U.A. Local 125
Health and Welfare Fund

Benefits Booklet
2022 Edition

Contents

1. INTRODUCTION

The U.A. Local 125 Health and Welfare Fund maintains several benefit Plans that together provide a comprehensive set of benefits. This Benefits Booklet is your guide to those benefits. It describes your rights and obligations under each Plan. This Booklet supersedes all plan documents and summary plan descriptions that have previously been issued by the U.A. Local 125 Health and Welfare Fund.

The Plans provide many benefits to help maintain your health and save you money. But you must understand your benefits to take advantage of them. There is a table of contents at the front of the Booklet. This will help you find information on particular benefits. Capitalized terms throughout this Booklet have the meanings given in the Definitions section of the Uniform Terms for Plans and Programs of the U.A. Local 125 Health and Welfare Fund, which is located at the end of this Booklet. We encourage you to review all the documents in this Benefits Booklet. Keep this book in a place where you will have access to it when you need to file a claim.

We have tried to describe all of your benefits as completely as possible in everyday language. However, if you have any questions, please call the Fund Office. The only people authorized to answer your questions are the Board of Trustees and the Fund Office.

Periodically, the Trustees may amend one or more of the documents in this Booklet. If that happens, you will receive a notice of the amendment called a "summary of material modification" ("SMM"). Be sure to keep any SMMs you receive with this Booklet, as the terms of the SMM will supersede this Booklet.

The Board of Trustees has the sole discretion and authority to administer the Fund and its Plans and to make final determinations regarding an individual's eligibility, any application for benefits, and the interpretation and administration of the Fund's trust agreement, the Plans, and any associated administrative rules. The Trustees' decisions in such matters are final and binding on all persons dealing with the Fund or claiming a benefit under a Plan. The Board of Trustees is the sole and exclusive fact-finder with respect to the Fund and the Plans. The Board of Trustees may delegate any portion of its authority to another person or entity by written agreement, in which case a decision under delegated authority will have the same effect as a decision by the Board of Trustees. If the Fund makes inadvertent, mistaken, excessive, erroneous, or fraudulent payment of benefits, the Trustees or their representative will have the right to recover these types of payments. The Trustees reserve the right to change, modify, or discontinue all or part of the benefits in this Booklet at any time by action or amendment.

2. IMPORTANT CONTACT INFORMATION

For information about:	Contact:	At:
• Eligibility • Medical or prescription drug benefit questions • Dental benefits • Vision benefits • Death benefits • Claims and appeals regarding the above • Prior authorization for medical benefits • Finding an In-Network Healthcare Provider • Obtaining the current list of Specialty drugs and Formulary drugs	Fund Office	800-929-8007 or 319-362-7977 Submit appeals to: Eastern Iowa Fringe Benefit Funds, Inc. 1831 16th Avenue SW Cedar Rapids, Iowa 52404 Provider locator: aetna.com/individuals-families/find-a-doctor.html
• Finding medical clinical policies	Aetna	aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins.html#
• Locating an In-Network Pharmacy • Prior authorization for prescription drugs • Finding prescription drug Prior Authorization, step-therapy, and quantity limit policies	Express Scripts	Call the number on the back of your ID card express-scripts.com/index.html Pharmacy locator: express-scripts.com/NATPLSNOFORM/index.html
• Obtaining Specialty prescription drugs	Accredo	800-803-2523 accredo.com/getting_started
• E-visit	Teladoc	teladoc.com/Aetna 855-835-2362

3. YOUR RESPONSIBILITIES

You must notify the Fund Office of certain events or changes in your status which occur during the year. Notify the Fund Office when you:

- Become eligible for Medicare
- Get married or divorced
- Gain or lose a Dependent
- Change your address (including email address)
- Change your telephone number
- Gain or lose other insurance
- Want to change your designated beneficiary

Call the Fund Office when you:

- Receive workers' compensation benefits
- Receive benefits arising out of an automobile accident
- Enter or are discharged from the uniformed services of the United States
- Plan to retire

4. HOW YOU CAN HELP CONTAIN COSTS

There are a number of things you can do to help contain costs for your family and for everyone in the Fund.

- Go to Healthcare Providers who are In-Network – The Fund has contracted with Aetna, which has negotiated discounted rates with providers for nearly all types of services.
- Fill your prescription at In-Network retail pharmacies—The Fund has contracted with Express Scripts to provide you with access to a network of retail pharmacies that have agreed to charge negotiated rates for prescription medications.
- Take generic medications instead of brand name medications whenever possible and approved by your doctor. Request generic drugs when your physician is writing you a prescription. You can also ask the pharmacist if a generic equivalent is available if your doctor prescribes a brand-name medication.
- Review receipts and explanations of benefits ("EOBs") carefully—if you ever receive an EOB or bill from a hospital that is incorrect, notify the provider, the applicable PPO, and the Fund Office.
- Whenever possible, use outpatient services (including outpatient surgery) rather than obtaining services on an inpatient basis.
- Only use the emergency room in an actual emergency. An emergency room is the most expensive place to obtain care and as a general rule should not be used for minor illness such as sore throats, ear infections, etc. Use urgent care facilities or your own physician whenever possible for these situations.
- Use an e-visit for diagnosis and prescriptions for common medical conditions such as the flu, colds, sinus infections, eczema, and rashes. An e-visit takes less time and costs less than visiting a clinic in person.

5. ELIGIBILITY FOR BENEFITS

Employees and their Dependents who satisfy the Fund's Eligibility requirements participate in the following benefit plans:

Type of Participant	**Benefit Plans**
Journeymen and Apprentices	Health Plan (including Rx) Dental Plan Vision Plan Health Reimbursement Arrangement Death Benefit Plan
Retirees	Health Plan (including Rx) Dental Plan Vision Plan Health Reimbursement Arrangement
Dependents of Journeymen, Apprentices, and Retirees	Health Plan (including Rx) Dental Plan Vision Plan
Non-Collectively-Bargained Employees and their Dependents	Health Plan (including Rx) Dental Plan Vision Plan

A. Hour Bank (Journeymen/Apprentices)

Your Eligibility generally depends on the number of hours for which your Employer is required to contribute to the Fund on your behalf. The Fund maintains a notional account of your work hours as reported by your Employer. This account is called your Hour Bank. When the Fund receives a contribution on your behalf, the Fund adds to your Hour Bank the number of hours your Employer reported to the Fund in connection with the contribution. The hours you work are generally reflected in your Hour Bank by the second calendar month following the month in which you worked. Once you become Eligible, hours are subtracted from your Hour Bank to maintain your Eligibility. If contributions on your behalf exceed the amount required to maintain Eligibility, you will accumulate excess hours in your Hour Bank up to a maximum of 8,600 hours. You may contact the Fund Office for your Hour Bank balance.

The balance of your Hour Bank will be automatically reduced to zero if your Eligibility is terminated because:

- You became Medicare-eligible;[1]
- You voluntarily ceased working for a Contributing Employer;

[1] If you have a positive balance in your Hour Bank when you become Medicare-eligible (for any reason), the Fund will credit your account under the U.A. 125 Health Reimbursement arrangement with an amount that is equal in value to the balance of your Hour Bank immediately before termination of your Eligibility.

- You began working for a non-contributing employer in the plumbing and pipefitting industry;
- You began working in a job classification for which your Employer is not required to contribute to the Fund; or,
- You continued working for an Employer that is delinquent in paying contributions or any other amounts due to the Fund after being notified of the Employer's delinquent status.

The Trustees may periodically adjust the number of hours in your Hour Bank to account for changes in the amount per hour that your Employer is required to contribute to the Fund on your behalf. The Hour Bank does not represent a vested benefit. The Fund's Plans may be amended at any time to modify or eliminate your Hour Bank.

B. Eligibility Quarters

Once you become Eligible, ongoing Eligibility is determined quarterly. Eligibility Quarters are defined as the following three-month periods:

- February 1 through April 30;
- May 1 through July 31;
- August 1 through October 31; and,
- November 1 through January 31.

