing x-rays (no frequency limit)
full-mouth x-ray (once per 3-year period)
Additional benefits during pregnancy

Preventive Services100% paid by the Plan (Maximum waived)
Prophylaxis / Cleaning (2x per calendar year)
Fluoride treatments (2x per calendar year to age 19)
Sealants (to age 14)
Space maintainers (to age 14)
Additional benefits during pregnancy

Basic Restorative100% paid by the Plan
Fillings (amalgam “silver” and composite “white” non-molar)

Major Restorative	60% paid by the Plan
Single crowns, inlays, onlays	
Oral Surgery	100% paid by the Plan
Extraction and other oral surgery procedures including pre- and post-operative care	
Endodontics	100% paid by the Plan
Root canal, pulpal therapy	
Surgical Periodontics	100% paid by the Plan
Surgical treatment of the gums and supporting structures of the teeth	
Non-Surgical Periodontics	100% paid by the Plan
Non-surgical treatment of the and supporting structures of the teeth Additional benefits during pregnancy	
Prosthodontics	60% paid by the Plan
Orthodontics	50% paid by the Plan
To age 19. \$50 Deductible (lifetime).	
General Anesthesia and IV Sedation	100% paid by the Plan
Covered when used in conjunction with covered oral surgical procedures and other selected endodontic and periodontic procedures	

4.3: Dental Benefits: Out-of-Network

The Plan will pay a certain percentage of the Out-of-Network dentist's charges for treatments and services covered by the Plan, up to the Annual Maximum Limit, after payment by the patient of an annual Deductible (\$50 per individual, \$100 per family). The percentage of the dentist's charges that the Plan will pay is set in the following chart. You will owe the remaining part of the Dentist's charges.

Note that the percentages are based on the PPO Allowed Amount, which is the lesser of the Dentist's submitted fee or the PPO Maximum Plan Allowance. Out-of-Network Dentists have not agreed to accept the PPO Maximum Plan Allowance as full payment for each service, and so their charges for each service will normally be higher than In-Network Dentists. Some ("Premier Dentists") have agreements with Delta Dental to accept a higher discounted fee level as full payment.

Diagnostic Services	100% paid by the Plan (maximum and Deductible waived)
Includes periodic exams (2 x per calendar year), bitewing x-rays (no frequency limit) full-mouth x-ray (once per 3-year period) Additional benefits during pregnancy	

Preventive Services	100% paid by the Plan (maximum and Deductible waived)
Prophylaxis / Cleaning (2x per calendar year)	
Fluoride treatments (2x per calendar year to age 19)	
Sealants (to age 14)	
Space maintainers (to age 14)	
Additional benefits during pregnancy	
Basic Restorative	100% paid by the Plan
Fillings (amalgam “silver” and composite “white” non-molar)	
Major Restorative	60% paid by the Plan
Single crowns, inlays, onlays	
Oral Surgery	100% paid by the Plan
Extraction and other oral surgery procedures including pre- and post-operative care	
Endodontics	100% paid by the Plan
Root canal, pulpal therapy	
Surgical Periodontics	100% paid by the Plan
Surgical treatment of the gums and supporting structures of the teeth	
Non-Surgical Periodontics	100% paid by the Plan
Non-surgical treatment of the and supporting structures of the teeth	
Additional benefits during pregnancy	
Prosthodontics	60% paid by the Plan
Orthodontics	50% paid by the Plan
To age 19. \$50 Deductible (lifetime).	
General Anesthesia and IV Sedation	100% paid by the Plan
Covered when used in conjunction with covered oral surgical procedures and other selected endodontic and periodontic procedures	

4.4: Annual Maximum Limits On Benefits

The Plan will pay no more than \$2,500 per patient (for you and for each of your Eligible Dependents, if you have Family Coverage) in a Calendar Year for covered dental benefits. Orthodontic benefits are not included in this annual maximum limit.

Orthodontic benefits are separately limited to lifetime limit of \$1,500 per patient.

4.5: Additional Benefits During Pregnancy

If the patient is pregnant, the Plan will pay for additional services: one (1) additional routine cleaning or one (1) additional periodontal scaling and root planing per quadrant. Written proof

of pregnancy may be required.

4.6: Exclusions: Dental Expenses For Which No Benefits Are Payable By The Plan

The following services and items are excluded from coverage as Dental Benefits, and no benefits are payable as Dental Benefits of the Plan (although coverage might be available under other provisions of the Plan, such as Medical Benefits):

- (a) Treatment or materials that are benefits to the patient under Medicare or Medicaid, unless this exclusion is prohibited by law.
- (b) Treatment or materials to correct congenital or developmental malformations (including treatment of enamel hypoplasia); except for newborn children for whom coverage will include cleft lip or cleft palate, subject to other limitations in the Plan.
- (c) Treatment that increases the vertical dimension of an occlusion, replaces tooth structure lost by attrition or erosion, or otherwise unless it is part of a treatment dentally necessary due to accident or injury.
- (d) Treatment or materials primarily for cosmetic purposes including but not limited to treatment of fluorosis and porcelain, or other veneers not for restorative purposes, except as part of treatment dentally necessary due to accident or injury. If services are not excluded as to particular teeth under this provision, cosmetic treatment of teeth adjacent or near the affected teeth are excluded.
- (e) Treatment or materials for which you or the patient has no legal obligation to pay.
- (f) Services provided and materials furnished while you or the patient were not eligible for coverage, unless the treatment was a year in duration and completed after you and the patient became eligible if no other limitations apply.
- (g) Periodontal splitting, equilibration, gnathological recordings and associated treatment and extra-oral grafts.
- (h) Preventive plaque control programs, including oral hygiene instruction programs.
- (i) Myofunctional therapy, unless saved from exclusion under (b), above.
- (j) Temporomandibular joint dysfunction, unless saved from exclusion under (b), above.
- (k) Prescription drugs including topically applied medication for treatment of periodontal disease, pre-medication, analgesics, separate charges for local anesthetics, general anesthesia except as a covered benefit in conjunction with a covered oral surgery procedure.
- (l) Experimental procedures that have not been accepted by the American Dental Association.
- (m) Services provided or material furnished after the termination of your or the patient's coverage eligibility, except that this exclusion shall not apply to services commenced while coverage eligibility was in effect.
- (n) Charges for hospitalization or any surgical treatment facility, including hospital visits.
- (o) Dental proactive administrative services including but not limited to preparation of claims, any on-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of

equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

- (p) Replacement of existing restorations for any purpose other than restoring active carious lesions or demonstrable breakdown of the restoration.
- (q) Any tax imposed (or incurred) by a government, state or other entity in connection with any fees charged for benefits provided under the Plan. Such taxes will be the responsibility of the patient or provider, and not of the Plan.

4.7: Limitations on Benefits

The following limitations apply to covered benefits:

- (a) **Optional Treatment Plans:** The Plan will pay benefits only for the least costly course of treatment, if there are optional plans of treatment, provided that such treatment will restore the oral condition in a professionally accepted manner. Procedures that are not customarily performed alone in a generally accepted dental practice cannot be unbundled.

- (b) **Major Restorative Benefits:** If a tooth can be restored with amalgam, synthetic porcelain or plastic, but the Dentist and patient decide on an another type of restoration, the Plan will pay benefits only for the least costly restorative procedure.

Replacement of crowns, jackets, inlays and onlays will be covered no more often than once in any five-year period and then only in the event that the existing crown, jacket, inlay or onlay is not satisfactory and cannot be made satisfactory. The five-year period is measured from the date on which any prior restoration was last supplied, whether paid for by the Plan or otherwise.

- (c) **Prosthetic Benefits:** Replacement of an existing denture will be made only if it is unsatisfactory and cannot be made satisfactory. Services, including denture repair and relining, which are necessary to make such appliances fit will be covered benefits. Prosthetic appliances and abutment crowns will be replaced only after five years has elapsed following any prior provision of such appliances and abutment crowns.
- (d) **Orthodontic Benefits:** Benefits are limited to devices and procedures for the correction of misposed teeth of patients up to age 19, through the completion of the procedure, or the termination of coverage, whichever occurs first. No benefits are provided for the repair or replacement of appliances.
- (e) **Oral Surgery Benefits:** If oral surgery procedures (including reduction of fractures, removal of tumors and removal of impacted teeth) are covered by the Medical Benefits of this Plan, the Dental Benefits will be limited to the amounts not paid under the Medical Benefits provisions, subject to the provisions of the Dental Benefits.
- (f) **Periodontal Surgery Benefits:** Benefits for surgery in the same quadrant is limited to once in any five-year period. The five-year period is measured from the date on which any prior surgery was last performed, whether paid for by the Plan or otherwise.

- (g) Sealants: Benefits are limited to applications to eight posterior teeth. Applications to deciduous teeth or teeth with caries are not covered. Benefits are payable for sealant replacement only after three years have elapsed following any prior provision of such materials.
- (h) Occlusal Restorations: Single-surface occlusal restorations of a tooth to which a sealant has been applied within twelve months, and two or three surface restorations within six months, which include occlusal surfaces on which sealants have been placed are not covered services. If a single-surface occlusal restoration is performed on a tooth from twelve to thirty-six months after a sealant has been applied to that tooth, Benefits will be payable only for the fee appropriate to the restoration in excess of the fee paid for application of the sealant.

4.8: Pre-Treatment Estimate of Cost

If you or your Dentist is unsure whether a specific course of treatment will be covered by the Plan, or if the costs are expected to exceed \$300, you should ask Delta Dental for a pre-treatment estimate of the costs for you and the Plan. A Dentist can obtain an estimate by submitting a claim form to Delta Dental before beginning the treatment. The estimate will show whether the treatment is covered, the share of the cost that the Plan would pay, and the share of the costs that would be your responsibility.

4.9: Claims For Dental Benefits & Appeals

If you receive dental services from an In-Network Dentist or a Premier Dentist, you will not be required to submit a claim form. The Dentist will automatically submit a claim for payment to Delta Dental. You will be required to pay to the Dentist only the Co-Payment, if any is required for the service you receive. Delta Dental will submit payment of the Plan's share directly to the Dentist.

If you receive dental services from an Out-Of-Network Dentist, you or the Dentist will have to submit a dental benefits claim form to Delta Dental to receive payment of the Plan's share of the charges. You can print a dental claim form off of Delta Dental's website (www.deltadentalins.com). The claim form should be sent to Delta Dental, P.O. Box 2105, Mechanicsburg, PA 17055-6999.

Payment of the Plan's share of the cost will be sent directly to the In-Network Dentist or Premier Dentist who submitted the claim. If you used an Out-of-Network Dentist, the Plan's share will be sent to you and you will be responsible for paying the Dentist.

If your claim for benefits is denied, in whole or in part, you have a right to appeal to the Fund's Board of Trustees. See Section 9, "How To Claim Benefits & Appeal Denials Of Benefits".

4.10: General Incorporation Of Delta Dental Contract

With regard to matters not expressly addressed in this Section, the terms and conditions of the Fund's contract with Delta Dental, as amended from time to time, are incorporated into this Plan Description by reference.

SECTION 5: VISION CARE COVERAGE

5.1: Overview

The Plan pays benefits for vision-related services and materials received by you and, if you have Family Coverage, your Dependent(s). In general, the Plan pays up to a certain amount for covered services and materials. In addition, if you or your Dependent obtain covered vision-related services and materials from a participating In-Network vision provider, you will receive money-saving discounts from the provider.

The PPO Network of vision providers is maintained by Cigna Health and Life Insurance Company for the Fund. Participating providers are considered In-Network.

5.2: Covered Vision Benefits

The vision benefits payable under the Plan are as follows:

- (a) **Eye Exam Benefit:** The Plan will pay the actual cost of a vision and eye health evaluation, including dilation, refraction, and prescription for eyeglasses or contact lenses, up to a maximum of \$60.00. This benefit can be used by an individual (you, and if you have Family Coverage, your Spouse and each Child) once in any 12-month period. This benefit is payable regardless of whether the vision care provider is In-Network or Out-of-Network.
- (b) **Eyeglasses & Contact Lenses Benefit:** The Plan will pay the actual cost of prescription eyeglass lenses, frames and /or contact lenses up to \$150. This benefit can be used by an individual (you, and if you have Family Coverage, your Spouse and each Child) once in any 12-month period. This benefit is payable regardless of whether the materials provider is In-Network or Out-of-Network.
- (c) **Patient's Share of Cost:** There is no Deductible for Covered Vision Benefits. However, the patient (you, your Spouse or your Child) is responsible for any costs of vision care services or materials in excess of the benefit payable.
- (d) **Declining Balance:** The Eye Exam Benefit and the Eyeglasses & Contact Lenses Benefit can be used by you, your Spouse or your Child multiple times in a calendar year. However, the maximum benefits stated in paragraphs (a) and (b) above limit the amount that the Plan will pay for the individual in any calendar year.

5.3: In-Network Discounts On Materials And Services

- (a) If an eye exam, eye glasses and/or contact lenses are obtained by you or your Dependent (if you have Family Coverage) from a participating In-Network provider, the following discounts are generally available: (1) 20% discount on glasses frames, lenses and lens options; and (2) up to a 15% discount on contact lens professional services

(including fitting and evaluation). Note this discount does not include the contact lenses themselves.

Note: Some vision care providers in the Network may not offer discounts or the same level of discounts. You should ask your provider if there are discounts available.

- (b) The Eye Exam Benefit and Glasses and Contact Lens Benefits can be applied to the discounted services. For example, if you obtain eyeglasses from an In-Network provider at a price that is discounted by 20%, you can still receive up to \$150 towards the discounted cost of the eyeglasses.
- (c) To use your benefits In-Network, visit an In-Network vision care provider and present your Fund Member Identification Card. The provider will verify your eligibility with the Fund and take care of submitting a claim for benefits to Cigna for you. You can find an In-Network provider on the Cigna website (www.myCigna.com). You may also go through the hyperlink to Cigna on the Fund's website (www.Inhwf.org).