Generally, Eligibility for Journeymen and Apprentices works as follows:

Hours Worked In…	**…Provide Eligibility In**
January, February, March	May 1 through July 31
April, May, and June	August 1 through October 31
July, August, and September	November 1 through January 31
October, November, and December	February 1 through April 30

C. Journeymen Eligibility

You will become Eligible on the first day of the month following the month in which:

- You are an Employee of a Contributing Employer in a job classification for which your employer is required to contribute to the Fund, or of an employer who is party to a collective bargaining agreement with a local union of the United Associated of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada; and,
- You are a Journeymen; and,

- You have accumulated at least 430 hours in your Hour Bank within the immediately preceding 12-months; and,
- You have submitted complete and accurate enrollment forms to the Fund Office.

When you first become Eligible as a Journeymen, the Fund will subtract hours from your Hour Bank to maintain your Eligibility for the remainder of the current Eligibility Quarter. The Fund will subtract 430hours if Eligibility begins in the first month of an Eligibility Quarter, 287 hours if Eligibility begins in the second month, or 143 hours if Eligibility begins in the third month.

After the Eligibility Quarter in which you first become Eligible, you will be Eligible throughout every following Eligibility Quarter where:

- You were Eligible at the end of the immediately preceding Eligibility Quarter; and,
- You have at least 430 hours in your Hour Bank at the beginning of the Eligibility Quarter.

At the beginning of each Eligibility Quarter in which you maintain your Eligibility, the Fund will subtract 430 hours from your Hour Bank.

If, at the beginning of an Eligibility Quarter, you were Eligible at the end of the immediately preceding Eligibility Quarter but you have fewer than 430 hours in your Hour Bank, you may make a self-payment to maintain your Eligibility or you may elect COBRA Eligibility. The Fund Office will notify you of the amount of the required self-payment and COBRA premium. The amount of the required self-payment will be "affordable" as defined by 26 U.S.C. § 4980H. You must pay by check. You may self-pay for Eligibility (in part or in whole) for no more than five consecutive quarters. If you elect COBRA Eligibility, you waive your right to self-pay Eligibility. If the Fund Office does not receive your self-payment before the Eligibility Quarter to which the self-payment applies, you may no longer elect to self-pay and your only option to maintain Eligibility is COBRA Eligibility.

Your Eligibility will terminate at 11:59 PM Central on the earliest of the following dates:

- The date the Plan is terminated;
- The last day of the Eligibility Quarter in which you voluntarily stop working for a Contributing Employer[2];
- The last day of the Eligibility Quarter containing the 18th month in a period of 18 consecutive months during which no Employer contributions were made on your behalf[3];
- The last day of the Eligibility Quarter in which you begin working for a non-contributing employer in the plumbing and pipefitting industry;
- The last day of the Eligibility Quarter in which you are no longer working in a job classification for which your Employer is required to contribute to the Fund;

[2] If you stop working involuntarily (e.g., because a project ended) and you subsequently fail to secure work for any contributing employer, you will be deemed to have voluntarily stopped working.
[3] This clause (pertaining to 18 months without contributions) goes into effect on September 1, 2022.

- The last day of the Eligibility Quarter in which you continued working for an Employer that is delinquent in paying contributions or any other amounts due to the Fund after being notified of the Employer's delinquent status;
- The last day of the Eligibility Quarter that is immediately followed by a Eligibility Quarter for which you failed to maintain Eligibility by having 430 hours in your Hour Bank or making the appropriate self-payment[4];
- The last day of the Eligibility Quarter that is the fifth consecutive Eligibility Quarter for which you made a self-payment to maintain Eligibility (unless you accumulated 430 hours in your Hour Bank within the Eligibility Quarter) [5];
- The date of your death.

D. Apprentice Eligibility

You will become Eligible on the first day that you are employed as an Apprentice by a Contributing Employer. When you first become Eligible, the Fund will add 525 hours to your Hour Bank. Thereafter, Apprentice Eligibility is maintained according to the same rules that apply to Journeymen Eligibility, with the following exceptions:

- You may make self-payments to maintain Eligibility for up to six consecutive Eligibility Quarters (as opposed to five Eligibility Quarters for Journeymen Eligibility).
- The Fund may loan 430 hours to your Hour Bank, which must be repaid after you commence Eligibility as a Journeymen. Contact the Fund Office for information on receiving a loan.

Apprentice Eligibility is terminated according to the same rules that apply to termination of Journeymen Eligibility.

E. Retiree Eligibility

When you retire from working for a Contributing Employer, you may qualify for Retiree benefits from the Fund. For information on when you will be considered "Retired", see the definition of Retired in the Uniform Terms For U.A. Local 125 Health And Welfare Benefit Plans.

You will become Eligible as a Retiree on the first day of the Eligibility Quarter following the Eligibility Quarter in which you satisfy all of the following criteria:

- You have at least 15 years of uninterrupted Eligibility as a member of, and working in the jurisdiction of, the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada;

[4] You may extend Eligibility under COBRA if your Eligibility terminates for this reason. You may not extend Eligibility with COBRA (or self-pay) if your Eligibility terminates for any reason that does not have a footnote to the contrary.
[5] You may extend Eligibility under COBRA if your Eligibility terminates for this reason.

- You have been Eligible (or covered by another plan associated with the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada) for the five immediately preceding years;
- You have attained at least age 55;
- You are not Eligible as a result of self-payments;
- You have Retired;
- You have submitted complete and accurate enrollment forms for Retiree Eligibility to the Fund Office; and,
- You have 430 hours in your Hour Bank or you have submitted the required self-payment for the first Eligibility Quarter of Retiree Eligibility.

If you have sufficient hours in your Hour Bank when you first become Eligible as a Retiree, the Fund will subtract 430 hours from your Hour Bank for your Eligibility Quarter as a Retiree.

Retiree Eligibility is maintained according to the same rules that apply to Journeymen Eligibility, with the exception that you may make self-payments to maintain Eligibility until you become eligible for Medicare.

Your Retiree Eligibility will terminate at 11:59 PM Central on the earliest of the following dates:

- The date the Plan is terminated;
- The last day of the Eligibility Quarter that is immediately followed by an Eligibility Quarter for which you failed to maintain Eligibility by having 430 hours in your Hour Bank or timely making the appropriate self-payment;
- The day immediately preceding the day you become eligible for Medicare;
- The date of your death.

F. Post-Retirement Employment

If you are receiving retiree benefits from the Fund, your decision to return to employment could affect your benefits.

- If you return to work after gaining Eligibility as a Retiree and you perform more than 39.5 hours of work in a month, your Eligibility will terminate at the end of that month.
- If you return to work for a Contributing Employer performing less than 39.5 hours of work per month, you may continue receiving Retiree benefits from the Fund (so long as you satisfy the other requirements for maintaining your retiree Eligibility). Contributions the Fund receives with respect to your work will not be credited to your Hour Bank or your HRA account.
- If you return to work for a non-union employer that performs services within the jurisdiction of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada, your retiree Eligibility will terminate immediately. This rule

applies regardless of whether you specifically are performing work within the jurisdiction of the U.A.

- Termination of your Eligibility for post-retirement employment will result in the loss of your remaining bank hours (if any).
- The Fund may inquire as to your current employment status. If you fail to timely respond to such an inquiry, the Fund will terminate your Eligibility. The loss of Eligibility will be irrevocable unless you demonstrate that the failure to respond was beyond your control (and that you were not working such that your Eligibility should have been terminated for post-retirement employment).
- If your Retiree Eligibility is terminated due to post-retirement employment, you may, at a later date, become Eligible as a journeyman by meeting the general requirements for journeyman Eligibility. If that occurs, Retiree Eligibility is not available. You may not transition from journeyman to Retiree Eligibility twice.

G. Dependent Eligibility

Your Dependent will become Eligible as follows:

- If your Dependent qualified as a Dependent before the first day of your Eligibility and you submitted enrollment forms to the Fund Office providing complete and accurate information regarding your Dependent, your Dependent becomes Eligible on the day you become Eligible.
- If you are Eligible on the day an individual becomes your Dependent (due to birth, adoption, marriage, etc.) the individual becomes Eligible on the day the individual qualifies as your Dependent if you submit to the Fund Office complete and accurate enrollment forms within 90 days of the event that results in the individual becoming a Dependent.
- If your Dependent meets all criteria for Eligibility as a Dependent except that you did not timely submit to the Fund Office complete and accurate enrollment information regarding your Dependent, your Dependent becomes Eligible on the date the Fund Office receives complete and accurate enrollment forms.

If you have more than one Dependent, each Dependent will become Eligible by separate application of the above rules.

Upon enrollment and any time thereafter, the Fund may require satisfactory proof that your Dependent qualifies for Dependent status. If you fail to respond or fail to provide proof within a reasonable period following the Fund's request, the Fund will presume that your Dependent does not qualify as a Dependent. Any denial of Eligibility based on this presumption is final. If you subsequently provide satisfactory proof of Dependent status, the Fund will not provide retroactive Eligibility. For information on qualifying as a Dependent, see the definition of Dependent in the Uniform Terms For U.A. Local 125 Health And Welfare Benefit Plans at the end of this Booklet.

Once your Dependent becomes Eligible, your Dependent remains Eligible until Eligibility is terminated. If you are a Journeymen or an Apprentice, your Dependent's Eligibility will terminate at 11:59 PM Central on the earliest of the following dates:

- The date that your Eligibility is terminated (unless otherwise provided in this section);
- The last day of the month in which your Dependent ceases to be a Dependent.

If your Eligibility terminates due to your death, your Dependents as of the date of your death may maintain their Eligibility with your Hour Bank. If you have fewer than 430 hours in your Hour Bank, your Dependents may make a self-payment to maintain eligibility or may elect COBRA Eligibility. Your Dependents may self-pay for Eligibility for no more than five consecutive quarters. Making a self-payment is a waiver of COBRA Eligibility.

If you are a Retiree, your Dependent's Eligibility will be terminated according to the above rules with the exception that, if your Eligibility is terminated due to Medicare eligibility, your Dependent's Eligibility will not terminate on account of your loss of Eligibility so long as you make self-payments for your Dependent's Eligibility. You may maintain your Dependent's Eligibility under this exception until the earlier of the date your Dependent qualifies for Medicare, or the date that is five years from the date your Eligibility was terminated. When you have exhausted your right to use this exception, Eligibility terminates for your Dependent.

To the extent that this section on Dependent Eligibility pertains to Spouses, it is modified by the Working Spouse Rule. In any case where a Spouse is Eligible under this section but is not Eligible under the Working Spouse Rule, the Spouse is not Eligible.

You must contact the Fund Office within 30 days if an event occurs that causes your Dependent's Eligibility to terminate (e.g., a divorce). If you fail to notify the Fund Office within 30 days and the Fund makes payments for charges incurred after your Dependents' Eligibility should have been terminated, you or your Dependent must repay the Fund within 10 days of receiving a request for repayment. If you or your Dependent do not timely repay the Fund, the Fund may offset the amount you owe against any unpaid benefits to which you would otherwise be entitled, take legal action to collect the repayment from you, or take any other action authorized by law.

H. Working Spouse Rule

Under the "Working Spouse Rule", if your Spouse has health coverage available through his or her employer at a cost of $125 per month or less, then your Spouse must enroll in his or her employer's health plan. If the Working Spouse Rule applies to your Spouse, he or she will not be Eligible to receive benefits from the Fund at any time that your Spouse is not covered by his or her employer's health plan. Employer-sponsored coverage costs $125 or less if your Spouse's required contribution toward the monthly cost of coverage is $125 or less, regardless of whether the contribution is made with taxable income, by pre-tax wage deduction, or through a health reimbursement arrangement, health savings account, or flexible spending account. If your Spouse has coverage available for $125 or less, your Spouse will remain Eligible so long as he or she enrolls in some employer-sponsored coverage. For instance, if your Spouse's employer offers single-only coverage for $100 per month or family coverage for $200 per month, your Spouse satisfies the working spouse rule if she enrolls in either coverage option.

When your Spouse is covered by his or her employer's health plan, the Fund's Plans will coordinate benefits with the other plan. The other plan will be primary. After the other plan has paid a claim, submit the expenses that the other plan did not reimburse to the Fund Office for reimbursement in accordance

with the Fund's Plans. For more information on how benefits coordinate between plans, see the subsection of the Benefits Booklet entitled "Coordination of Benefits with Other Plans".

You must provide any information that the Fund requests to determine whether the Working Spouse Rule applies to your Spouse. If you fail to respond within a reasonable period following the Fund's request, the Fund will terminate your Spouse's Eligibility until you provide the requested information. Your Spouse's Eligibility will not be retroactively reinstated if you subsequently provide the requested information. If employer-sponsored coverage becomes available to your Spouse such that this rule applies, you must notify the Fund Office within 30 days. If you fail to timely notify the Fund Office and the Fund makes payments in excess of the amount that would have been paid under the Working Spouse Rule, you must repay the Fund within 10 days of receiving a request for repayment. If you do not timely repay the Fund, the Fund may offset the amount you owe against any unpaid benefits to which you would otherwise be entitled, take legal action to collect the repayment from you, or take any other action authorized by law. The Working Spouse Rule does not apply to Non-Collectively Bargained Employees.

I. COBRA Eligibility (All Eligible Individuals)

If your Eligibility terminatesdue to COBRA qualifying event, you may elect to pay for COBRA Eligibility. COBRA Eligibility will begin on the day immediately following the day that your previous Eligibility under the Plan terminated. Under COBRA Eligibility, your benefits will generally be the same as under your previous Eligibility. Death benefits do not continue under COBRA Eligibility. You must pay a monthly premium for COBRA Eligibility. For information about COBRA Eligibility premiums, contact the Fund Office. This section of this Booklet is intended to fulfill the initial notice requirements under 26 U.S.C. § 4980B(f)(6).

A COBRA qualifying event occurs for you or your Dependents when you or your Dependents cease to be Eligible because:

- Your hours were reduced; or,
- Your employment was terminated (for any reason other than gross misconduct).

A COBRA qualifying event occurs for your Dependent(s) (and not you) when your Dependent(s) lose Eligibility because:

- You died;
- You were divorced or legally separated;
- Your Child ceased qualifying as a Dependent; or,
- You became eligible for Medicare.

The Fund will determine whether a reduction of hours or termination occurred. If you get divorced or your Child ceased qualifying as a Dependent, you must notify the Fund Office within 60 days. If you do not provide timely notice, you and your Dependents will lose your right to COBRA. The Fund will notify you within 30 days of becoming aware that a qualifying event occurred. To elect COBRA, you must notify the Fund Office within 60 days of the date you receive notice of your right to elect COBRA.

If the COBRA qualifying event is a reduction in hours or termination of employment, the maximum period of COBRA Eligibility for you and your Dependents is 18 months beginning on the day of the qualifying event. However, if a second qualifying event occurs during this 18-month period, the maximum period of COBRA Eligibility extends to 36 months from the date of the first qualifying event (for the individuals for whom the second event is a qualifying event). If the qualifying event is divorce, separation, failure to continue qualifying as a Dependent, or Medicare eligibility, the maximum period of COBRA Eligibility is 36 months.

If you or one of your Dependents is totally disabled at the time of an initial qualifying event (or within 60 days of the initial qualifying event) as determined by the Social Security Administration, the maximum period of COBRA Eligibility for the disabled individual is 29 months. You must notify the Fund Office within 60 days of the date that Social Security determines that you or your Dependent is totally disabled.

If you have a qualifying event due to termination or reduction of hours within 18 months of becoming eligible for Medicare and your Medicare eligibility was not a qualifying event for your Dependents (because they did not lose Eligibility), the Maximum period of COBRA Eligibility for your Dependents due to the termination qualifying event is 36 months from the date of your Medicare eligibility.

Your COBRA Eligibility will end on the earliest of the following dates:

- The date you fail to timely pay the COBRA premium;
- The date on which the applicable maximum period of COBRA Eligibility ends;
- The date on which the Fund or a Plan terminates;
- The date you become covered under another group health plan;
- The date you become entitled to Medicare benefits; or
- The date you engage in conduct that would justify terminating Eligibility of a similarly situated individual with non-COBRA Eligibility (such as fraud).