5.4: Out-Of-Network Materials And Services

To use your benefits Out-Of-Network, obtain your eye examination, eyeglasses or contact lenses from a vision care provider who is not in the Cigna Network. You can submit a claim for your benefits by obtaining, completing and submitting a Cigna Vision claim form (including any required receipts or other documentation) to Cigna. You can obtain a Cigna Vision claim form by going to Cigna's website (www.myCigna.com) and selecting Forms, then Vision Forms. You may also go through the hyperlink to Cigna on the Fund's website (www.Inhwf.org).

The completed Cigna Vision claim form should be mailed to: Cigna Vision, Claims Department, P.O. Box 385018, Birmingham, Alabama 35238-5018. Cigna will mail you a check for your benefits, usually within 10 business days after the claim is received.

5.5: Exclusions: No Vision Benefits Payable

The following treatments, conditions and situations are excluded from coverage by the vision program, and no benefit is payable for them under the Plan:

- (a) Orthoptic or vision training, and any associated supplemental testing.
- (b) Medical and surgical treatment of the eyes. (Such treatment may be covered by the Plan's medical benefits coverage.)
- (c) Any eye examination, or corrective eyewear, required by an employer as a condition of employment.
- (d) Any injury or illness when paid or payable by Workers Compensation or similar law, or which is work related.
- (e) Charges in excess of reasonable and customary charges for examinations, other services, eyeglass frames and lenses, and contact lenses.

- (f) Charges incurred after eligibility for benefits under the Plan or Fund ends.
- (g) Experimental or non-conventional treatment or device.
- (h) Magnification or low vision aids.
- (i) Eyeglasses or contact lenses for video display terminal (VDT) / computer viewing.
- (j) Services or materials for which a claim is not submitted within twelve (12) months from the date of incurrence.

5.6: Appeal Of Benefit Denial

If your claim for benefits is denied, in whole or in part, you have a right to appeal to the Fund's Board of Trustees. See Section 9, "How To Claim Benefits & Appeal Denials Of Benefits", below.

5.7: General Incorporation Of Cigna Contract

With regard to matters not expressly addressed in this Section, the terms and conditions of the Fund's contract with Cigna concerning vision benefits, as amended from time to time, are incorporated into this Plan Description by reference.

SECTION 6: SHORT TERM DISABILITY BENEFITS

6.1: Benefits

In general, if you become Disabled while eligible under the Plan, you are entitled to a Weekly Income Benefit of one hundred twenty-five dollars (\$125), after completing a Benefit Waiting Period, for the duration of your Disability up to a maximum of twenty-six (26) weeks, subject to the provisions of this Section.

6.2: Definitions

For purposes of this Section:

- (a) "Disabled" and "Disability" means:
 - (1) you are unable to perform the essential duties of your regular occupation or a reasonable employment option offered to you by the Fund,
 - (2) because of a change in your functional capacity to work due to sickness or accidental injury,
 - (3) and, as a result, you are unable to earn more than 80% of your basic weekly earnings,
 - (4) and, you are receiving regular and appropriate care.
- (b) "Essential duties" are duties that are normally required for the performance of an occupation as it is normally performed in the national economy and which cannot be reasonably omitted or modified.
- (c) "Regular occupation" means the work that you were performing immediately prior to your sickness or accidental injury and for which contributions were made to the Fund.
- (d) "Sickness" means any physical illness, mental disorder, normal pregnancy or complication of pregnancy.
- (e) "Accidental injury" means bodily injury resulting from a sudden, violent, unexpected and external event, as well an infection resulting from a cut or wound caused by an accident. Accidental injury does not include any other type of infection, poisoning, or disease.
- (f) "Regular and appropriate care" means: (1) you personally visit a doctor as often as is medically required consistent with generally accepted medical standards to effectively manage and treat your sickness or injury, (2) you are receiving care that conforms to generally accepted medical standards for treating your sickness or injury, (3) the care is rendered by a doctor whose specialty or experience is the most appropriate for your sickness or injury according to generally accepted medical standards, and (4) you are receiving or actively seeking appropriate physical or psychological rehabilitative

services.

- (g) "Benefit Waiting Period" is the seven (7) day period that you must be continuously disabled before you can qualify to receive any benefits. You must complete the Benefit Waiting Period before any benefits are payable.
 - (1) Exception: you may return to work for up to five (5) days during the Benefit Waiting Period without having to begin a new Benefit Waiting Period. The days you work (and are, therefore, not disabled) do not count toward meeting the Benefit Waiting Period requirement, however.
 - (2) The Benefit Waiting Period begins on the first day that you see a doctor and the doctor states in writing that you are disabled because of sickness or accidental injury.

6.3: Exclusions: No Disability Benefits Payable

No benefit is payable if your Disability results from:

- (a) sickness or injury that occurs in any armed conflict, whether or not a declared war;
- (b) sickness or injury that occurs while you are in the military service for any country;
- (c) intentionally self-inflicted injury or illness, whether you are sane or insane;
- (d) injury that occurs while you are committing or attempting to commit a felony;
- (e) injury suffered during a fight in which you were the aggressor;
- (f) sickness or injury due to cosmetic or reconstructive surgery, except for surgery necessary to correct a deformity caused by sickness or accidental injury;
- (g) sickness or accidental injury for which you had or have a right to payment under workers compensation law or similar law; or
- (h) sickness or accidental injury arising out of or in the course of work for pay, profit or gain.
- (i) No benefits are payable for any period of Disability during which you are confined to a penal or correctional facility as a result of conviction for a criminal or other public offense.
- (j) No additional benefit is payable if the Disability is caused by multiple sicknesses and/or accidental injuries.

6.4: Benefit Claims

Benefits are not automatically payable. You must submit written notice of Disability to the Fund Administrator as soon as reasonably possible and normally within twenty (20) days after you

become Disabled.

Upon receipt of the notice, the Fund Administrator will send to you a claim form. You will have to complete the claim form and return it to the Fund Administrator as soon as possible but no later than ninety (90) days after you are disabled. No benefit is payable unless the claim form is completed and submitted to the Fund Administrator.

The Fund Administrator or the Fund's insurer may require additional information to prove your claim for benefits. In addition, you may be required to submit to examination by one or more doctors or vocational experts of the Fund's or insurer's choosing if the Fund or the insurer reasonably believes it necessary to properly evaluate your claim or potential for rehabilitation. Failure to cooperate with such an examination may result in the denial, loss, deferral or suspension of Benefits.

The procedural requirements and protections of 29 CFR Section 2560.503-1, as amended, will be followed by the Fund's Short Term Disability insurer to the extent applicable.

6.5: Appeal Of Benefit Denial

If your claim for benefits is denied, in whole or in part, you have a right to appeal to the Fund's Board of Trustees. See Section 9, "How To Claim Benefits & Appeal Denials Of Benefits", below.

6.6: General Incorporation Of Insurance Contract

With regard to matters not expressly addressed in this Section, the terms and conditions of the Fund's contract with its Short Term Disability insurer, as amended from time to time, are incorporated into this Plan Description by reference.

**SECTION 7:
LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS**

7.1: Life Insurance Benefit

If you (an Eligible Participant) die from any cause while eligible under the Plan, a life insurance benefit of Twenty Thousand Dollars (\$20,000.00) will be paid to your designated Beneficiary or Beneficiaries by an insurance company from which the Fund has purchased and maintains a group insurance policy for this purpose. The life insurance benefit is payable in the event of your death in addition to any Accidental Death & Disability death benefit that may be payable under the Plan.

If your Eligible Dependent dies from any cause while eligible under the Plan, a life insurance benefit of Two Thousand Dollars (\$2,000.00) will be paid to you unless you have died before the Eligible Dependent.

The benefits will be paid in a single lump sum unless other arrangements are made with the insurance company by the Beneficiary or Beneficiaries

7.2: Accidental Death & Dismemberment Benefit (AD&D)

(a) If you die or suffer another type of permanent loss listed in this Section as a direct result of an accident, and independent of all other causes, while you are eligible under this Plan, an AD&D benefit will be paid to you or, in the event of your death, to your Beneficiary or Beneficiaries, by an insurance company from which the Fund has purchased and maintains a group insurance policy for this purpose. The losses for which AD&D benefits are payable and the amount of the benefits payable are as follows:

<u>Permanent Loss Of:</u>	<u>Benefit</u>
(1) life	\$20,000
(2) two hands	\$20,000
(3) two feet	\$20,000
(4) sight of two eyes	\$20,000
(5) one hand and one foot	\$20,000
(6) one hand and sight of one eye	\$20,000
(7) one foot and sight of one eye	\$20,000
(8) one foot or one hand	\$10,000
(9) sight of one eye	\$10,000

(b) No AD&D benefit is payable unless the loss occurred within ninety (90) calendar days after the date of the accident. If you suffer more than one loss in a single accident, an AD&D benefit will be payable only for the loss for which the largest benefit is payable.

7.3: Exclusions

No AD&D benefit is payable if your death or other loss is caused, directly or indirectly, in whole or in part, by any of the following:

- (a) bodily or mental illness or disease of any kind;
- (b) ptomaines or bacterial infections, except infections caused by a pyogenic organism that occurs with and through an accidental cut or wound;
- (c) hernia;
- (d) suicide or self-inflicted injury while sane or insane;
- (e) participation in the commission of a felony;
- (f) war or act of war, or service in the Armed Forces of any country when that country is engaged in war; or
- (g) police duty as a member of any military, naval or air organization.

7.4: Beneficiary Rules

To be eligible under the Plan, you must fill out and submit to the Fund Administrator an Enrollment Form. On the Enrollment Form you can designate your Beneficiary or Beneficiaries—the person or persons to whom any life insurance or AD&D death benefits for which you are eligible will be paid if you die while eligible. If you wish to change your Beneficiary or Beneficiaries at any time, you must submit a new Enrollment Card designating the new Beneficiary or Beneficiaries to the Fund Administrator. The change will not be effective until the new Enrollment Form is received by the Fund Administrator.

If your Beneficiary dies before you, the Beneficiary's interest automatically terminates. If you name more than one Beneficiary, the total amount of benefits due will be divided equally among the surviving Beneficiaries. If no named Beneficiary is surviving at the time of your death, or if you did not name a Beneficiary, the life insurance benefit or AD&D death benefit will be paid to the first surviving class in the following order of preference: your Spouse; your Children in equal shares; your parents in equal shares; your siblings in equal shares; or the executors or administrators of your estate. If your Eligible Dependent dies before you, any benefit payable upon the death of the Eligible Dependent will be paid to the Eligible Dependent's estate or as otherwise determined to be appropriate by the Fund Administrator.

7.5: Claims For Benefits & Appeals Of Denied Claims

Life insurance and AD&D benefits must be claimed by you or your Beneficiary or Beneficiaries by contacting the Fund Administrator for a claim form and instructions on submitting the claim and supporting documentation (including proof of death or other loss) that is satisfactory to the Fund and to the insurer. All life insurance and AD&D benefit claims must be submitted to the Fund Administrator.

The procedural requirements and protections of 29 CFR Section 2560.503-1, as amended, will be followed by the Fund's Disability insurer to the extent applicable.

If your claim for benefits is denied, in whole or in part, you have a right to appeal to the Fund's

Board of Trustees. See Section 9, "How To Claim Benefits & Appeal Denials Of Benefits", below.

7.6: Extension Of Life Insurance If You Become Totally Disabled

If you become Totally Disabled while eligible under the Plan before age sixty (60), you will nonetheless remain eligible for the life insurance benefit provided by this Plan for as long as the Total Disability continues, subject to the terms and conditions described in Section 7 of the Plan Description.

7.7: Conversion Of Life Insurance Benefit To Individual Policy

If you cease to be eligible for the life insurance benefit under the Plan, you have a right to convert to an individual life insurance policy, other than a term policy, offered by the insurance company without a medical examination or other proof of good health. If your Eligible Dependent ceases to be eligible for the life insurance benefit under the Plan, he or she has a right to convert to an individual life insurance policy, other than a term policy, offered by the insurance company without a medical examination or other proof of good health.

7.8: General Incorporation Of Insurance Contract

With regard to matters not expressly addressed in this Section, the terms and conditions of the Fund's contract with its Life Insurance and AD&D insurer, as amended from time to time, are incorporated into this Plan Description by reference.

SECTION 8: MEMBERSHIP ASSISTANCE PLAN (MAP) BENEFITS

8.1: Overview

Most American families are affected, at some point in their lives, by personal problems such as marital stress, alcoholism, drug addiction, grief and loss, financial trouble, legal problems, and child and elder care needs. Many people do not know where to turn for help. Unfortunately, their problems often go unaddressed and get worse.

The Member Assistance Program (MAP) of the Plan is intended to give you and your family a place to turn for help and guidance in these situations, especially in times of crisis. Through MAP, problems can be identified and arrangements made for you to obtain the type of assistance needed to deal with your problems. This assistance may include referrals to professionals who specialize in handling your type of problem.

You, as well as your Eligible Dependents (if you have Family Coverage), are eligible for MAP benefits if you have eligibility under the Plan.

8.2: Accessing MAP Benefits

You can access MAP benefits at any time by calling Cigna Behavior Health's telephone number: 1-888-325-3978, and speaking with a MAP counselor. You can also obtain information through the special website maintained by Cigna Behavior Health: www.cignabehavioral.com.

8.3: Benefits: Confidential Counseling

You can contact a MAP counselor for help over the telephone as often as you need. Your conversation will be confidential. You will not be charged for the call or the counseling.

If an in-person meeting with a MAP counselor is necessary or appropriate for dealing with your problem, you can have up to 3 meetings per issue with a counselor in the Cigna Behavioral Health network of providers. A list of the network counselors can be obtained from Cigna Behavioral Health's website: www.cignabehavioral.com.

8.4: Benefits: Access To Work / Life Resources

Through the Cigna Behavioral Health website (www.cignabehavioral.com) you can obtain information and resources regarding emotional well-being, handling life events, family and caregiving, educational programs, disability programs, adoption programs, health and wellness, career assistance, daily living needs, pet care, and professional services. Discounts and referrals for various health services and products are also available through the Cigna Healthy Rewards program described on the website.

8.5: Benefits: Legal Services

MAP offers legal consultation of up to 30 minutes without charge and a 25% discount on legal fees normally charged by lawyers to which MAP refers you. You will be responsible for any

additional fees and costs.