J. Military Leave Eligibility (Journeymen/Apprentices)

If you are Eligible and you leave work with a Contributing Employer for military service that lasts more than 30 days, your Hour Bank will be frozen and you will have the option to elect military leave Eligibility. During the time you are on military leave, you should be covered under a health insurance program provided through the military. However, you may elect to continue Eligibility under the Plan for yourself and your Dependents by notifying the Fund Office within 60 days of the start of your military leave. If you elect to continue Eligibility, you will be required to make payments for Eligibility according to the rules for COBRA Eligibility. The maximum period of military leave Eligibility is the lesser of:

- The 24-month period beginning on the date on which your military leave began; or
- The period beginning on the date on which the military leave began, and ending on the day you fail to timely apply for or return to a position of covered employment with a Contributing Employer.

If you return from a military leave and resume employment with a Contributing Employer before the end of the maximum period of Eligibility, your Hour Bank will be unfrozen and the Eligibility you had before your military service leave will resume.

K. Eligibility of Non-Collectively Bargained Employees and their Dependents

Non-collectively bargained employees and their Dependents may become Eligible if their employer enters into a written Participation Agreement with the Fund. Enrollment and Eligibility rules for such individuals will be as specified in the Participation Agreement. Notwithstanding anything to the contrary: a non-collectively bargained employee or his or her Dependent who would otherwise become Eligible under a Participation Agreement will not become Eligible if such Eligibility would cause a Plan or the Fund to fail to satisfy the non-bargained participation limits under 29 C.F.R. § 2510.3-40 or 26 C.F.R. § 1.419A-2T; and, the working spouse rule does not apply to non-collectively bargained employees.

L. Rescission of Eligibility

The Fund will rescind – or retroactively void – Eligibility as permitted by applicable law, including, without limitation, 29 C.F.R. § 2590.715-2712. The Fund will rescind your Eligibility (and your Dependent(s)') if, by act or omission, you (or your Dependent(s)) intentionally misrepresent a material fact or commit fraud in obtaining or maintaining Eligibility. If the Fund determines to rescind Eligibility in part or in whole, the Fund will notify you 30 days in advance of the rescission. You may appeal the decision. See "How to Appeal" under the Uniform Terms for U.A. Local 125 Health And Welfare Benefit Plans for more information. If the Fund rescinds your Eligibility, you and your Dependents are jointly and severally liable to the Fund in an amount equal to any payments the Fund made to or for you or your Dependents on account of the Eligibility that was rescinded. For more information, see "Right to Recover" under the Uniform Terms for U.A. Local 125 Health And Welfare Benefit Plans.

6. PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION OF THE U.A. LOCAL 125 HEALTH PLAN

A. Introduction

This Plan is generally designed to mitigate and limit the financial harm that you experience as a result of an unexpected Injury or Illness. It is not designed to cover every healthcare expense, nor is it designed to make healthcare decisions for you. The decisions about how and when you receive care are up to you, not the Plan. The Plan merely determines whether and how much it will reimburse for healthcare expenses. You must decide what care is best for you.

B. Participation

You become a Participant in this Plan when you become Eligible for benefits from the Fund (see the section of this Benefits Booklet entitled "Eligibility For Benefits" for information on when you become Eligible for benefits from the Fund). You cease to be a Participant in this Plan when your Eligibility for benefits is terminated. The same rule applies separately to each of you and your Dependents.

C. Covered Expenses

1. In General

The Plan provides benefits for Covered Expenses, which generally include physician, hospital, skilled nursing facility, prescription drug, and Preventive Care expenses. Specifically, an expense is a Covered Expense if:

a. The expense is for Medically Necessary items or services for treatment of a non-occupational Illness or Injury[6] or for Preventive Care, and,

b. The expense is not expressly excluded by this Plan.

2. Limitations

Coverage of certain expenses is limited and conditioned as described below. To the extent that an expense exceeds a limitation or fails to meet a condition, it is excluded and is not a Covered Expense.

a. The portion of an expense that exceeds the Allowed Amount is not a Covered Expense.

b. All Covered Expenses are limited as described in the applicable PPO's coverage criteria to the extent that such criteria are not inconsistent with this Plan. To review coverage criteria, see the website that is identified under the applicable PPO in the Important Contact Information section at the beginning of this Booklet or contact the Fund Office.

c. Covered Expenses for durable medical equipment are limited to rental unless the cost of rental equals or exceeds the purchase price.

[6] An expense for sterilization need not be for treatment of a non-occupational Illness or Injury to satisfy the condition of coverage described in this clause.

d. Covered Expenses for room and board during inpatient treatment are limited to the semi-private room rate.

e. Prior Authorization is required: for certain Prescription Drugs; for organ transplants; for non-emergency inpatient services; for outpatient surgery; and when required by the applicable PPO's coverage criteria. To review coverage criteria, see the website that is identified under the applicable PPO in the Important Contact Information section at the beginning of this Booklet or contact the Fund Office. See the section of this Booklet entitled Important Contact Information for information about who to contact for Prior Authorization.

f. Covered Expenses for prescription drugs do not include expenses for drugs that are not included in the Plan's Formulary at the time that the expense is incurred.

g. Step therapy is a prerequisite to coverage for certain prescription drugs.

D. Your Costs For Covered Expenses

This Plan will reimburse you a portion of your Covered Expenses up to the limits and under the conditions established by the Plan. How a Covered Expense is divided between you and the Plan depends on the Deductible, Copayment, Coinsurance, Maximum Out-Of-Pocket, the Allowed Amount, and whether you incurred the Covered Expense In-Network or Out-Of-Network. These rules apply differently to different types of Covered Expenses – for specific information on how they apply, see the reimbursement schedule below. Note that what you pay and what the Plan reimburses are determined only for Covered Expenses. Expenses you incur for healthcare that are not Covered Expenses[7] are solely your responsibility. Such expenses do not count toward any Deductible or Maximum Out-Of-Pocket and are not subject to a Copayment or Coinsurance.

1. Deductible

A Deductible is a total amount of Covered Expenses for Essential Health Benefits that you must pay before the Plan will reimburse any part of any expense.[8] Expenses for items and services that are not Essential Health Benefits do not count toward any Deductible. Deductibles apply on an individual basis and a family basis. If you incur Covered Expenses exceeding the individual Deductible within a calendar year, you have met the individual Deductible and any further Covered Expenses you incur will be reimbursed by the Plan according to the applicable Copayment, Coinsurance, and Maximum Out-Of-Pocket.[9] If your family incurs Covered Expenses exceeding the family Deductible within a calendar year, you have met the family Deductible and any further Covered Expenses you or your Dependents incur will be reimbursed by the Plan according to the applicable Copayment, Coinsurance, and Maximum Out-Of-Pocket. At the beginning

[7] For instance, expenses for items or services that are expressly excluded by the Plan, or the portion of an expense that exceeds the Allowed Amount.

[8] Note, however, that some Covered Expenses (e.g., Preventive Care and prescription drugs) are not subject to a Deductible.

[9] This rule applies separately to each individual in your Family.

of each calendar year, all Deductibles reset. See the section of this Plan entitled "Reimbursement Schedule" for Deductible amounts.

2. Copayment

A Copayment is a fixed dollar amount (e.g., $25) that you pay for a Covered Expense. The Plan covers the portion of a Covered Expense that exceeds the Copayment. If a Covered Expense is less than the applicable Copayment, you pay the actual Covered Expense. Copayments do not count toward any Deductible or Maximum Out-Of-Pocket (In-Network Copayments do count toward the cost-sharing limit).

3. Coinsurance

Coinsurance is a percentage of a Covered Expense for which the Plan will not reimburse you. The Plan will reimburse the remainder of the expense. Coinsurance applies only after you have met the applicable Deductible. Coinsurance payments do not count toward any Deductible, but do count toward your Maximum Out-Of-Pocket. See the section of this Plan entitled "Reimbursement Schedule" for coinsurance percentages for specific items and services.