8.6: Cost

The benefits described in this Section are provided without cost to you. However, if you receive professional services for mental or behavioral health, substance abuse or other health issues, you will be responsible for the cost of those services except to the extent that they are covered by other benefits offered by the Plan (e.g. Medical Benefits).

8.7: Appeals

If your claim for benefits is denied, in whole or in part, you have a right to appeal to the Fund's Board of Trustees. See Section 9, "How To Claim Benefits & Appeal Denials Of Benefits", below.

8.8: General Incorporation Of Contract

With regard to matters not expressly addressed in this Section, the terms and conditions of the Fund's contract regarding MAP benefits with Cigna, as amended from time to time, are incorporated into this Plan Description by reference.

**SECTION 9:
HOW TO CLAIM BENEFITS & APPEAL DENIALS OF BENEFITS**

9.1: Overview

Benefits under the Plan are payable to or for you and your Dependents only if the Fund receives a timely claim from you or for you. This Section contains a description of your rights and obligations regarding benefit claims, claims determinations, appeals of denials of claims, and making other complaints.

9.2: Claims For Medical Benefits

- (a) **In-Network:** If you or your eligible Dependent receives medical services from an In-Network hospital, doctor or other provider, the provider will submit an electronic claim for benefits to Cigna on your behalf. The In-Network provider may also request pre-authorizations from Cigna and submit urgent claims, pre-service claims and concurrent care claims to Cigna. You pay the provider your Co-Payment, if one is owed for the services.
- (b) **Out-of-Network:** If you or your eligible Dependent receives medical services from a hospital, doctor or other provider that is not In-Network, you will have to submit an approved claim form to Cigna. Your provider can submit the claim form to Cigna for you, if the provider is willing and able to do so. The form may also be submitted to Cigna by your Authorized Representative on your behalf. An approved medical claim form can be obtained on the Cigna website listed on your Member Identification Card, by calling the toll-free telephone number on your Member Identification Card, or through the Fund's website (www.lnhwf.org). It is important that you or your provider include your Member Identification Number and Group Number on the claim form.
- (c) **Time Limit For Claims:** A claim is timely if submitted to Cigna within 180 days after the medical treatment, services, supplies or equipment to which the claim relates were received by the patient. A claim received after that 180-day period may be denied as untimely and no benefits paid.
- (d) **Processing Claim:** Upon receipt of a benefit claim, Cigna will check with the Fund Administrator to confirm the patient's eligibility for benefits. Cigna will then process the claim to determine what amount, if any, is payable by the Fund under the terms and conditions of the Plan. Cigna will pay directly to the provider the amount of benefits due under the Plan if you have assigned your benefits to the provider. If you have not assigned your benefits under the Plan to the provider, Cigna will pay directly to you the benefits payable under the Plan and you will be responsible for paying the provider. A Cigna or other Fund representative may contact you or your provider for additional information needed to properly process your claim.
- (e) **Provider Billing:** The provider may bill you directly for payment of the cost of the services to the extent not payable under the Plan.
- (f) **Notice of Decision:** A written or electronic Explanation of Benefits ("EOB") will be sent

by Cigna to the provider and to you regarding the claim. The EOB will show the amount of the provider's charges, the amount payable by the Fund, the amount payable by you, and other important information. If the claim is denied in whole or in part, the EOB will also include the reason for the denial, explain that you have a right to appeal the denial, and include other important information required by law.

If you have a question regarding an EOB, you can contact a Cigna Customer Service Representative by calling the toll-free telephone number on your Member Identification Card or the EOB. Cigna will review or investigate your question as soon as possible, but in any case within 30 days. If you are not satisfied with Cigna's response, you can start the appeals procedure, described below.

- (g) **First Level Of Appeal: Internal Appeal To Cigna:** To appeal the denial, in whole or in part, you must submit a request for an appeal in writing to Cigna within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone at the toll-free number on your Member Identification Card, EOB or claim form.

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

Cigna will generally respond in writing with a decision within 30 calendar days after it receives an appeal for a required preservice or concurrent care coverage determination or a postservice Medical Necessity determination.

Cigna will generally respond within 60 calendar days after it receives an appeal for any other post service coverage determination.

If more time or information is needed to make the determination, Cigna will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the appeal, this information will be provided automatically to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

- (h) **Expedited Appeals:** You may request that the appeal process be expedited if, (1) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your health care provider would cause you severe pain which cannot be managed without the requested services; or (2) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.

If you request that your appeal be expedited, you may also ask for an expedited External Review at the same time, if the time to complete an expedited review would be detrimental to your medical condition.

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include the information described in Section 9 of the Plan Description.

- (i) **Second Level Of Appeal: Internal Appeal To Fund's Board Of Trustees:** If your First Level appeal to Cigna is denied, in whole or in part, you can appeal to the Fund's Board of Trustees for review of Cigna's actions in denying your claim. You can appeal to the Board of Trustees by sending a letter by mail, fax or email to:

Fund Administrator
Laborers' National Health & Welfare Fund
905 16th Street, N.W.
Washington, D.C. 20006
Fax Number: 202-318-0654
E-Mail Address: info@lnhwf.org

Your appeal must be received by the Fund Administrator within 120 days following the date of Cigna's notice to you that your First Level appeal has been denied in whole or in part. Your appeal should state clearly the reason(s) for your appeal, and be accompanied by any documents or other proof that you have to support your appeal.

Your appeal will be reviewed and decided by the Board of Trustees or by the Board's Appeals Committee, ordinarily at the first meeting after the appeal is received. If additional information is needed, the Fund Administrator will contact you.

In the event any new or additional information (evidence) is considered, relied upon or generated by the Board or Committee in connection with the appeal, this information will be provided automatically to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by the Board or Committee, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

Once the Board of Trustees makes a decision on the appeal, a written notice and explanation of that decision will be sent to you. If the decision is to deny the appeal in whole or in part, the notice and explanation will include all information required by applicable law and regulations and in particular 29 CFR Section 2560.503-1, as amended, to the extent applicable.

The Board or Committee may decide to refer your appeal to Independent External Appeal without deciding the appeal itself.

- (j) **Third Level Of Appeal: Independent External Review:** Certain types of medical claims may be appealed to an Independent Review Organizations (IRO) composed of persons who are not employed by the Fund, by Cigna, or by any Cigna affiliate to conduct

External Reviews of qualifying claims to the extent required by the Affordable Care Act.

An External Review of medical claims will be conducted under any of the following circumstances:

- (1) You request an expedited appeal of a claims denial by Cigna for permitted reasons and request an External Review as part of that expedited appeal. In this circumstance, Cigna will conduct an expedited First Level review and, if that review upholds the denial, Cigna will refer the claim to External Review if a decision on the claim requires medical judgment. Alternatively, Cigna may decide to refer the claim immediately to External Review without making a First Level appeal decision.
- (2) If you file a Second Level appeal with the Fund's Board of Trustees and the Board denies your appeal, you can request that the Board refer your claim to External Review if a decision on the claim involves medical judgment. The Board's notice of decision to you will explain the procedure for requesting an External Review. Your request for an External Review must be received by the Fund Administrator within 90 days following the date of the notice to you of the Board's decision on your Second Level appeal.

You are not required to pay any fee or other charge to initiate an External Review.

The IRO will conduct the External Review and render a decision within 45 days after receiving the claim file. Cigna and the Fund will abide by the IRO's decision. You will be promptly notified in writing by Cigna or the Fund Administrator of the IRO's decision.

When requested, and if a delay would be detrimental to your medical condition, as determined by Cigna, or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility, the External Review shall be completed within 72 hours.

9.3: Claims For Prescription Drug Benefits

- (a) **In-Network:** If you or your Eligible Dependent use the Mail Service Pharmacy or a Participating Retail Pharmacy to fill prescriptions, you will not have to submit any claim forms to receive benefits. You need only to pay the applicable Co-Payment to the Pharmacy.
- (b) **Out-Of-Network:** If your prescription is filled at a Pharmacy that is not the Mail Service Pharmacy or a Participating Retail Pharmacy, you will have to pay the full cost of the prescription to the Pharmacy and submit a claim form to Express Scripts, the Fund's Pharmacy Benefit Manager, for reimbursement of the share of the cost payable by the Plan. You can obtain a claim form through the Express Scripts website (www.express-scripts.com).
- (c) **Problem Solving:** If you encounter any difficulty in having a prescription fill or re-filled by

a Retail Pharmacy or the Mail Service Pharmacy, you (or your Pharmacist) should first contact ESI by calling the telephone number on your Identification Card to discuss the problem.

- (d) To Appeal A Denial Of Prescription Drug Benefits: If your claim for prescription drug benefits from the Plan is denied, in whole or in part, you can appeal to the Fund's Board of Trustees for review of the denial. You can appeal to the Board of Trustees by sending a letter by mail, fax or email to:

Fund Administrator
Laborers' National Health & Welfare Fund
905 16th Street, N.W.
Washington, D.C. 20006
Fax Number: 202-318-0654
E-Mail Address: info@lnhwhf.org

Your appeal will be reviewed and decided by the Board of Trustees or by the Board's Appeals Committee, ordinarily at the first meeting after the appeal is received. Once the Board of Trustees makes a decision on the appeal, a written notice and explanation of that decision will be sent to you. If the decision is to deny the appeal in whole or in part, the notice and explanation will include all information required by applicable law and regulations and in particular 29 CFR Section 2560.503-1, as amended, to the extent applicable.

9.4: Claims For Dental Benefits

- (a) In-Network: If you receive dental services from an In-Network Dentist, you will not be required to submit a claim form. The Dentist will automatically submit a claim for payment to Delta Dental. You will be required to pay to the Dentist only the Co-Payment, if any is required for the service you receive.
- (b) Out-Of-Network: If you receive dental services from an Out-Of-Network Dentist, you or the Dentist will have to submit a dental benefits claim form to Delta Dental to receive payment of the Plan's share of the charges. You can print a dental claim form off of Delta Dental's website (www.deltadentalins.com).
- (c) Problem Solving: If you encounter any difficulty in receiving covered dental benefits, you should first contact Delta Dental by calling the telephone number on your Member Identification Card to discuss the problem.
- (d) To Appeal A Denial Of Dental Benefits: If your contact with Delta Dental is unsatisfactory and your claim for dental benefits from the Plan is denied, in whole or in part, you can appeal to the Fund's Board of Trustees for review of the denial. You can appeal to the Board of Trustees by sending a letter by mail, fax or email to:

Fund Administrator
Laborers' National Health & Welfare Fund
905 16th Street, N.W.
Washington, D.C. 20006
Fax Number: 202-318-0654

E-Mail Address: info@lnhwhf.org

Your appeal will be reviewed and decided by the Board of Trustees or by the Board's Appeals Committee, ordinarily at the first meeting after the appeal is received. Once the Board of Trustees makes a decision on the appeal, a written notice and explanation of that decision will be sent to you. If the decision is to deny the appeal in whole or in part, the notice and explanation will include all information required by applicable law and regulations and in particular 29 CFR Section 2560.503-1, as amended, to the extent applicable.

9.5: Claims For Vision Benefits

- (a) In-Network: To use your benefits In-Network, visit an In-Network vision care provider and present your Fund Member Identification Card. The provider will verify your eligibility with the Fund and take care of submitting a claim for benefits to Cigna for you. You can find an In-Network provider on the Cigna website, which can be accessed directly or through the Fund's website.
- (b) Out-Of-Network: To use your benefits Out-Of-Network, obtain your eye examination, eyeglasses or contact lenses from a vision care provider who is not in the Cigna Network. You can submit a claim for your benefits by obtaining, completing and submitting a Cigna Vision claim form (including any required receipts or other documentation) to Cigna. You can obtain a Cigna Vision claim form by going to Cigna's website (www.myCigna.com) and selecting Forms, then Vision Forms.

The completed Cigna Vision claim form should be mailed to: Cigna Vision, Claims Department, P.O. Box 385018, Birmingham, Alabama 35238-5018. Cigna will mail you a check for your benefits, usually within 10 business days after the claim is received.

- (c) Problem Solving: If you encounter any difficulty in obtaining covered vision benefits, you can contact a Cigna Customer Service Representative by calling the toll-free telephone number on your Member Identification Card or the EOB. Cigna will review or investigate your question as soon as possible, but in any case within 30 days. If you are not satisfied with Cigna's response, you can start the appeals procedure, described below.
- (d) To Appeal A Denial Of Vision Benefits: If your contact with Cigna is unsatisfactory and your claim for vision benefits from the Plan is denied, in whole or in part, you can appeal to the Fund's Board of Trustees for review of the denial. You can appeal to the Board of Trustees by sending a letter by mail, fax or email to:

Fund Administrator
Laborers' National Health & Welfare Fund
905 16th Street, N.W.
Washington, D.C. 20006
Fax Number: 202-318-0654
E-Mail Address: info@lnhwhf.org

Your appeal will be reviewed and decided by the Board of Trustees or by the Board's Appeals Committee, ordinarily at the first meeting after the appeal is received. Once the Board of Trustees makes a decision on the appeal, a written notice and explanation of

that decision will be sent to you. If the decision is to deny the appeal in whole or in part, the notice and explanation will include all information required by applicable law and regulations and in particular 29 CFR Section 2560.503-1, as amended, to the extent applicable.

9.6: Claims For Short Term Disability Benefits

- (a) Claim: To make a claim for Short Term Disability (STD) benefits, you must submit written notice of Disability to the Fund Administrator as soon as reasonably possible and normally within twenty (20) days after you become Disabled. Upon receipt of the notice, the Fund Administrator will send to you a claim form. You will have to complete the claim form and return it to the Fund Administrator as soon as possible but no later than ninety (90) days after you are disabled. No benefit is payable unless the claim form is completed and submitted to the Fund Administrator.

The Fund Administrator or the Fund's insurer may require additional information to prove your claim for benefits. In addition, you may be required to submit to examination by one or more doctors or vocational experts of the Fund's or insurer's choosing if the Fund or the insurer reasonably believes it necessary to properly evaluate your claim or potential for rehabilitation. Failure to cooperate with such an examination may result in the denial, loss, deferral or suspension of Benefits.