4. Maximum Out-Of-Pocket

The Maximum Out-Of-Pocket is the most you will pay in Coinsurance in any calendar year for Covered Expenses. Amounts you pay that count toward a deductible do not count toward any Maximum Out-Of-Pocket. There are Maximum Out-Of-Pocket amounts for each individual and family, and separate Maximum Out-Of-Pocket amounts for In-Network and Out-Of-Network expenses. Expenses accumulate toward the individual and family Maximum Out-Of-Pocket concurrently, but expenses accumulate toward the In-Network and Out-Of-Network Maximum Out-Of-Pockets separately. For instance, if you pay coinsurance for an In-Network Covered Expense, the amount paid will count toward your In-Network individual and family Maximum Out-Of-Pocket but it will not count toward your Out-of-Network individual and family Maximum Out-Of-Pocket. If you, your Dependent, or your Family reaches an applicable Maximum Out-Of-Pocket, the Plan will pay 100% of the applicable Covered Expenses for the remainder of the calendar year. Each Maximum Out-Of-Pocket resets each calendar year. Expenses for items and services that are not Essential Health Benefits do not count toward any Maximum Out-Of-Pocket. See the section of this Plan entitled "Reimbursement Schedule" for Maximum Out-Of-Pocket amounts.

5. Limit on Cost-Sharing

The total amount you actually pay towards In-Network Deductibles, Coinsurance, and Copayments for Covered Expenses that are Essential Health Benefits will not exceed the annual individual and family cost-sharing limits under the Affordable Care Act (42 U.S.C. § 300gg–6(b)), as adjusted annually by U.S. Department of Health and Human Services regulations. Out-Of-Network expenses do not count toward the limits on cost-sharing. Amounts that you do not pay, or that are reimbursed by a third party (for instance, by a manufacturer's coupon or patient assistance program), do not count toward the limits on cost-sharing.

6. In-Network vs. Out-Of-Network

The Plan has contracted with Preferred Provider Organizations, through which the Plan receives significant discounts from healthcare providers within the PPO networks. In general, you may incur Covered Expenses with an Out-Of-Network provider and still receive benefits.[10] But you and the Plan will spend

[10] Some items and services that are covered In-Network may not be covered Out-Of-Network.

less when you choose In-Network providers. For information on how to locate and contact In-Network healthcare providers, see the back of your ID card or the section entitled Important Contact Information at the beginning of this Benefits Booklet.

The Plan's rules for determining what you pay and what the Plan will reimburse often differ depending on whether a Covered Expense was incurred In-Network or Out-Of-Network. In cases where the rules are different, the Plan will usually reimburse a greater share of an In-Network Covered Expense than an Out-Of-Network Covered Expense. For information on how Deductibles, Coinsurance, Copayments, and Maximum Out-Of-Pockets apply In-Network and Out-Of-Network, see the section of this Plan entitled "Reimbursement Schedule".

When you incur Covered Expenses with an In-Network healthcare provider, the Plan deems the negotiated rates for the items and services you receive to be the Allowed Amount. The Plan has no negotiated rates with Out-Of-Network healthcare providers. Before applying any other payment rules, the Plan determines whether an Out-Of-Network expense exceeds the Allowed Amount. If an Out-of-Network expense exceeds the Allowed Amount, the excess is not a Covered Expense. The Plan will not pay anything toward that portion of the expense, and the healthcare provider will "balance bill" you for it. You will never be "balance billed" for an In-Network expense.

7. Billing

Deductibles, Coinsurance, Copayment, Maximum-Of-Pocket, and Network rules will generally be applied separately to each charge for which a Healthcare Provider bills you. Healthcare Providers typically bill a number of charges for one service event. As a result, a single service event may result in charges to which different rules apply.[11] A single service event may result in both In-Network and Out-Of-Network charges.[12] A single service event may result in separate invoices that are received at different times. The Fund may determine benefits with respect to an item, service, or encounter based on modifications to your provider's invoices that correct inaccuracies, duplications, and attempts to inflate the value of the items or services provided beyond the intrinsic value.

8. Hidden Out-Of-Network Services

When you visit an In-Network facility, some of the expenses you incur may be from Out-Of-Network providers. We call these "Hidden Out-Of-Network Services". To the extent that the Plan can determine you incurred expenses for Out-Of-Network services during a visit to an In-Network facility, the Plan will apply the In-Network Deductible, Coinsurance, and Copayment (as applicable) and the charges will count toward the In-Network Maximum Out-Of-Pocket and the limits on cost-sharing.

The Plan will pay an amount toward Hidden Out-of-Network Services, or take other action, so as to prevent the provider from "balance billing" you – i.e., holding you liable for amounts that exceed your cost-sharing obligations under the Plan. If the Plan determines that a provider's payment demands for Hidden Out-of-Network Services are excessive, the Plan may refuse to pay a portion of the invoiced amount. In such a case, however, the Plan will indemnify and defend you against any claims the provider may make against you for the unpaid amount.

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[11] For instance, some charges from a service event may be Preventive Care with the remainder being subject to the general rule for Covered Expenses.

[12] For example, an In-Network provider may order laboratory or radiology services from an Out-Of-Network provider.

Note that this rule is a very limited exception to the general rules for determining the Allowed Amount. You should not rely on this exception to apply when, by reasonable diligence, you can determine that a provider is out-of-network before incurring expenses. For instance, if your physician recommends an MRI and refers you to a clinic with a different name than your physician's clinic, you must determine whether the radiology clinic is in-network before incurring expenses – even if the radiology clinic happens to be in the same building or office complex.

9. Out-Of-Network Emergency Services

If you receive Emergency Services at an Out-Of-Network Hospital while you are experiencing an Emergency, the Plan will apply special reimbursement rules to the Covered Expenses for Emergency Services. The In-Network Deductibles and Maximum Out-Of-Pocket will apply. In-Network Coinsurance and Copayments will apply. To the extent that a visit to an Out-Of-Network Hospital results in services that are not Emergency Services, the rules in this section do not apply. If, for example, you are stabilized in an Emergency room and then admitted to the same Hospital for surgery, this rule ceases to apply once you are stabilized. The inpatient and surgery expenses would be subject to the Plan's general rules for Out-Of-Network expenses.

10. Medical vs. Prescription Drug Expenses

The Plan applies different reimbursement rules to expenses for prescription drugs and medical items and services. The prescription drug rules apply to expenses that are directly for the procurement of prescription drugs. The medical rules apply to all other expenses. Expenses associated with a prescription drug that are not for the drug itself, such as expenses for laboratory testing or infusion services, are reimbursed under the rules for medical expenses. The site of care does not change whether an expense is a medical or prescription drug expense. For instance, if you receive a drug at a healthcare provider's office instead of a pharmacy, the expense for the drug is still a prescription drug expense.

11. Reimbursement Schedule

U.A. Local 125 Health Plan
Medical Deductible (per calendar year): $500/individual and $1000/family (In-Network) $1,000/individual and $2,000/family (Out-of-Network) Medical Maximum Out-of-Pocket (per calendar year): $1,000/individual and $2,000/family (In-Network) $2,000/individual and $4,000/family (Out-of-Network) Prescription Drug Deductible: None Prescription Drug Maximum Out-of-Pocket: None Cost-Sharing Limits (In-Network Medical and Prescription Drug Combined): $8,550/individual and $17,100/family per calendar year (for 2021, amounts adjusted annually in later years per regulations)

Type of Benefit	In-Network	Out-of-Network	Notes
All Covered Expenses not listed in this schedule	15% Coinsurance	35% Coinsurance	None
Ambulance	15% Coinsurance	35% Coinsurance	Not Covered: Non-emergency ambulance transportation; Air ambulance.
Chemical Dependency	15% Coinsurance	35% Coinsurance	None
Emergency COVID-19 Coverage	0%	0%	Includes test, administration of test, and evaluation to determine whether test is necessary. Coverage excludes testing for non-medical purposes (e.g., travel, work). Emergency COVID-19 coverage ends when the COVID-19 national emergency ends.

Type of Benefit	In-Network	Out-of-Network	Notes
Dental Care As A Result Of Injury To Or Care For Mouth, Teeth and Gums	15% Coinsurance	35% Coinsurance	Charges will be covered under the Health Plan only if for the following: surgically impacted wisdom teeth; fractured jaws, within 6 months of the date of injury; replacement of natural teeth due to accidental injury, within 6 months of the date of injury; other incision or excision procedures on the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth such as: alveolar abscesses, alveolectomies, apicoectomies (resection of root of tooth), cysts of jaws, epulis (fibrous tumor of the gum). Charges for anesthesia will be covered under medical benefits for children age 18 and younger and disabled dependents, on all teeth, if medically necessary. Not Covered: Dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.
Durable Medical Equipment	15% Coinsurance	35% Coinsurance	None
Emergency Room Care	15% Coinsurance	15% Coinsurance	Emergency room expenses are not covered unless you are experiencing an Emergency.