Once a decision is made by the Fund's STD insurer on your claim, you will be sent a notice of the decision. The notice will contain all information required by applicable law and regulations and in particular 29 CFR Section 2560.503-1, as amended, to the extent applicable..

- (b) To Appeal A Denial Of STD Benefits: If your claim for benefits is denied in whole or in part by the Fund Administrator or the Fund's STD insurer, you may appeal to the Fund's Board of Trustees by sending a letter to:

Fund Administrator
Laborers' National Health & Welfare Fund
905 16th Street, N.W.
Washington, D.C. 20006
Fax Number: 202-318-0654
E-Mail Address: info@lnhwf.org

Your appeal must state clearly the reason(s) for your appeal. You must submit with the appeal any documents or other proof that you have to support your appeal.

Your appeal will be reviewed and decided by the Board of Trustees or by the Board's Appeals Committee, ordinarily at the first meeting after the appeal is received. In the event any new or additional information (evidence) is considered, relied upon or generated by the Board or Committee in connection with the appeal, this information will be provided automatically to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by the Board or Committee, the Board or Committee will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

Once the Board of Trustees makes a decision on the appeal, a written notice and explanation of that decision will be sent to you. If the decision is to deny the appeal in whole or in part, the notice and explanation will include all information required by applicable law and regulations and in particular 29 CFR Section 2560.503-1, as amended, to the extent applicable.

9.7: Claims For Life Insurance Or Accidental Death & Dismemberment Benefits

- (a) Claims: To claim Life Insurance or AD&D benefits, you or your Beneficiary must contact the Fund Administrator for a claim form and instructions on submitting the claim and supporting documentation (including proof of death or other loss) that is satisfactory to the Fund and to the insurance company. All Life Insurance or AD&D benefit claims must be submitted to the Fund Administrator within sixty (60) days after death or other covered loss.
- (b) To Appeal A Denial Of Life Insurance Or AD&D Benefits: If your claim for Life Insurance or AD&D benefits is denied in whole or in part by the Fund Administrator or the Fund's insurer, you may appeal to the Fund's Board of Trustees by sending a letter to:

Fund Administrator
Laborers' National Health & Welfare Fund
905 16th Street, N.W.
Washington, D.C. 20006
Fax Number: 202-318-0654
E-Mail Address: info@lnhwhf.org

Your appeal must state clearly the reason(s) for your appeal. You must submit with the appeal any documents or other proof that you have to support your appeal.

Your appeal will be reviewed and decided by the Board of Trustees or by the Board's Appeals Committee, ordinarily at the first meeting after the appeal is received. Once the Board of Trustees makes a decision on the appeal, a written notice and explanation of that decision will be sent to you. If the decision is to deny the appeal in whole or in part, the notice and explanation will include all information required by applicable law and regulations and in particular 29 CFR Section 2560.503-1, as amended, to the extent applicable.

9.8: Claims For Member Assistance Benefits

- (a) Claims: To access MAP benefits at any time, call Cigna Behavior Health's telephone number: 1-888-325-3978, and speak with a MAP counselor. Some benefits are available through the special Cigna Behavior Health website (www.cignabehavioral.com).
- (b) To Appeal A Denial Of MAP Benefits: If your claim for benefits is denied in whole or in part by Cigna Behavioral Health, you may appeal to the Fund's Board of Trustees by sending a letter to:

Fund Administrator
Laborers' National Health & Welfare Fund

905 16th Street, N.W.
Washington, D.C. 20006
Fax Number: 202-318-0654
E-Mail Address: info@lnhwhf.org

Your appeal will be reviewed and decided by the Board of Trustees or by the Board's Appeals Committee, ordinarily at the first meeting after the appeal is received. Once the Board of Trustees makes a decision on the appeal, a written notice and explanation of that decision will be sent to you. If the decision is to deny the appeal in whole or in part, the notice and explanation will include all information required by applicable law and regulations and in particular 29 CFR Section 2560.503-1, as amended, to the extent applicable.

9.9: COBRA Coverage & All Other Matters / Complaints

- (a) If your claim for COBRA continuation coverage is denied in whole or in part by the Fund Administrator, you may appeal to the Fund's Board of Trustees by sending a letter to:

Fund Administrator
Laborers' National Health & Welfare Fund
905 16th Street, N.W.
Washington, D.C. 20006
Fax Number: 202-318-0654
E-Mail Address: info@lnhwhf.org

Your appeal must state clearly the reason(s) for your appeal. You must submit with the appeal any documents or other proof that you have to support your appeal.

If you have any complaint regarding the Plan or Fund, including a denial of benefits, not covered by any other provision above, you may appeal to the Fund's Board of Trustees by sending a letter to the Fund Administrator at the address given above. Your letter should state clearly the reason(s) for your complaint and you should enclose any documents that relate to your complaint.

Your appeal or complaint will be reviewed and decided by the Board of Trustees or by the Board's Appeals Committee, ordinarily at the first meeting after it is received. Once the Board of Trustees makes a decision on the appeal or complaint, a written notice and explanation of that decision will be sent to you. If the decision is to deny the appeal in whole or in part, the notice and explanation will include all information required by applicable law and regulations and in particular 29 CFR Section 2560.503-1, as amended, to the extent applicable.

9.10: Lawsuits & Limitations

- (a) The Board of Trustees' intention is to comply in all respects with ERISA's claims and appeals procedure requirements and with the ACA's requirements relating to external review. The claims and appeals procedure will be interpreted and applied accordingly. ERISA Section 502(a) provides a cause of action to enforce the terms of the Plan and your benefit rights under the Plan.

- (b) However, before filing a lawsuit regarding the denial of a benefit claim, you must have exhausted the Appeals Procedure for the type of claim you are making. This exhaustion requirement is intended to ensure that your claim is fully and fairly reviewed under the Plan's internal and external (where applicable) procedures before a lawsuit is commenced. No lawsuit will be timely unless it is brought within three years (1,095 days) after the date on which notice of the denial of the final appeal (internal or external) is sent to the claimant.
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**SECTION 10:
LOSS OF COVERAGE UNDER THE PLAN--
"COBRA" TEMPORARY CONTINUATION OF COVERAGE
ON A SELF-PAY BASIS**

10.1: Overview

A federal law commonly called "COBRA" (for the "Consolidated Omnibus Budget Reconciliation Act") generally requires the Fund, as a group health plan, to offer you and / or your Eligible Dependent(s) an opportunity to purchase a continuation of coverage under the plan for a temporary period of time if you and / or your Eligible Dependent(s) would otherwise lose eligibility under the Plan because of certain "Qualifying Events".

You and, if you have Family Coverage, your Eligible Dependents can choose to pay for a temporary continuation of eligibility under the Plan for medical, prescription drug, dental and vision benefits ("COBRA continuation coverage") if you and / or your Eligible Dependent(s) would otherwise lose eligibility because of a Qualifying Event. COBRA continuation coverage is not automatic. You must take action to choose the coverage, and have to pay the monthly cost of the coverage to the Fund.

The COBRA Administrator under this Plan is the same as the Fund Administrator whose address and telephone number follows:

Adam M. Downs, Fund Administrator
Laborers' National Health & Welfare Fund
905 16th Street, N.W.
Washington, D.C. 20006
Telephone: 202-737-1898 or 1-800-540-0113

To maximize your COBRA rights, it is very important that you keep the Fund Administrator informed of your, your Eligible Spouse's and your other Eligible Dependents' current mailing addresses. Important notices may have to be sent by the Fund Administrator to these addresses.

10.2: Eligibility for COBRA Continuation Coverage

- (a) You will have a right to choose COBRA continuation coverage under the Plan if you lose eligibility under the Plan because of any of the following Qualifying Events:
- > your Covered Employment ends for any reason other than your gross misconduct (including your Employer ceases to have an obligation to contribute to the Fund for you);
 - > insufficient hours of contributions are made on your behalf (e.g. your hours of Covered Employment are reduced);

- > the end of a period of Family and Medical Leave.
- (b) If you have Family Coverage, your Spouse will have a right to choose COBRA continuation coverage under the Plan if he / she loses eligibility under the Plan because of any of the following Qualifying Events:
- > you die;
 - > your Covered Employment ends for any reason other than your gross misconduct (including your Employer ceases to have an obligation to contribute to the Fund for you);
 - > insufficient hours of contributions are made on your behalf (e.g. your hours of Covered Employment are reduced);
 - > you become entitled to Medicare benefits (under Medicare Part A, Part B, or both); or
 - > you become divorced or legally separated from your Spouse.
- (c) If you have Family Coverage, your Eligible Child will have a right to choose COBRA continuation coverage under the Plan if he / she loses eligibility under the Plan because of any of the following Qualifying Events:
- > you die;
 - > your Covered Employment ends for any reason other than your gross misconduct (including your Employer ceases to have an obligation to contribute to the Fund for you);
 - > insufficient hours of contributions are made on your behalf (e.g. your hours of Covered Employment are reduced);
 - > you become entitled to Medicare benefits (under Medicare Part A, Part B, or both);
 - > you become divorced or legally separated from your Eligible Spouse; or
 - > the Dependent ceases to qualify as your Eligible Dependent Child under the Plan (for example: he / she loses eligibility due to age).

10.3: Required Notice To The Fund of a Qualifying Event

- (a) The Fund will offer COBRA continuation coverage to you and / or your Eligible Dependents only if the Fund Administrator is notified in writing that a Qualifying Event has occurred and that notice is received within the time limit. If the Fund Administrator does not receive timely notice, you and / or your Eligible Dependent(s) might lose any right to choose COBRA continuation coverage.

- (b) You Must Give Notice of Certain Qualifying Events: If you or your Dependent(s) experience one of the following qualifying events, you must notify the Fund Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:
- (1) your divorce or legal separation; or
 - (2) your child ceases to qualify as a Dependent under the Plan.
 - (3) the occurrence of a secondary qualifying event (which must be received prior to the end of the initial 18- or 29-month COBRA period).

Notice must be made in writing and must include: the name of the Plan, name and address of the Member covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

- (c) Newly Acquired Dependents: If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.
- (d) Under the law, your Employer is required to notify the Fund of the following Qualifying Events within 30 days after the event occurs:
- (1) termination or reduction in hours of employment of the covered employee;
 - (2) death of the covered employee;
 - (3) covered employee becoming entitled to Medicare; or
 - (4) the Employer's bankruptcy.

The Fund Administrator will normally send you a COBRA notice if your contribution hours fall below the levels required for eligibility for Single or Family Coverage without waiting for your Employer's notice..

Even though your Employer is required to notify the Fund Administrator of these Qualifying Events, you or your Eligible Dependent(s) should confirm with the Employer or the Fund Administrator that timely notice has been given. You

or your Dependent(s) may notify the Fund Administrator of any Qualifying Event.

10.4: Choosing COBRA Continuation Coverage

Once the Fund Administrator receives written notice that a Qualifying Event has occurred, the Fund Administrator will determine whether you and / or your Eligible Dependant(s) are eligible for COBRA continuation coverage. If the Fund Administrator determines that you and / or your Eligible Dependant(s) are eligible for COBRA continuation coverage, the Fund Administrator will send to you and / or your Eligible Dependents(s) written information on how to choose COBRA continuation coverage. That information will contain a notice of rights, an election form and an explanation of the cost that you would have to pay to the Fund for the coverage.

If the Fund Administrator determines that you and / or your Eligible Dependant(s) are not eligible for COBRA continuation coverage, the Fund Administrator will send to you and / or your Eligible Dependant(s) a written explanation. If you disagree with the decision, you can appeal to the Fund's Board of Trustees as described in Section 9 of the Plan Description.

If you and /or your Eligible Dependents wish to choose COBRA continuation coverage, the election form must be completed and returned to the Fund Administrator within 60 days after you receive the notice of rights and election form from the Fund Administrator (or, if coverage will not be lost until later, 60 days after the actual loss of coverage).

If the completed election form is not returned to the Fund Administrator within the 60-day election period, you and / or your Eligible Dependent(s) will lose any and all right to COBRA continuation coverage.

You and each of your Eligible Dependents has an individual right to elect COBRA continuation coverage. You or your Eligible Spouse may elect COBRA continuation for you and all Eligible Dependents.

10.5: Types Of Coverage

The COBRA continuation coverage will keep you and / or your Eligible Dependent(s) eligible for the same benefit coverage as similarly situated active Participants and their Eligible Dependents for whom a Qualifying Event has not occurred. Usually this is the same coverage that you had immediately before your COBRA continuation coverage begins.

However, you can choose COBRA continuation coverage only for "core" benefits (medical and prescription drug) and pay a lower cost than if you continue the full range of benefits offered under the Plan including "non-core" benefits.

10.6: Cost Of COBRA Coverage / Paying For Coverage

- (a) You and / or your Eligible Dependent(s) must pay for COBRA continuation coverage on a monthly basis. The monthly amount that you and / or your Eligible Dependent(s) have to pay for this coverage is called the "COBRA Premium".

- (b) The Fund Administrator will notify you as to the amount of the monthly COBRA Premium (for both "core only" and "core plus non-core" coverage). In general, the COBRA Premium will be 102% of the cost of the coverage as determined by the Board of Trustees. The Board of Trustees sets COBRA Premium rates yearly, and they may increase while you have COBRA continuation coverage. COBRA Premium payments are usually due on the first day of each month. The materials sent to you by the Fund Administrator will include information on when and how to make a payment. Failure to pay the COBRA Premiums when due will result in a termination of the coverage unless payment is made during a "grace period".
- (c) First payment for COBRA continuation: If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.
- (d) Subsequent payments: After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.
- (e) Grace periods for subsequent payments: Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

10.7: Maximum Period Of COBRA Continuation Coverage

- (a) COBRA continuation coverage is temporary. There is a maximum number of months for which COBRA continuation coverage may be kept by you and / or your Eligible Dependents. This Maximum Period varies somewhat according to the type of Qualifying Event that caused your and / or your Dependent's eligibility. The Maximum Period begins with the date of the Qualifying Event even if eligibility is not lost until a later date.

Your and / or your Dependent's COBRA continuation coverage may terminate before the applicable Maximum Period expires under certain circumstances, including non-payment of the COBRA Premium.

(b) Generally, the Maximum Periods are as follows:

- > If the Qualifying Event is the termination of your Covered Employment or insufficient hours of contributions, the Maximum Period is 18 months.
- > If the Qualifying Event is your death, the Maximum Period is 36 months.
- > If the Qualifying Event is your divorce or separation from your spouse, the Maximum Period is 36 months.
- > If the Qualifying Event is your eligibility for Medicare, the Maximum Period is 36 months.
- > If the Qualifying Event is your Dependent loses status as a Dependent Child, the Maximum Period is 36 months.

(c) Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

(d) Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under Title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

- (1) SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
- (2) A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for Termination of COBRA Continuation will also apply to the period of disability extension.

(e) Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

10.8: Termination Of COBRA Coverage

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- (a) the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
 - (b) failure to pay the required premium within 30 calendar days after the due date;
 - (c) termination of the Plan or Fund;
 - (d) after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
 - (e) after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the Qualified Beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described above;
 - (f) any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).
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**SECTION 11:
DUPLICATE COVERAGE OF COVERED EXPENSES AND BENEFITS
(Coordination Of Coverage & Subrogation)**

11.1: Coverage Under Multiple Health Plans: Coordination Of Benefits Rules

(a) Generally, when you and/or your Eligible Dependents are covered by two or more Health Plans and received medical, prescription drug, dental or vision services and/or supplies that are covered by this Plan and the other Health Plan, the benefits under this Plan will be coordinated with the other Health Plan to prevent more than one plan from paying for the same health services and/or supplies. The Coordination of Benefits (“COB”) rules described in this subsection and in any related insurance policy, contract or law, apply if you and/or your Eligible Dependents are covered under this Plan and another Health Plan. These COB rules are necessary to avoid unnecessary costs for you and the Fund.

(b) Definitions

For the purposes of this section, the following terms have the meanings set forth below:

- (1) Plan: Any of the following that provides benefits or services for medical care or treatment:
- > Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
 - > Governmental benefits as permitted by law, excepting Medicaid, Medicare and Medicare supplement policies.
 - > Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

- (2) Closed Panel Plan: A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.
- (3) Primary Plan: The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.
- (4) Secondary Plan: A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash

Value of any services it provided to you.

- (5) **Allowable Expense:** The amount of charges considered for payment under the plan for a Covered Service prior to any reductions due to coinsurance, copayment or deductible amounts. If Cigna contracts with an entity to arrange for the provision of Covered Services through that entity's contracted network of health care providers, the amount that Cigna has agreed to pay that entity is the allowable amount used to determine your coinsurance or deductible payments. If the Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- > An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- > If you are confined to a private Hospital room and no Plan provides coverage for more than a semi-private room, the difference in cost between a private and semi-private room is not an Allowable Expense.
- > If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- > If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- > If your benefits are reduced under the Primary Plan (through the imposition of a higher co-payment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and pre-certification of admissions or services.

- (6) **Reasonable Cash Value:** An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

(c) Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- (1) the Plan that covers you as an enrollee or a Member shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- (2) if you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or Member;
- (3) if you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
 - > first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
 - > then, the Plan of the parent with custody of the child;
 - > then, the Plan of the spouse of the parent with custody of the child;
 - > then, the Plan of the parent not having custody of the child, and
 - > finally, the Plan of the spouse of the parent not having custody of the child.
- (4) The Plan that covers you as an active Member (or as that Member's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired Member (or as that Member's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- (5) The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active Member or retiree (or as that Member's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result,

the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

- (6) If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.
- (7) If none of the rules of (1) - (6) determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.
- (d) **Effect on the Benefits of This Plan:** If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans are not more than 100% of the total of all Allowable Expenses.
- (e) **Recovery of Excess Benefits:** If the Fund pays charges for benefits that should have been paid by the Primary Plan, or if the Fund pays charges in excess of those for which we are obligated to provide under the Policy, the Fund will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

The Fund will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

- (f) **Right to Receive and Release Information:** The Fund, including its service providers, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

11.2: Coordination With Medicare Coverage

- (a) If you, your Spouse and/or your Dependent Child are covered by this Plan and by Medicare, this Plan generally pays its maximum benefit on a claim first and Medicare pays second. There may be circumstances under which the law does not require the Plan to pay first. In those circumstances, Medicare will be responsible for paying its maximum before the Plan has any responsibility to pay benefits.
- (b) The medical coverage under this Plan for:

- > a former Participant who is eligible for Medicare and whose insurance is continued for any reason as provided in this Plan;
- > a former Participant's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan; or
- > a Participant, retired Participant, Participant's Dependent or retired Participant's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

will be modified, where permitted by the rules established by the Social Security Act of 1965 as amended, as follows:

- (1) the amount payable under this plan will be reduced so that the total amount payable by Medicare and by Cigna will be no more than 100% of the expenses incurred.
- (2) The Fund will assume the amount payable under:
 - > Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.
 - > Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.
 - > Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.
- (c) A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.
- (d) This reduction will not apply to any Participant and his Dependent or any former Participant and his Dependent unless he is listed under (b), above.

11.3: Medicaid

If you are covered by both this Plan and Medicaid, this Plan pays its maximum benefits on a claim first and then Medicaid pays any unpaid amount to the extent provided under Medicaid rules. Medicaid may pay contributions required for a Medicaid eligible Employee covered by the Fund that are necessary to make the Employee and/or his Dependents eligible for coverage under the Plan.

11.4: TRICARE

If you are covered by both this Plan and TRICARE, this Plan pays its maximum benefits on a claim first and then TRICARE pays any unpaid amount to the extent provided under TRICARE rules.

11.5: Services Received At A Veterans Affairs Facility

No benefits are payable under the Plan for any services, treatment, supplies or equipment you receive at or from a U.S. Department of Veterans Affairs hospital or facility on account of a military service-related illness or injury.

If you receive services, treatment, supplies or equipment at or from a U.S. Department of Veterans Affairs hospital or facility on account of any condition that is not military service-related illness or injury, benefits are payable by the Plan under the same terms and conditions that apply under the Plan.

11.6: Other Coverage Provided by State or Federal Law

If you are covered by both this Plan and any other coverage provided by any other state or federal law, the coverage provided by any other state or federal law must pay its maximum benefits before benefits become payable under the Plan.

11.7: Workers' Compensation Benefits

No benefits are payable under the Plan if the medical, prescription drug, dental or vision expenses are covered by workers' compensation or occupational disease laws or programs.

If your employer contests the application of workers' compensation for the illness or injury for which expenses are incurred, the Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under workers' compensation. However, before such payment will be made, you (or your Spouse or Child, if they are the patient) must execute an agreement to reimburse the Fund that is acceptable to the Fund Administrator or its designee. Cigna will send a notice to you.

11.8: Motor Vehicle No-Fault Coverage

If you are covered by both this Plan and any motor vehicle no-fault coverage that is required by law, the motor vehicle coverage must pay its maximum benefits before benefits become payable under the Plan.

11.9: Third Party Causes Your Injury Or Illness (Subrogation)

- (a) If your (or your Spouse or Child, if you have Family Coverage) illness or injury is caused by another person ("third party"), the Plan imposes conditions on payment of any benefits for services, treatment, supplies or equipment related to the illness or injury. In general, if the Plan pays benefits for you relating to an illness or injury caused by a third party, you are automatically deemed to agree that the Plan is entitled: (a) to

reimbursement of all the benefits related to the injury or illness it paid from you if you recover money from the third party; and (b) to be subrogated to your claims and rights to recover from the third party.

These conditions on benefits apply to medical, prescription drug, dental, and vision benefits as well as accidental death and dismemberment benefits and short term disability benefits. The Fund and Plan are exempt from State anti-subrogation laws, at least to the extent that they are self-funded (medical, prescription drugs, dental, vision), by virtue of ERISA's preemption of State laws.

- (b) These conditions are intended to protect the rights of the Fund to reimbursement for the benefits it pays in case you recover money from the third party. By protecting its rights to reimbursement if and when you recover money from the third party, the Plan is able to pay benefits for you up front when you need coverage to immediately obtain medical services, treatment, drugs, supplies or equipment. Without this right to reimbursement, the Fund would have to always exclude from coverage illness and injury caused by third parties to protect the Fund's financial soundness and keep contribution rates lower than they would otherwise be.
- (c) You (or your Spouse or Child, if you have Family Coverage and he or she is the patient) may be required by the Fund Administrator or his designee to sign a written agreement with the Fund acknowledging its reimbursement and subrogation rights. If you do not sign an agreement when presented to you by the Fund Administrator or his designee, your benefits under the Plan may be suspended or withheld. The Fund's reimbursement and subrogation rights under the Plan Description apply and are enforceable even if you do not sign an agreement. Your, and your lawyers' and other agents', compliance with the Fund's subrogation and reimbursement rights are a condition of your (and your Spouse's and Child's) coverage under the Plan.
- (d) The Fund has delegated and assigned its subrogation rights and enforcement authority to Cigna and a law firm selected by Cigna. Any requirements, rules and procedures adopted by Cigna shall be enforceable to the extent not inconsistent with this Plan Description and applicable law.
- (e) Cigna's rules are as follows:
 - (1) Except as otherwise provided in this subsection, this Plan does not cover:
 - > Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
 - > Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or under-insured

motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage. The coverage under this plan is secondary to any automobile no-fault or similar coverage.

(2) Subrogation/Right of Reimbursement

- (i) If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above.
- (ii) Subrogation: The Plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.
- (iii) Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.
- (iv) Lien of the Fund: By accepting benefits under this Plan, a Participant:
 - > grants a lien and assigns to the Fund an amount equal to the benefits paid under the Plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the Fund or its agents;
 - > agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
 - > agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the Fund.

(3) Additional Terms

- (i) No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The Fund's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- (ii) No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided under the Plan.
- (iii) The Fund's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- (iv) No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the Fund. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- (v) The Fund shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- (vi) The Fund hereby disavows all equitable defenses in pursuit of its right of recovery. The Fund's subrogation or recovery rights are neither affected nor diminished by equitable defenses.
- (vii) In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The Fund shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.

- (viii) Any reference to state law in any other provision of this plan shall not be applicable to this provision, inasmuch as the Fund and Plan are governed by ERISA. By acceptance of benefits under the Plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Fund shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

 - (ix) Participants must assist the Fund in pursuing any subrogation or recovery rights by providing requested information.
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**SECTION 12:
GOVERNANCE, ADMINISTRATION & MISCELLANEOUS**

12.1: Governance & Administration

- (a) Pursuant to the Fund's Agreement and Declaration of Trust, the Fund is governed by the Board of Trustees ("Board") composed of Union and Employer Trustees. The Board has overall authority and responsibility regarding the structure and operations of the Fund, including the design of the benefit programs ("Plans") offered by the Fund and the adoption of rules and regulations governing the Fund and Plan.
- (b) As of January 1, 2017, the day-to-day administration of the Fund has been assigned by the Board to an "in-house" administrative staff based in offices at 905 16th Street, N.W., Washington, D.C. ("the Fund Office"). The staff is headed by the Fund Administrator (Adam M. Downs) and the Assistant Fund Administrator (Michael J. Davis).

The Fund Office is assisted in its administrative functions by various service providers including Cigna Health and Life Insurance Company (Cigna, medical claims administration, vision benefits administration, and member assistance program administration), Express Scripts Inc. (prescription drug administration), Delta Dental (dental benefits administration), and Union Labor Life Insurance Company (short term disability and life insurance).

12.2: Board's Authority

The Board's broad, discretionary authority includes, but is not limited to, the following:

- (a) to amend, suspend, or terminate any Benefit Plan of the Fund, at any time and for any reason, including the right to set the effective date of any such action;
- (b) to limit participation in any Benefit Plan for any reason;
- (c) to terminate or suspend the participation, coverage or eligibility of any employer or employee group due to a contribution delinquency or to otherwise protect the Fund or Plan;
- (d) to restore participation, coverage or eligibility, prospectively and / or retrospectively;
- (e) to make exceptions and grant waivers from Benefit Plan provisions, rules, regulations and procedures if the Board deems necessary or appropriate under the circumstances and without setting a precedent;

- (f) to set from time to time the rates of contributions to the Fund required for obtaining and maintaining coverage and eligibility under a Benefit Plan;
- (g) to settle or compromise any dispute involving the Fund or a Benefit Plan, including the right to forgive or waive any debt to the Fund, in whole or in part;
- (h) to delegate or assign any Board authority: to the Executive Committee, Appeals Committee, or any other committee of Trustees; to the Fund Administrator or Assistant Fund Administrator; or to any service provider to the Fund;
- (i) to interpret, construe and apply the terms of the Fund's Agreement and Declaration of Trust as well as the terms and conditions of any Benefit Plan, rule, regulation or procedure of the Fund or Benefit Plan;
- (j) to decide all claims appeals and other appeals to the Board, including the discretionary authority to determine the procedures for making decisions and decide all questions of fact, evidence and law; and
- (k) to engage in any other action, to to refrain from taking any action, that the Board determines to be in the best interests of the Fund and the Participants.

12.3: Board's Decisions Binding And Enforceable

The Board's decisions and actions shall be binding on all Participants, Beneficiaries, Employers, Unions, and other persons, including governmental authorities.

12.4: Agent For Service Of Process

The Board of Trustees has designated the Fund Administrator, Adam M. Downs, as the Fund's agent for receipt of process. He is located at the Fund Office. Service of process may be made on the Fund Administrator at the Fund Office which is located at 905 16th Street, N.W., Washington, D.C. 20006. Service on any other person shall not be effective.

12.5: Fraud & Recissions

- (a) Any person who knowingly submits to the Fund materially false information, or conceals from the Fund material information, for the purpose of misleading or defrauding the Fund may be denied eligibility, be denied coverage, have his or her claim denied, and be subject to any civil or criminal liability imposed by law. This includes knowingly submitting a false benefit claim (including a claim for services not provided) and false enrollment information (such as falsely claiming a person to be a Spouse or Dependent).
- (b) The Fund is an employee benefit plan regulated by the Employee Retirement Income Security Act ("ERISA"). ERISA and related federal criminal statutes impose penalties

for intentionally submitting false material information to the Fund for the purpose of wrongly depriving the Fund of assets.