Type of Benefit	In-Network	Out-of-Network	Notes
Home Health Care	15% Coinsurance	35% Coinsurance	Covered only for care and treatment when Hospital or Skilled Nursing Facility confinement would otherwise be required. Diagnosis, care and treatment plan must be certified by the attending physician and contained in a Home Health Care Plan.
Inpatient Services	15% Coinsurance	35% Coinsurance	Charges for room and board are limited to the semi-private room rate. Room charges by a Hospital having only private rooms will be paid at the actual private room rate.
Mental Health	15% Coinsurance	35% Coinsurance	Not covered: Charges for marital, relationship, family or other counseling or training services, religious counseling, or sex therapy.
Oncological Care and Treatment	15% Coinsurance	35% Coinsurance	None

Type of Benefit	In-Network	Out-of-Network	Notes
Organ Transplant Services	15% Coinsurance	35% Coinsurance	Prior Authorization is required. Contact the Fund Office for Prior Authorization. Related expenses of the donor are covered. Donor screening tests for any full sibling potential donors are covered. Up to $10,000 per transplant for transportation and reasonable living expenses for the recipient and one other individual (or in the case of a minor, two other individuals), if the recipient lives more than 100 miles from the designated transplant facility.
Outpatient Services	15% Coinsurance	35% Coinsurance	None
Physician Services	15% Coinsurance	35% Coinsurance	None

Type of Benefit	In-Network	Out-of-Network	Notes
Prescription Drugs (Non-Specialty - Retail)	Generic drugs (retail): greater of $10 Copayment or 10% Coinsurance Brand drugs (retail): greater of $30 Copayment or 30% Coinsurance	Generic drugs (retail): greater of $10 Copayment or 10% Coinsurance Brand drugs (retail): greater of $30 Copayment or 30% Coinsurance	Retail covers up to a 90-day supply with 3 Copayments. Certain drugs are subject to Prior Authorization, step-therapy, or quantity limits. If you choose a brand drug when a generic equivalent is available and the brand drug was not specifically prescribed, you pay the difference in cost between the brand and generic in addition to the brand drug coinsurance/copayment (your cost will not exceed the total cost of the drug). Any drug that is not on the Formulary will not be covered and you will pay 100% of the cost. Specialty drugs are not covered at retail.

Type of Benefit	In-Network	Out-of-Network	Notes
Prescription Drugs (Non-Specialty – Mail Order)	Generic drugs (mail-order/online): greater of $20 Copayment or 10% Coinsurance, Deductible does not apply Brand drugs (mail-order/online): greater of $60 Copayment or 30% Coinsurance, Deductible does not apply	Generic drugs (mail-order/online): greater of $20 Copayment or 10% Coinsurance, Deductible does not apply Brand drugs (mail-order/online): greater of $60 Copayment or 30% Coinsurance, Deductible does not apply	Mail order and online cover up to 90-day supply. Certain drugs are subject to Prior Authorization, step-therapy, or quantity limits. If you choose a brand drug when a generic equivalent is available and the brand drug was not specifically prescribed, you pay the difference in cost between the brand and generic in addition to the brand drug coinsurance/copayment (your cost will not exceed the total cost of the drug). Any drug that is not on the Formulary will not be covered and you will pay 100% of the cost. See below for information on Specialty drugs.

Type of Benefit	In-Network	Out-of-Network	Notes
Prescription Drugs (Specialty)	Greater of $30 Copayment or 30% Coinsurance, up to a maximum of $100 per prescription or refill per 30-day supply	Not Covered	Specialty drugs are not covered unless obtained from the Plan's designated specialty pharmacy. Certain drugs are subject to Prior Authorization, step-therapy, or quantity limits. If you choose a brand drug when a generic equivalent is available and the brand drug was not specifically prescribed, you pay the difference in cost between the brand and generic in addition to the brand drug coinsurance/copayment (your cost will not exceed the total cost of the drug). Any drug that is not on the Formulary will not be covered and you will pay 100% of the cost.
Preventive Care	0% Coinsurance	0% Coinsurance	For a current list of items and services that are Preventive Care, see https://www.healthcare.gov/coverage/preventive-care-benefits/ Preventive care also includes certain preventive screenings at events organized by the Plan. Not covered as preventive care: Any expense that would ordinarily be covered as a diagnostic expense.

Type of Benefit	In-Network	Out-of-Network	Notes
Rehabilitative Services	15% Coinsurance	35% Coinsurance	Physical and occupational therapy services are covered if the rehabilitative care is to correct the effects of Illness or Injury. To be considered rehabilitative, functional improvement and measurable progress must be made toward achieving functional goals within a predictable period of time toward a Participant's maximum potential ability.
Skilled Nursing Facility	15% Coinsurance	35% Coinsurance	Confinement must begin within 14 days of hospitalization that was 3 days or more in duration. Successive periods of confinement are considered one period of confinement for purposes of determining maximum benefits payable unless: the later confinement is due to causes entirely unrelated to the causes of the prior confinement; or the periods of confinement are separated by 180 calendar days during which the eligible person is confined neither to a Hospital nor to a Skilled Nursing Facility.
Urgent Care	15% Coinsurance	35% Coinsurance	None

E. Expenses That Are Excluded From Coverage

Notwithstanding anything to the contrary, the following are not Covered Expenses and are excluded from coverage under this Plan:

1. An expense for an item or service that is not Medically Necessary.
2. An expense to the extent that it exceeds the Allowed Amount.
3. An expense for an item or service that is Experimental or Investigative.

4. An expense that is not a Covered Expense, or to the extent that the expense is not a Covered Expense.

5. An expense to the extent that coverage of the expense is contrary to any term of this Plan regardless of whether the relevant term is located in the section of this Plan entitled "Expenses That Are Excluded From Coverage".

6. An expense for an item or service for which Prior Authorization was required and either Prior Authorization was not sought or Prior Authorization was denied.

7. An expense excluded by the applicable PPO's coverage criteria to the extent that such criteria are not inconsistent with this Plan. To review coverage criteria, see the website that is identified under the applicable PPO in the Important Contact Information section at the beginning of this Booklet or contact the Fund Office.

8. An expense for an item or service that is not described in 26 U.S.C. § 213(d) (which defines tax-deductible medical care).

9. An expense for any item or service that is not furnished or rendered for the treatment of, or in connection with, an Illness or Injury, unless the item or service is for Preventive Care.

10. An expense you incurred more than one year before the date you (or another person on your behalf) submitted a Claim for coverage of the expense.

11. An expense for an item or service provided before you became a Participant or after your participation was terminated.

12. An expense you are not liable to pay, or with respect to which you have an arrangement or understanding that your liability will be reduced or eliminated if the Plan denies coverage.

13. An expense for which a person or entity other than you or the Plan is or may be liable to pay.[13]

14. An expense to the extent that a third-party (i.e., a person or entity other than you or the Plan) pays the expense, reimburses you for the expense, or otherwise acts to relieve you of the economic burden of paying the expense.

15. An expense for which a third party may be liable and for which you did not submit the required acknowledgement of the Fund's first priority right of subrogation and reimbursement to the Fund. The term "third party" means any individual, insurer, entity, or federal, state or local government agency, which is or may be in any way legally obligated to reimburse, compensate, or pay for a participant's loss, damages, injuries, or claims relating in any way to the injury, occurrence, condition, or circumstance giving rise to the Fund's provision of medical, or dental benefits, including but not limited to, insurers

[13] See the section of this Plan entitled "First Priority Right of Subrogation and Reimbursement" for further information regarding expenses that may or may not be another party's responsibility.

providing liability, medical expense, wage loss, uninsured motorist or underinsured motorist coverages.

16. An expense arising out of or related to an injury, occurrence, condition or circumstance for which you have received a recovery or the Fund deems it likely a recovery will be received. This means that claims submitted after the participant receives a recovery that are related to the recovery will be excluded from coverage. The amount of future related claims that will be excluded from coverage is the full amount of the recovery. This exclusion applies to any recovery received by a participant regardless of how it is characterized, including, but not limited to any apportionment to a spouse for loss of consortium

17. An expense for treatment of an Illness or Injury that results from or is related to your employment or occupation or that is covered (or claimed to be covered) under workers' compensation or employer liability laws.