- (c) Rescissions: Your coverage may not be rescinded (retroactively terminated) by the Fund except: you (or a person seeking coverage on behalf of you) performs an act, practice or omission that constitutes fraud; or if you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact. Your coverage may be terminated or rescinded in the event that required contributions are not received by the Fund when due, to the extent permitted by applicable law.

12.6: Benefit Payments: Assignment, Overpayments, Etc

(a) Assignment and Payment of Benefits

- (1) Generally, you may not assign to any party, including, but not limited to, a provider of healthcare services/items, your right to benefits under this Plan, nor may you assign any administrative, statutory, or legal rights or causes of action you may have under ERISA, including, but not limited to, any right to make a claim for Plan benefits, to request Plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits under ERISA. Any attempt to assign such rights shall be void and unenforceable under all circumstances.
- (2) You may, however, authorize Cigna to pay any healthcare benefits under this policy to a Participating or Non-Participating Provider. When you authorize the payment of your healthcare benefits to a Participating or Non-Participating Provider, you authorize the payment of the entire amount of the benefits due on that claim. If a provider is overpaid because of accepting duplicate payments from you and the Fund, it is the provider's responsibility to reimburse the overpayment to you. The Fund may pay all healthcare benefits for Covered Services directly to a Participating Provider without your authorization. You may not interpret or rely upon this discrete authorization or permission to pay any healthcare benefits to a Participating or Non-Participating Provider as the authority to assign any other rights under this policy to any party, including, but not limited to, a provider of healthcare services/items.
- (3) Even if the payment of healthcare benefits to a Non-Participating Provider has been authorized by you, the Fund may, at its option, make payment of benefits to you. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the Non-Participating Provider.
- (4) If any person to whom benefits are payable is a minor or, in the opinion of the Fund is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our Participants passes away, the Fund may receive notice that an executor of the estate has been established. The executor has the same rights

as our insured and benefit payments for unassigned claims should be made payable to the executor.

- (5) Payment as described above will release the Fund from all liability to the extent of any payment made.

(b) Recovery of Overpayment

When an overpayment has been made by the Fund, the Fund will have the right at any time to:

- (1) recover that overpayment from the person to whom or on whose behalf it was made; or
- (2) offset the amount of that overpayment from a future claim payment.

In addition, your acceptance of benefits under this Plan and/or assignment of Benefits separately creates an equitable lien by agreement pursuant to which the Fund may seek recovery of any overpayment. You agree that the Fund, in seeking recovery of any overpayment as a contractual right or as an equitable lien by agreement, may pursue the general assets of the person or entity to whom or on whose behalf the overpayment was made.

(c) Calculation of Covered Expenses

Cigna, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- (1) the methodologies in the most recent edition of the Current Procedural terminology; and
 - (2) the methodologies as reported by generally recognized professionals or publications.
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SECTION 13: DEFINITION OF TERMS

The following are definitions of specific capitalized terms and words used in this document, arranged in alphabetic order generally. Other terms, capitalized or not, may be defined elsewhere in this document. These definitions will apply whenever the defined term is used in this Plan Description, the Summary Plan Description, and related insurance policies and contracts, unless: (a) a different definition is applicable under an insurance or administrative contract with the Fund; or (b) the Board determines in any particular situation that the definition is inappropriate.

Active Employee: An Employee Actively at Work is deemed an Active Employee.

Actively At Work or Active Employee: To be Actively at Work, an Employee must be performing all of the regular duties of his/her employment in the customary manner either at the Employer's regular place of business or at some other location to which the Employer's business requires employees to travel. An Employee will be deemed to be Actively at Work on each day of a regularly paid vacation, holiday, sick leave or annual leave, as long as the Employee is not Totally Disabled and is able to perform all of the regular duties of his/her occupation in the customary manner.

Activities of Daily Living: Activities performed as part of a person's daily routine, such as getting in and out of bed, bathing, dressing, feeding or eating, use of the toilet, ambulating, and taking drugs or medicines that can be self-administered.

Acupuncture: The practice of insertion of needles into specific exterior body locations to relieve pain, to induce surgical anesthesia, and for other therapeutic purposes.

Adult: A person who is age 18 or older.

Acupuncturist: A person who is legally licensed and authorized to practice Acupuncture under the laws of the state or jurisdiction where the services are rendered.

Alcohol and Substance Abuse: Any pattern of regular excessive compulsive drinking of alcohol and/or the physical habitual dependence or non-dependence on drugs that results in an acute or chronic disorder affecting physical health and/or personal, social, or occupational functioning. This does not include dependence on tobacco and ordinary caffeine - containing drinks.

Allowable Expense: A health care service or expense, including Deductibles and Co-Payments, that is covered in whole or in part by a health care plan under which you and/or your Eligible Dependents have coverage. Any expense or service, or portion thereof, that is not covered by any such plan is not an Allowable Expense. When a health plan provides benefits in the form of services, rather than in cash, the reasonable

cash value of each service rendered will be covered as an Allowable Expense whether or not a claim is filed under that Health Plan.

Ambulance: A legally licensed vehicle, helicopter, or airplane certified for emergency patient transportation.

Ambulatory Surgical Facility: A public or private surgical facility, either free-standing or Hospital-based, licensed and operated according to law, that does not provide services for a patient to stay overnight, and that admits and discharges patients from the facility on the same day.

Ancillary Services: Services provided by a Hospital or other Health Care Facility other than room and board, including but not limited to, use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

Anesthesia: The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (general anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (local anesthesia). Anesthetics are commonly administered by injection or inhalation by a physician or professional anesthetist.

Authorized Representative: An individual whom you authorize to act on behalf of you or your Eligible Dependent with respect to the pre-certification process, claims filing process or claims appeal process. Such authorization will be effective once you complete the Representative Authorization Form at the back of this Book and return it to the Fund Administrator. However, in the event of a claim for Urgent Care, a Health Care Practitioner with knowledge of your medical condition will be permitted to act as your Authorized Representative, without regard to whether a completed Representative Authorization Form is on file.

Bed and Board: The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

Behavior Health Disorders: Disorders, conditions and diseases are defined within the mental disorders section of the current edition of the International Classification of Diseases manual, published by the U.S. Department of Health and Human Services ("HHS"), or are listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Behavioral Health Practitioners: A psychiatrist, psychologist or certified social worker who:

- > is legally licensed and/or legally authorized to practice or provide service, care or treatment of Behavioral Health Disorders under the laws of the state or jurisdiction where the services are rendered; and
- > acts within the scope of his or her license; and
- > is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Beneficiary: A person designated by you or under the terms of the Plan to receive benefits payable under the Plan upon your death.

Behavioral Health Treatment Facility: A public or private facility licensed and operated according to law, that provides a program for diagnosis, evaluation and effective treatment of Behavioral Health Disorders by one or more Physicians or Behavioral Health Practitioners.

Benefit or Benefit Payment: The amount of money payable for a Claim after applying the Plan's rules including calculation of all Deductibles, Co-Payments and Co-Insurance, and after determination of the Plan's exclusions, limitations and maximums.

Biologic: A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, protein (except any chemically synthesized polypeptide), or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound), used for the prevention, treatment, or cure of a disease or condition of human beings, as defined under Section 351(l) of the Public Health Service Act (42 USC 262(l)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

Biosimilar: A Biologic that is highly similar to the reference Biologic product notwithstanding minor differences in clinically inactive components, and has no clinically meaningful differences from the reference Biologic in terms of its safety, purity, and potency, as defined under Section 351(l) of the Public Health Service Act (42 USC 262(l)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

Birthing Center: A public or private licensed health facility which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. The facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located. The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-

midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre-or post-delivery confinement.

Board of Trustees (Board): The Board of Trustees of the Fund consisting of individual Trustees. The Board is the sponsor and plan administrator of the Fund, and governs the administration and operations of the Fund.

Business Decision Team: A committee comprised of voting and non-voting representatives across various Cigna business units such as clinical, medical and business leadership that is duly authorized by Cigna to make decisions regarding coverage treatment of Medical Pharmaceuticals based on clinical findings provided by the P&T Committee, including, but not limited to, decisions regarding tier placement and application of utilization management to Medical Pharmaceuticals.

Calendar Year: The 12-month period beginning January 1 and ending December 31.

Case Management: A process administered by the Utilization Management Company whose medical professionals work with the patient, family, caregivers, Health Care Practitioners and Providers, and the Claims Administrator to coordinate a timely and cost-effective treatment program. Case Management services are most often used when the patient needs complex, costly, and/or long-term services, and when assistance is needed to determine how the patient's health needs can be met within the existing health care benefits.

Case Manager: The medical professional assigned to you and your family members by the Utilization Management Company to coordinate, monitor and manage complex, costly, and/or long-term cases, usually involving serious Injury or Illness.

Charges: The term "Charges" means the actual billed charges; except when the provider has contracted directly or indirectly with Cigna for a different amount or where Cigna has directly or indirectly contracted with an entity to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies.

Child:

- (a) Generally, the term Child means any of a Participant's children (natural child, stepchild, adopted child, prospective adoptive child placed in your home, or foster child) whose age is less than 26 years, except as provided in (c), below.
- (b) The fact that a Child, as defined above, is married, or is not a student, or is not dependent on the Participant for support, or does not live in the Participant's household does not disqualify him or her from eligibility as a Child of the Participant.

- (c) A Child includes a Participant's child who is age 26 or older, unmarried, and primarily supported by the Participant and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered under this Plan, or while covered as a dependent under a prior plan with no break in coverage. Proof of the child's condition and dependence may be required to be submitted to the Fund Administrator within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, the Fund Administrator may require proof of the continuation of such condition and dependence.
- (d) A child of a Spouse or of a Child is not a Child under this rule unless he or she is the adopted child or stepchild of the Participant.

Chiropractic Care/Spinal Manipulation: The term Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function. 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 Chiropractor to remove nerve interference from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Chiropractor: A person who:

- (a) holds the degree of Doctor of Chiropractic (DC); and
- (b) is legally licensed and authorized to provide chiropractic care; and
- (c) acts within the scope of his/her license; and
- (d) is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Claim: A request for payment of a Benefit or Benefit Payment under a Benefit Plan. A Claim also includes any complaint regarding interpretation or application of Benefit Plan terms or rules, or complaint regarding any administrative or operational action or omission by the Fund or a service provider to the Fund. All Claims are subject to the Claims and Appeals Procedure of the Benefit Plans.

Claims Administrator: A person or company retained by the Fund to administer the claims payment responsibilities of the Plan. For medical and vision benefits, the claims administrator is Cigna. For prescription drugs, the claims administrator is Express Scripts, Inc. For dental benefits, the claims administrator is Delta Dental.

Co-Insurance: Your share (percentage) of Covered Expenses that you must pay in

addition to any applicable Deductible and any applicable Co-Payment, as described in this Plan Description.

Complications of Pregnancy - For Medical Benefits: Expenses will be considered to be incurred for Complications of Pregnancy if they are incurred for: (a) an extrauterine pregnancy; (b) a pregnancy which ends by Caesarean section or miscarriage (other than elective abortion); or (c) a Sickness resulting from pregnancy. Complications of Pregnancy does not include: false labor; occasional spotting; Physician-prescribed rest during the period of pregnancy; morning sickness; hyperemesis gravidarum; preclampsia; and similar conditions which are associated with the management of a difficult pregnancy but do not constitute a nosologically distinct complication of pregnancy.

Concurrent Review: A Managed Care Program designed to assure that Hospitalization and other Health Care Facility admissions and length of stay, surgery or other Ancillary Services are Medically Necessary by having the Utilization Management Company conduct an ongoing assessment of the health care as it is being provided.

Congenital Abnormality: A defective development, abnormality, or malformation of a part of the body which is determined by a Physician to have been present at the time of birth, including cleft lip and cleft palate. Abnormality refers to a medical condition which is contrary to the body's usual size, location, condition, or system and which prevents normal bodily functions.

Contributions / Contribution Rate: The rate at which an Employer or, in the case of a self-payment, a Participant is required to contribute to the Fund. The contributions rates are set by the Board of Trustees and may be changed from time-to-time, with or without advance notice, as the Board deems necessary or appropriate to meet the Fund's funding needs.

Convalescent Care Facility or Hospital: See the definition of Skilled Nursing Facility.

Coordination of Benefits (COB): The rules and procedures applicable to determine how Plan benefits are payable when a person is covered by two or more group health care plans. Coordination of Benefits also applies to individual no-fault or personal injury protection motor vehicle insurance coverage.

Co-Payment: A portion of your Covered Expenses that you must pay in addition to any applicable Deductible and any applicable Co-Insurance, as described in this Plan Description.

Corrective Appliances: An externally worn brace which supports, aligns or corrects deformities to or improves the function of a limb or other moving body part. Corrective braces, casts, slings and crutches are examples of Corrective Appliances.

Cosmetic Surgery or Treatment: Surgery or medical treatment provided primarily to improve or preserve physical appearance, but not physical function, as distinguished from surgery or medical treatment to correct defects resulting from trauma, infection, or other diseases or the consequences of treatment of trauma, infection, or other diseases, or to correct a Congenital Abnormality of a Covered Dependent Child that causes a functional defect. Cosmetic surgery does not include the reconstruction of a breast following a mastectomy necessitated by disease, illness or accidental injury.

Coverage: The types of benefits provided under the Plan to you and your Eligible Dependents if the conditions for payment of the benefits are met.

Covered Charges: Medical, Prescription Drug, Dental and Vision Expenses that are payable under the Benefit Plan.

Covered Employment: Employment with an Employer for which the Employer is required to make contributions to the Fund pursuant to a collective bargaining agreement or other agreement that is deemed acceptable by the Board of Trustees to allow participation in the Fund.

Covered Expenses: The types of expenses (e.g. medical services, prescription drug, dental services) for which benefits are payable under this Plan. See Section 2.3 regarding Covered Medical Expenses.

Covered Individual: You or an Eligible Dependent.

Custodial Services / Care: Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

- (a) Services related to watching or protecting a person;
- (b) Services related to performing or assisting a person in performing any activities of daily living, such as: walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can be self administered, and
- (c) Services not required to be performed by trained or skilled medical or paramedical personnel.

Deductible: The portion of your Covered Expenses that you must pay before the Fund

pays for any portion of the expenses, as described in this Plan Description. Deductibles are in addition to any Co-Payment and Co-Insurance. Once the applicable maximum Deductible for a year has been reached, no further Deductible will be payable for the year.

Dental: Any services performed by or under the supervision of a Dentist, or supplies, including Dental Prosthetics, prescribed by a Dentist, even if the services or supplies are necessary because of symptoms, illness or injury affecting another part of the body.

Dental Hygienist: A person specifically trained in dental prophylaxis who works under the direct supervision of a Dentist and who is legally licensed and authorized to be a Dental Hygienist under the laws of the state or jurisdiction where the services are rendered. Dental Hygienists' functions include scaling and polishing the teeth, dental radiography, and teaching oral hygiene.

Dentist: A person who has received a degree from an accredited school of dentistry and is legally licensed and/or legally authorized to practice dentistry by a state board of dental examiners under the laws of the state or jurisdiction where the services are rendered.

Dependent: A Participant's Spouse and any Child of a Participant.

Durable Medical Equipment: Equipment that:

- (a) is prescribed by the Physician as essential in the treatment of the Injury or Illness; and
- (b) can withstand repeated use; and
- (c) is not generally useful in the absence of an Injury or Illness; and
- (d) is appropriate for use in the home; and
- (e) is not disposable or non-durable; and
- (f) is Medically Necessary for the care and treatment of the Covered Individual's Injury or Illness.

Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds (with safety rails), electric and manual wheelchairs, home dialysis equipment, respirators, nebulizers, oximeters, oxygen and supplies, and ventilators.

Elective Hospital Admission, Service or Procedure: Any non-emergency Hospital admission, service or procedure that can be scheduled or performed at the patient's or

Physician's convenience without jeopardizing the patient's life or causing serious impairment of bodily function.

Eligible: A Participant or Dependent that has satisfied and continues to satisfy the requirements for eligibility for coverage under Section 1 of this Plan Description.

Eligible Dependents: Dependents who are eligible for coverage under the Plan because the Participant has Family Coverage.

Emergency Hospitalization or Confinement: An admission into a Hospital or some other Health Care Facility that takes place within twenty-four (24) hours of the sudden and unexpected severe symptom of an Illness or within twenty-four (24) hours of an accidental Injury causing a life-threatening situation.

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

Emergency Services: Emergency services means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, to stabilize the patient.

Emergency Surgery: A surgical procedure performed within twenty-four (24) hours of the sudden and unexpected severe symptom of an Illness or within twenty-four (24) hours of an accidental Injury causing a life-threatening situation.

Employee: A person employed by an Employer as a common law employee and working in Covered Employment.

Employer: An employer that is required to make contributions to the Fund on behalf of Employees pursuant to a collective bargaining agreement or other agreement that is deemed acceptable by the Board of Trustees and which employer has been accepted into participation by the Fund by the Board of Trustees. Employer does not include an employer that has been expelled from participation in the Fund by the Board of Trustees, except this shall not be deemed to excuse any former Employer from any indebtedness to the Fund incurred before it was expelled.

ERISA: A Federal law called the Employee Retirement Income Security Act, as

amended.

Essential Health Benefits: To the extent covered under the Benefit Plan, expenses incurred with respect to Covered Services, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

Exclusions: Specific conditions, circumstances, services, treatments, drugs, equipment, supplies under or for which no Benefits are payable under the Benefit Plan or portions of the Benefit Plan. The cost of excluded services, treatments, drugs, equipment, supplies are the responsibility of the patient, not of the Fund.

Expense Incurred: An expense is incurred when the service, treatment or drug is provided or the equipment or supply is provided.

Experimental and/or Investigational: Drugs, services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, and relevant segment of the medical community or government oversight agencies at the time the services were rendered. The Fund Administrator or its designee has the discretion and authority to determine if a service, supply, care and treatment is or should be classified as Experimental and Investigational. A drug, service, supply, care and/or treatment will be deemed to be Experimental and Investigational if, in the opinion of the Fund Administrator or its designee, it is determined to be:

- (a) not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the "United States Pharmacopeia Dispensing Information" or the "American Hospital Formulary Service" as appropriate for the proposed use; or
- (b) subject to review and approval by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval for the proposed use; or
- (c) the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- (d) not demonstrated through prevailing peer-review medical and scientific literature as being safe and effective for treating or diagnosing the condition, Injury or Illness for which its use is proposed (whether it is permitted by law to be used in

testing or other studies on human patients).

Extended Care Facility: See the definition of Skilled Nursing Facility.

Family: A Participant and his / her Dependent(s).

Family Coverage: Coverage provided to a Participant and to his / her Spouse and Child / Children. Family Coverage is provided only if the Participant meets the eligibility requirements for such coverage set forth in Section 1 of this Plan Description at the relevant time.

Free-Standing Surgical Facility: The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- (a) it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- (b) it maintains at least two operating rooms and one recovery room;
- (c) it maintains diagnostic laboratory and x-ray facilities;
- (d) it has equipment for emergency care;
- (e) it has a blood supply;
- (f) it maintains medical records;
- (g) it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- (h) it is licensed in accordance with the laws of the appropriate legally authorized agency.

Fund: The Laborers' National Health and Welfare Fund, the trust fund that offers this Plan to Employees of Employers.

Fund Administrator: Adam M. Downs, Laborers' National Health and Welfare Fund, Fund Office, 905 16th Street, N.W., Washington, D.C. 20006. The ERISA statutory "plan administrator" of the Fund is the Board of Trustees.

Handicap or Handicapped (Physically or Mentally): The inability of a person to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder, psychosis, or is otherwise Totally Disabled, provided the condition was diagnosed by a Physician, and accepted by the Fund Administrator or its designee, as a permanent and continuing condition. See the definition of Totally Disabled.

Health Care Facility: A Hospital, an Ambulatory Surgical Facility, a Behavioral Health Treatment Facility, a Birthing Center, a Convalescent Care Facility, a Hospice or Qualified Hospice Care Program, or a Skilled Nursing Facility licensed or certified (or both) and operating according to the law of the state or the jurisdiction in which it is located.

Health Care Practitioner: A Physician, Acupuncturist, Behavioral Health Practitioner, Chiropractor, Dental Hygienist, Dentist, Nurse, Podiatrist, Physical or Speech Therapist or Speech Pathologist, or Ophthalmologist or Optometrist, as those terms are defined in this chapter, who:

- (a) is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered; and
- (b) acts within the scope of his or her license and/or scope of practice; and
- (c) is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Health Care Provider: A Health Care Practitioner, a Health Care Facility, or a Home Health Care Agency, as those terms are defined in this Section.

Home Health Care: Services and supplies provided under a Home Health Care Plan which include part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.), part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, speech or other therapy; medical supplies; and laboratory services by or on behalf of a Hospital.

Home Health Care Agency: A public or private organization, licensed and operating according to law, that is federally certified as a Home Health Care Agency, and that provides Home Health Care.

Home Health Care Plan: A formal written plan made by the patient's attending Physician which is reviewed every 30 days. The plan must state the diagnosis, certify that the Home Health Care is in place of Hospital confinement, and specify the type and extent of Home Health Care required for the treatment of the patient.

Hospice Care Program: Means:

- (a) a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- (b) a program that provides palliative and supportive medical, nursing and other

health services through home or inpatient care during the illness; and

- (c) a program for persons who have a Terminal Illness and for the families of those persons.

Hospice Care Services: Any services provided by: a Hospital, a Skilled Nursing Facility or a similar institution, a Home Health Care Agency, a Hospice Facility, or any other licensed facility or agency under a Hospice Care Program.

Hospice Facility: Means an institution or part of it which:

- (a) primarily provides care for Terminally Ill patients;
- (b) is accredited by the National Hospice Organization;
- (c) meets standards established by Cigna; and
- (d) fulfills any licensing requirements of the state or locality in which it operates.

Hospital: Means:

- (a) an institution licensed as a hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and provides 24-hour service by Registered Graduate Nurses;
- (b) an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- (c) an institution which: specializes in treatment of Mental Health and Substance Use Disorder or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

Hospital Confinement or Confined in a Hospital: A person will be considered Confined in a Hospital if he is:

- (a) a registered bed patient in a Hospital upon the recommendation of a Physician; and
- (b) receiving treatment for Mental Health and Substance Use Disorder Services in a Mental Health or Substance Use Disorder Residential Treatment Center.

Illness: Any bodily sickness or disease, including any Congenital Abnormality of a newborn Child, as diagnosed by a Physician and as compared to the person's previous condition. Your or your Spouse's pregnancy will be considered to be an Illness for the purpose of coverage under this Plan, but not the pregnancy of a Dependent who is a Child.

Independent Review Organization / IRO: An organization that is qualified to conduct an external review of medical claims required under the Affordable Care Act and applicable regulations, and is independent of the Fund and Cigna.

Injury: Any damage to a body part resulting from trauma from an external source.

Inpatient Services: Services provided in a Hospital or other Health Care Facility during the period when charges are made for room and board.

Maintenance Care: Services, treatment, equipment and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

Maintenance Treatment: Treatment rendered to keep or maintain the patient's current status.

Managed Care Program: A program adopted by the Board of Trustees consisting of procedures designed to help control health care costs by avoiding unnecessary services or services that are more expensive than other services that are just as appropriate.

Maximum Reimbursable Charge - Medical: The Maximum Reimbursable Charge for Covered Medical Services is determined by Cigna based on the lesser of:

- (a) the provider's normal charge for a similar service or supply; or
- (b) a percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.

Medicaid: A state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medical Emergency: A sudden unexpected onset of a medical condition, not normally treatable in a Physician's office, that manifests itself by such acute symptoms of sufficient severity, including severe pain, that urgent and immediate medical attention is required either to prevent (1) placing the patient's health in serious jeopardy; (2) serious impairment of bodily functions; (3) serious and/or permanent impairment or dysfunction of any body organ or part; (4) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Examples of such conditions include, but are not limited to heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions and other acute medical conditions.

Medical Pharmaceutical: An FDA-approved prescription pharmaceutical product, including a Specialty Prescription Drug Product, typically required to be administered in connection with a covered service by a Physician or other health care provider within the scope of the provider's license. This definition includes certain pharmaceutical products whose administration may initially or typically require Physician oversight but may be self-administered under certain conditions specified in the product's FDA labeling. This definition does not include any charges for mobile, web-based or other electronic applications or software, even if approved for marketing as a prescription product by the FDA.

Medically Necessary/Medical Necessity: Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization acting on behalf of the Fund:

- (a) required to diagnose or treat an illness, Injury, disease or its symptoms;
- (b) in accordance with generally accepted standards of medical practice;
- (c) clinically appropriate in terms of type, frequency, extent, site and duration;
- (d) not primarily for the convenience of the patient, Physician or other health care provider;
- (e) not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your Sickness, Injury, condition, disease or its symptoms; and
- (f) rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting.

All of these criteria must be met. Merely because a Physician recommends or approves certain treatment, service or supply does not mean that it is Medically Necessary. Cosmetic and Experimental and/or Investigational services and procedures are not Medically Necessary.

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act (Parts A and/or B) as it is now amended and as it may be amended in the future.

Member: A Participant in the Fund and Plan.

Midwife or Nurse Midwife: A person legally licensed as a midwife or certified as a nurse midwife in the area of managing the care of mothers and babies throughout the maternity cycle, as well as providing general gynecological care, including history taking, performing physical examinations, ordering laboratory tests and x-ray procedures, managing labor, delivery and the post-delivery period, administering intravenous fluids and certain medications, providing emergency measures while awaiting aid, performing newborn evaluations, signing birth certificates, and billing and being paid in his or her own name.

Necessary Services and Supplies: Includes any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement, any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and any charges, by whomever made, for the administration of anesthetics during Hospital Confinement. The term Necessary Services and Supplies does not include any charges for special nursing fees, dental fees or medical fees.

New Prescription Drug Product (Medical): A Prescription Drug Product, or new use or dosage form of a previously FDA-approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or newly-approved use or dosage form becomes available on the market following approval by the U.S. Food and Drug Administration (FDA) and ending on the date Cigna's Business Decision Team makes a Prescription Drug List coverage status decision.

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, bandages, slings, hypodermic syringes, diapers, soap or cleansing solutions.

Nurse: A person legally licensed as a Registered Graduate Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife or Licensed Midwife, Nurse Practitioner, Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the same or jurisdiction where the services are rendered.

Ophthalmologist: A Physician who specialized in the diagnosis and medical and surgical treatment of diseases and defects of the eye and related structures.

Optometrist: A person legally licensed and authorized under the laws of the state or jurisdiction where the services are rendered, to practice Optometry.

Optometry: The professional practice of primary eye and vision care for the diagnosis, treatment and prevention of associated disorders and for the improvement of vision by the prescription of lenses and by the use of other functional, optical, and pharmaceutical means.

Orthotic Appliance (or Device): A type of durable Corrective Appliance or device, either customized or available "over-the-counter", designed to support a weakened

body part, including, but not limited to, crutches, specially designed corsets, leg braces, extremity splints, and walkers. For the purposes of the Medical Plan, this definition does not include Dental Orthotics.

Other Health Care Facility/Other Health Professional: The term Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities. The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses. Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.

Outpatient Services: Services provided either outside of a Hospital or other Health Care Facility setting or at a Hospital or other Health Care Facility when room and board charges are not incurred.

Participant: The term Participant means an Employee of an Employer who is eligible for coverage under this Plan. This term does not include the Dependent of a Participant.

Participating Provider: The term Participating Provider means a Hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide services and/or supplies the Charges for which are Covered Expenses. It includes an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies the Charges for which are Covered Expenses. Generally means the same as an In-Network provider.