18. An expense for an item or service furnished or rendered by any federal or state governmental institution or facility, except to the extent that this exclusion is prohibited by law.

19. An expense for an item or service furnished to or rendered to a person who is not a Participant in this Plan, including, without limitation, an expense related to surrogate pregnancy.

20. An expense for an item or service furnished to or rendered to you by a person who is your relative.

21. An expense related to complications resulting from, or reversal of, any treatment, procedure, or surgery, the expenses of which do not qualify as Covered Expenses.

22. An expense for an item or service that is for personal comfort or convenience, including, without limitation: air conditioners, air purifiers, humidifiers, de-humidifiers, allergy-free pillows, blankets, mattress covers, orthopedic mattresses, articles of clothing, shoes, whirlpools, swimming pools, elevators, or stair lifts.

23. An expense for items or services rendered in an emergency room when you are not experiencing an Emergency.

24. An expense for non-durable medical equipment (e.g., blood pressure monitors).

25. An expense for treatment of an Injury or Illness that is connected to your commission, or attempted commission, of an act that the Board of Trustees determines in its sole discretion to be illegal.

26. An expense for educational, recreational, or milieu services, or other forms of non-medical self-care or self-help training.

27. An expense for diagnostic, radiology, or laboratory services that are not applicable to your diagnosis, except as specifically provided by the Plan.

28. An expense for nutritional support taken orally, except an expense for special medical foods for the treatment of phenylketonuria or maple syrup urine disease and except to the extent this exclusion is prohibited by law.

29. An expense for a regular food product, including, without limitation: a food thickener; a regular grocery product that can be used with an enteral system (whether taken orally or parenterally); a special infant formula; a food supplement; and, a vitamin or mineral taken orally.

30. An expense for biomedical feedback treatment.

31. An expense for Retin-A.

32. An expense for a prescription drug that is not on the Plan's Formulary.

33. An expense for a prescription drug where prior authorization, step therapy, or quantity limits apply and the requirements of prior authorization, step therapy, or quantity limits are not met.

34. An expense for an antiviral drug (e.g., Tamiflu (oseltamivir) and Relenza (anamivir)), except if the drug constitutes Preventive Care.

35. An expense for a drug that is available over-the-counter (i.e., a drug that may be legally obtained without a prescription).

36. An expense related to sexual dysfunction, including an expense for a drug that is prescribed for treatment of erectile dysfunction.

37. An expense for a drug that is prescribed for off-label use (i.e., use in a manner that is inconsistent with the drug's FDA-approved labeling, such as treatment of a disease that the FDA has not approved the drug to treat).

38. Expenses for repetitive drug testing.

39. An expense related to an abortion or complications from an abortion, except if the abortion was Medically Necessary to treat an Illness or Injury.

40. An expense related to treatment for obesity (or a comorbidity of obesity if there is also a diagnosis of obesity), except to the extent that the Plan is prohibited by law from excluding the expense from coverage. Examples of expenses excluded under this paragraph include gastric bypass surgery, bariatric surgery, weight loss clinics, appetite suppressants, etc.

41. An expense for an item or service that is primarily for cosmetic purposes such as an expense related to cosmetic surgery, except if the cosmetic surgery is: for the treatment of an Injury; incidental to surgery resulting from trauma, infection, or other disease of the involved part covered by the Plan; due to congenital disease or anomaly of a Dependent child covered by this Plan which has resulted in a functional defect; or required to be Covered by federal law.

42. An expense related to participation in a program specializing in the treatment of chronic pain.

43. An expense related to laboratory work performed by or ordered by a chiropractor.

44. An expense related to radial keratotomy surgery, eximer laser surgery, lasik, or any other refractive surgery.

45. Expenses for room and board, except if incurred during an inpatient stay at a Hospital.

46. An expense, to the extent that it is covered by no-fault auto insurance or, if you were required by law to have no-fault auto insurance and did not, to the extent that the expense would have been covered by no-fault auto insurance if you had carried the statutory minimum coverage.

47. An expense for treatment of an Injury that resulted from the use of a Motorized Vehicle to the extent that it is covered by Motorized Vehicle insurance.

48. An expense for treatment of an Injury that resulted from the use of your Motorized Vehicle when you did not have personal injury coverage, except to the extent that a portion of the expense, when aggregated with all other personal injury expenses you incurred as a result of Injury, exceeds $5,000 or the maximum personal injury coverage available in your state, if less.

49. An expense for services rendered by a massage therapist, or an expense for massage therapy.

50. An expense for long-term care including, without limitation, an expense for treatment that is not expected to result in an improvement in diagnosis or prognosis.

51. An expense related to surgery for temporomandibular joint dysfunction or any related condition.

52. An expense related to or for a wig.

53. An expense for the treatment of any Injury sustained in a physical contest, such as boxing, wrestling, hard man, or stunt man contests.

54. An expense for items or services provided mainly as a rest cure, maintenance, or Custodial Care.

55. An expense for acupuncture.

56. An expense for marital, family or other counseling or training services, religious counseling, or sex therapy.

57. An expense for hearing aids and or exams related to their fitting.

58. An expense for or relating to a cochlear device.

59. An expense for services that are normally provided without charge, including services of the clergy.

60. An expense for an autopsy.

61. An expense for vitamins or vitamin therapy.

62. An expense for the donor for major organ and bone marrow transplants when the recipient is not covered under the Plan; including all transplant-related follow-up treatment, exams, drugs and drug therapies, and complications from transplants.

63. An expense for dental or oral care, including dental x-rays, except as specified in the payment schedule of this Plan.

64. An expense for Hospital room and board that exceeds the semiprivate room rate.

65. An expense for ambulance service except transportation by ground ambulance in an Emergency to the nearest medical facility equipped to treat the Illness or Injury.

66. An expense for transport by air ambulance.

67. An expense for or related to transportation by any means other than ambulance.

68. An expense for travel, transportation, or living expenses, whether or not recommended by a Healthcare Provider.

69. An expense for medical care out of the United States if travel is for the sole purpose of obtaining medical care.

70. An expense for growth hormones.

71. An expense for orthotics, shoes or shoes inserts for the treatment of feet, unless prescribed by a physician and custom-fitted for the patient at a maximum of $300.00 per year for orthotics only.

72. An expense for private-duty nursing.

73. An expense for therapy submitted under procedure codes 97535, 97537 and 97545. Therapies including but not limited to self-care, home management training (activities of daily living) and compensatory training, meal preparation, safety procedures, and instructions in the use of adaptive equipment; community/work reintegration training (shopping, transportation, money management, vocation activities and/or work environment/modification analysis, work task analysis) and work hardening/conditions.

74. An expense for inpatient admission to the Hospital for diagnostic tests that can be performed on an outpatient basis.

75. An expense for inpatient surgery that is generally performed on an outpatient basis, unless such admission is Medically Necessary.

76. An expense for reversal of sterilization.

77. An expense for long-term storage of ova or sperm.

78. An expense for artificial insemination, in vitro fertilization or in vivo fertilization.

79. An expense for an elective abortion or related to an abortion except for expenses incurred, (a) which result directly from complications of an abortion, (b) for an abortion when the covered female's life would be endangered, if the fetus were to be carried to term, or (c) when the pregnancy is a result of an assault.

80. An expense for genetic screening, genetic counseling, services for genetic screening and testing, except (a) tests to check for mutations in genes BRCA1 and BRCA2 and (b) Cologuard colon cancer screening when such tests would constitute Preventive Care.

81. An expense for services for or related to functional capacity evaluations for vocational purposes and/or determination of disability or pension benefits.

82. An expense for a physical exam for purpose of obtaining employment, licensure, or insurance.

83. An expense for services and supplies related to court-ordered examinations.

84. An expense for services to hold or confine a person under chemical influence when no medical services are required regardless of where the services are received.

85. An expense that is due to war or any act of war, whether declared or undeclared, or any act of international armed conflict involving the armed forces of an international body.

86. An expense for the completing of claim forms (or any forms required by the Plan for the processing of claims) by a physician or other provider of medical services or supplies.

87. An expense for rental or purchase of any durable medical equipment or other equipment that is not used solely for the therapeutic or medical treatment of a single Participant's Injury or Illness.