Participation Date: The term Participation Date means the date on which you become a Participant in the Plan.

Patient Protection and Affordable Care Act of 2010 ("PPACA"): Patient Protection and Affordable Care Act of 2010 means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152). Also referred to as the Affordable Care Act ("ACA").

Pharmacist: A person legally licensed under the laws of the state or other United States jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

Pharmacy: A business or other organization that sells prescription drugs that is supervised by a Pharmacist in accordance with the laws of the state or other United States jurisdiction where the pharmacy is located and operates, subject to additional conditions set by the Fund's Pharmacy Benefit Manager. The Mail Service Pharmacy is the Pharmacy designated by the Pharmacy Benefit Manager, with the agreement of the Board of Trustees, as the exclusive provider of prescription drugs by mail or other home delivery service under the Plan. A Retail Pharmacy is a Pharmacy that offers prescription drugs for sale to the general public.

Pharmacy Benefit Manager: Express Scripts, Inc., which administers the Fund's prescription drug program, including processing drug benefit claims.

Pharmacy & Therapeutics (P&T) Committee: A committee comprised of both voting and non-voting Cigna-employed clinicians, Medical Directors and Pharmacy Directors and non-members such as Participating Providers that represent a range of clinical specialties. The committee regularly reviews Medical Pharmaceuticals for safety and efficacy, the findings of which clinical reviews inform coverage status decisions made by the Business Decision Team. The P&T Committee's review may be based on consideration of, without limitation, U.S. Food and Drug Administration-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.

Physical Therapist or Physiotherapist: A person legally licensed and authorized under the laws of the state or jurisdiction where the services are rendered, to practice Physical Therapy.

Physical Therapy or Physiotherapy: The evaluation and rehabilitation of patients disabled by pain, disease, illness or injury, with treatment using physical therapeutic measures as opposed to medical, surgical, or radiologic measures. For Physical Therapy expenses to be paid under the Benefit Plans, it must be ordered by a Physician.

Physician: The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the service is provided.

Plan: Benefit Plan 2 of the Laborers' National Health and Welfare Fund, whose terms and conditions are set forth in this document.

Podiatrist: A person legally licensed as a doctor of podiatric medicine (DPM) and authorized to provide care and treatment of the human foot (and in some states, the ankle and leg up to the knee) under the laws of the state or jurisdiction where the services are rendered.

Pre-Admission Testing: Laboratory tests and x-rays and other Medically Necessary tests performed on an out-patient basis prior to a scheduled Hospital admission or out-patient Surgery.

Pre-Certification / Pre-Authorization: A Managed Care Program designed to ensure that Hospital and other Health Care Facility admissions and lengths of stay, Surgery and other health care services are Medically Necessary by having the Utilization Management Company determine the Medical Necessity before the services are provided. As described in this document, Pre-Certification is generally obtained by a Participating Provider for In-Network services. Pre-Authorization is the patient's responsibility.

Pre-Existing Condition: Any Illness or Injury for which a diagnosis has been made or medical care and/or treatment has been provided (including the prescription of drugs or medicines) during the months immediately preceding the date coverage begins. The Plan has no Pre-Existing Condition Exclusions.

Prescription Drug List (Medical): A list that categorizes drugs, Biologics (including Biosimilars) or other products covered under the plan's Prescription Drug benefits that have been approved by the U.S. Food and Drug Administration (FDA). This list is developed by Cigna's Business Decision Team based on clinical factors communicated by the P&T Committee, and adopted by the Fund as part of the Plan. The list is subject to periodic review and change, and is subject to the limitations and exclusions of the Plan. A copy of the list can be obtained upon request.

Prescription Drug Product (Medical): A drug, Biologic (including a Biosimilar), or other product that has been approved by the U.S. Food and Drug Administration (FDA), certain products approved under the Drug Efficacy Study Implementation review, or products marketed prior to 1938 and not subject to review and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a drug, Biologic or product that, due to its characteristics, is

approved by the FDA for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Plan, this definition also includes:

- (a) The following diabetic supplies: alcohol pads, swabs, wipes, Glucagon/Glucagen, injection aids, insulin pump accessories (but excluding insulin pumps), needles including pen needles, syringes, test strips, lancets, urine glucose and ketone strips;
- (b) Needles and syringes for self-administered medications or Biologics covered under the plan's Prescription Drug benefit; and
- (c) Inhaler assistance devices and accessories, peak flow meters.

This definition does not include any charges for mobile, web-based or other electronic applications or software, even if approved for marketing as a prescription product by the FDA.

Prescription Order or Refill (Medical): The lawful directive to dispense a Prescription Drug Product issued by a Physician whose scope of practice permits issuing such a directive.

Primary Care Physician: The term Primary Care Physician means a Physician who qualifies as a Participating Provider in general practice, internal medicine, family practice or pediatrics; and who has been selected by you, as authorized by Cigna, to provide or arrange for medical care for you or any of your Dependents.

Prosthetic Appliance (or Device): A type of durable Corrective Appliance or device designed to replace all or part of a missing body part, including, but not limited to, artificial limbs, heart pacemakers, corrective lenses needed after cataract surgery. For the purposes of the Medical Plan, this definition does not include Dental Prostheses. See also the definitions of Corrective Appliances, Durable Medical Equipment, Nondurable Supplies and Orthotic Appliance (or Device).

Psychologist: The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is operating within the scope of his license and performing a service for which benefits are provided under this plan when performed by a Psychologist.

Qualified Medical Child Support Order (QMCSO): A court order that complies with

federal law requiring an employee to provide health care coverage for a Dependent Child, and requiring that Benefits payable on account of that Dependent Child be paid directly to the Health Care Provider who rendered the services or to the custodial parent of the Dependent Child.

Reasonable and Customary:

- (a) The Reasonable and Customary charge is the highest Allowable Expense that your Plan will accept for Medically Necessary services or supplies. If the Health Care Provider's actual charge is more than the Reasonable and Customary charge, you will have to pay the difference. A number of your Benefits are payable according to a percentage of charges. If the actual charge exceeds the Reasonable and Customary charge, the Fund will pay the Benefit based on a percentage of the Reasonable and Customary charge (not a percentage of the actual charge). Otherwise, the Fund will pay a percentage of the actual charge.
- (b) The Reasonable and Customary charge for Medically Necessary services or supplies will be determined by the Fund Administrator or its designee to be the lowest of:
 - > The Health Care Provider's actual charge; or
 - > No more than 90% of the "Prevailing Charge" of most other Health Care Providers in the same or similar geographic area for the same or similar health care supply, treatment or service.
- (c) The "Prevailing Charge" of most other Health Care Providers in the same or similar geographic area for the same or similar health care service or supply shall be determined by the Claims Administrator who shall use HIAA or MDR data that is updated at least annually.

Reconstructive Surgery: A surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease or tumor, or for breast reconstruction following a total or partial mastectomy.

Rehabilitation Therapy: Physical, speech or other types of therapy, that is prescribed by a Physician when the bodily function has been restricted or diminished as a result of Illness, Injury or Surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the Injury, Illness or Surgery, and that is performed by a licensed Therapist acting within the scope of his or her license.

Reimbursement: The right of the Plan to be reimbursed by a Covered Individual or by a Health Care Provider who received payments from the Fund to which he/she/they are

required to return to Fund under the terms of the Plan. This may include circumstances in which the Fund Administrator or Claims Administrator mistakenly made payments on the Covered Individual's behalf or when a Covered Individual receives payment from a liable third party for the Covered Individual's Injury or Illness. See Plan Section 10.4 for an explanation of how the Plan is entitled to recover medical and/or other benefits paid if the Covered Individual recovers any amount from a third party either by way of settlement or judgment.

Relevant Documents: Documents, records and other information (i) relied upon in making the benefit determination; (ii) submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination; (iii) demonstrating compliance with the administrative processes and safeguards required to ensure that benefit claim determinations are made in accordance with governing plan documents and that the plan provisions have been applied consistently with respect to similarly situated claimants; or (iv) constituting a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosed condition, without regard to whether such advice was relied upon in making the benefit determination.

Residential Treatment Facility: A public or private non-hospital facility, licensed and operated according to law, that provides a program in a residential setting for diagnosis, evaluation, and effective treatment of alcohol or substance abuse, and nervous, mental or emotional illnesses or disorders. See the definition of Behavioral Health Treatment Facility, in which one or more Physicians or Behavioral Health Practitioners provide treatment.

Review Organization: The term Review Organization refers to an affiliate of Cigna or another entity to which Cigna has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance use disorder professionals, and other trained staff members who perform utilization review services.

Sickness (Medical): The term Sickness means a physical or mental illness. It also includes pregnancy for you or your spouse and complications of pregnancy for your eligible Child. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

Single Coverage: Coverage provided to a Participant only, and not to any of his / her Dependents. Single Coverage is provided only if the Participant meets the eligibility requirements for such coverage set forth in this Plan.

Skilled Nursing Care: Services performed by a licensed Nurse.

Skilled Nursing Facility: The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- (a) physical rehabilitation on an inpatient basis, or skilled nursing and medical care on an inpatient basis;
- (b) but only if that institution: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of Physicians; and provides Nurses' services.

Specialist: The term Specialist or Specialty Physician means a Physician who provides specialized services, and is not engaged in general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics.

Specialty Care Unit: A section, ward, or wing within a Hospital that offers specialized care for the patient's needs. Such a unit usually provides constant observation, special supplies, equipment, and care provided by Registered Nurses or other highly trained personnel. Examples include Intensive Care Units (ICU) and Cardiac Care Units (CCU).

Specialty Prescription Drug Product (Medical): A Medical Pharmaceutical considered by Cigna to be a Specialty Prescription Drug Product based on consideration of the following factors, subject to applicable law: whether the Medical Pharmaceutical is prescribed and used for the treatment of a complex, chronic or rare condition; whether the Medical Pharmaceutical has a high acquisition cost; and, whether the Medical Pharmaceutical is subject to limited or restricted distribution, requires special handling and/or requires enhanced patient education, provider coordination or clinical oversight. A Specialty Prescription Drug Product may not possess all or most of the foregoing characteristics, and the presence of any one such characteristic does not guarantee that a Medical Pharmaceutical will be considered a Specialty Prescription Drug Product. Specialty Prescription Drug Products may vary by plan benefit assignment based on factors such as method or site of clinical administration, or utilization management requirements based on factors such as acquisition cost. You may determine whether a medication is a Specialty Prescription Drug Product through the website shown on your Membership Identification Card or by calling Member Services at the telephone number on your Card.

Speech Therapist or Speech Pathologist: A person legally licensed and authorized under the laws of the state or jurisdiction where the services are rendered, to practice Speech Therapy.

Speech Therapy: The use of special techniques for correction of speech and language disorders. For Speech Therapy expenses to be paid under the Benefit Plans, it must be ordered by a Physician and must be for the restoration of lost speech due to a diagnosed illness or injury.

Spouse: Any individual to whom a Participant is lawfully married under State law, including an individual married to a Participant of the same sex if the individual and the Participant were legally married in a State that recognizes such marriages even if they are domiciled in a State that does not recognize such marriages. The terms “marriage” and “married” refer to a legal union between a Participant and another individual that is recognized under State law as a marriage. Marriage does not include other types of formal relationships recognized by a State, such as domestic partnerships or civil unions, regardless of whether the individuals in those relationships have the same rights and responsibilities as individuals who are married under State law. A divorced spouse is not a Spouse. A spouse from whom a Participant is legally separated, but not divorced, will nonetheless be considered a Spouse unless the separation agreement provides otherwise in accordance with applicable State law.

Stabilize: Stabilize means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Substance Abuse: Alcohol and/or drug dependency as defined by the current edition of the ICD-9-CM manual or successor.

Surgery: Any operative or diagnostic procedure performed in the treatment of an Injury or Illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Fund Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan benefits.

Temporomandibular Joint (TMJ) Syndrome: Jaw joint disorders, including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Terminal Illness: A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

Therapist: See the definition of Health Care Practitioner.

Therapeutic Alternative (Medical): A Medical Pharmaceutical that is of the same therapeutic or pharmacological class, and usually can be expected to have similar outcomes and adverse reaction profiles when administered in therapeutically equivalent doses as, another Medical Pharmaceutical or over-the-counter medication.

Therapeutic Equivalent (Medical): A Medical Pharmaceutical that is a pharmaceutical equivalent to another Medical Pharmaceutical or over-the-counter medication.

Tort, Tortfeasor: A Tort is a civil wrong or injury, typically arising from a negligent or intentional act of an individual. The individual committing the tort is called a Tortfeasor.

Total Disability, Totally Disabled: To the extent not otherwise defined in the text of this document or by an insurance contract with the Fund, the inability of a Covered Employee to perform the duties of his or her occupation with the Employer as a result of an Illness or Injury, or the inability of a Covered Dependent to perform the normal activities or duties of a person of the same age and sex as a result of an Illness or Injury.

Urgent Care: Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by Cigna, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

Urgent Care Facility: A public or private free-standing facility, not located on the premises of or operating in conjunction with a Hospital, that is licensed or legally operating, that primarily provides minor Emergency and episodic medical care, in which one or more Physicians, Registered Nurses, and x-ray technicians are in attendance at all times the facility is open, and that includes x-ray and laboratory equipment and a life support system.

Utilization Review Provider: The company selected by the Board of Trustees to manage the Plan's Utilization Review Program including review your care and evaluate requests for approval of coverage to assess the Medical Necessity for the services and supplies, review the appropriateness of the Hospital or other Health Care Facility requested and determine the approved length of confinement or course of treatment. In addition, the company may engage in other aspects of utilization management such as second surgical opinion and/or pre-admission testing requirements, concurrent review, discharge planning and Case Management.

Utilization Management Company: Cigna Health and Life Insurance Company and / or an organization associated with or contracted by Cigna.

Well Baby Care; Well Child Care: Health care services provided to a newborn or Child through age eighteen (18) that are determined by the Plan to be Medically Necessary even though they are not provided as a result of Illness, Injury or Congenital Abnormality.

You, Your: When used in this document, these words refer to a Participant (an Employee who is eligible for coverage under the Benefit Plan).