88. An expense for replacement of durable medical equipment more frequently than once each 60 months.

89. An expense for items or services furnished or provided due to past or present service in the armed forces of a government.

90. An expense incurred in connection with any Injury or Illness for which you are not under the regular care of a Physician.

91. An expense incurred in connection with special home construction to accommodate a disabled person.

92. An expense for an Injury sustained in connection with air travel while racing, doing aerobatics or stunt flying, or while flying for testing or experimental purposes.

93. An expense for education, training, or room and board while you are confined in an institution which is primarily a school or institution of learning or training.

94. An expense incurred while confined in an institution which is primarily a place of rest, a place for the aged, or a nursing home unless the home is a Skilled Nursing Facility.

95. An expense for chiropractic care, treatment, or services.

96. An expense for or related to cellular or gene therapy, including, without limitation, an expense for a prescription drug, laboratory test, or physician visit for or related to cellular therapy or gene therapy.

97. An expense for Aducanumab (marketed as Aduhelm or otherwise)(this drug is a treatment for Alzheimers).

98. An expense that the Trustees determine to be the result of a billing error, billing designed to substantially inflate the cost of the services provided beyond the intrinsic value, or fraudulent billing.

F. Additional Plan Terms

The provisions of the section of this Booklet entitled "Uniform Terms For Plans And Programs Maintained By The U.A. Local 125 Health and Welfare Fund" are incorporated into this Plan in their entirety. There you will find definitions of capitalized terms, information regarding how to file a claim or appeal a denial of benefits, and other important information about the Plan.

7. PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION OF THE U.A. LOCAL 125 DENTAL PLAN

A. Introduction

This Plan provides certain benefits for dental care. It is not designed to cover every dental expense, nor is it designed to make dental care decisions for you. The decisions about how and when you receive care are up to you, not the Plan. The Plan merely determines whether and how much it will pay. You must decide what care is best for you.

B. Participation

Except if you decline to participate, you become a Participant in this Plan when you become eligible for benefits from the Fund (see the section of this Benefits Booklet entitled "Eligibility For Benefits" for information on when you become Eligible for benefits from the Fund). You cease to be a Participant in this Plan when your eligibility for benefits is terminated unless you extend your participation under COBRA. The participation rules apply separately to each of you and your Dependents. You may decline to participate in this Plan at any time by notifying the Fund Office in writing.[14]

C. Covered Expenses, Your Costs For Covered Expenses

This Plan will reimburse you for Allowed Amount of expenses you incur for necessary dental care. The maximum amount that this Plan will reimburse you for dental care expenses you incur within any calendar year is $300. This maximum reimbursement amount applies separately to each of you and your Dependents. Coverage for Preventive Services provided to Dependent Children under the age of 18 are not subject to the calendar year maximum benefit amount.

A dental expense is generally considered incurred on the date the item or service giving rise to the expense was performed or furnished. However, when one overall charge is submitted for all or part of a course of treatment, the expense is considered incurred on the date the dental care provider: took the impression and prepared the abutment for a prosthetic device (such as a full or partial denture); or prepared the tooth for a crown, inlay or onlay; or opened the tooth for root canal therapy.

D. Expenses That Are Excluded From Coverage

Notwithstanding anything to the contrary, this Plan will not pay benefits for:

1. Expenses that would be excluded from coverage under the U.A. Local 125 Health Plan (regardless of whether the expenses would qualify as Covered Expenses under the U.A. Local 125 Health Plan).
2. Expenses for services or supplies which are not necessary according to accepted standards of dental practice.

[14] The U.A. Local 125 Dental Plan provides only "excepted benefits" as described in 29 U.S.C. § 1191a.

3. Expenses for any duplicate appliance or prosthetic device.

4. Expenses for new denture or bridgework, if the existing denture or bridgework can be made serviceable.

5. Expenses for oral hygiene, plaque control programs or dietary instructions.

6. Expenses for implants, including any appliances and/or crowns and the surgical insertion or removal of implants.

7. Expenses associated with the initial installation of dentures for bridgework replacing a tooth or a group of teeth which were lost when not eligible to participate in the Plan.

8. Expenses for myofunction therapy.

9. Expenses for treatment other than by a licensed Dentist or licensed physician, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of and billed for by the Dentist.

10. Expenses for orthodontic care, treatment, services and supplies.

11. Expenses for procedures, restorations, and appliances to change vertical dimension or to restore occlusion (proper contact between opposing teeth). Occlusal guards and space maintainers are covered subject to dental necessity.

12. Expenses for replacement of lost, missing or stolen appliances, including both prosthetic devices and orthodontic appliances.

13. Expenses for crowns, fillings, or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

14. Expenses for non-surgical treatment, procedures or appliances for TMJ.

E. Additional Plan Terms

The provisions of the section of this Booklet entitled "Uniform Terms For Plans Maintained By The U.A. Local 125 Health and Welfare Fund" are incorporated into this Plan in their entirety. There you will find definitions of capitalized terms, information regarding how to file a claim or appeal a denial of benefits, and other important information about the Plan.

8. PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION OF THE U.A. LOCAL 125 VISION PLAN

A. Introduction

This Plan provides certain benefits for vision care. It is not designed to cover every vision expense, nor is it designed to make vision care decisions for you. The decisions about how and when you receive care are up to you, not the Plan. The Plan merely determines whether and how much it will pay. You must decide what care is best for you.

B. Participation

Except if you decline to participate, you become a Participant in this Plan when you become eligible for benefits from the Fund (see the section of this Benefits Booklet entitled "Eligibility For Benefits" for information on when you become eligible for benefits from the Fund). You cease to be a Participant in this Plan when your eligibility for benefits is terminated unless you extend your participation under COBRA. The participation rules apply separately to each of you and your Dependents. You may decline to participate in this Plan at any time by notifying the Fund Office in writing.[15]

C. Covered Expenses, Your Costs For Covered Expenses

This Plan will reimburse you for the Allowed Amount of expenses you incur for necessary vision care. The maximum amount that this Plan will reimburse you for vision care expenses you incur within any two-year period is $200. This maximum reimbursement amount applies separately to each of you and your Dependents. Coverage for Preventive Services provided to Dependent Children under the age of 18 are not subject to the calendar year maximum benefit amount.

D. Expenses That Are Excluded From Coverage

Notwithstanding anything to the contrary, this Plan will not pay benefits for:

1. Expenses that would be excluded from coverage under the U.A. Local 125 Health Plan (regardless of whether the expenses would qualify as Covered Expenses under the U.A. Charges incurred for services, treatment or supplies related to medical or surgical treatment of the eyes.
2. Expenses for lenses ordered without a prescription.
3. Expenses for special procedures, such as orthoptics, vision training, subnormal vision aids or aniseikonia.

E. Additional Plan Terms

The provisions of the section of this Booklet entitled "Uniform Terms For Plans Maintained By The U.A. Local 125 Health and Welfare Fund" are incorporated into this Plan in their entirety. There you will find

[15] The U.A. Local 125 Vision Plan provides only "excepted benefits" as described in 29 U.S.C. § 1191a.

definitions of capitalized terms, information regarding how to file a claim or appeal a denial of benefits, and other important information about the Plan.

9. U.A. LOCAL 125 ACTIVE HEALTH REIMBURSEMENT ARRANGEMENT

A. Introduction

This Plan provides benefits to reimburse you for Medical Care Expenses you or your Dependents incur that are not reimbursable by another source. Examples of expenses that may be reimbursed under this Plan include amounts you pay toward a Deductible or Coinsurance under the Health Plan and amounts you are required to pay to maintain your Eligibility for benefits from the Fund.

B. Participation

Only individuals who are Eligible for benefits from the Fund by virtue of employment may participate in this Plan. Individuals who are Eligible for benefits from the Fund by virtue of being a Dependent may not participate in this Plan.

Except if you decline to participate, you become a Participant in this Plan when you are Eligible for benefits from the Fund and the Fund has received a contribution to this Plan on your behalf (see the section of this Benefits Booklet entitled "Eligibility For Benefits" for information on when you become Eligible for benefits from the Fund). You may decline to participate in this Plan at any time by notifying the Fund Office in writing. Once you become a Participant, you remain a Participant until your participation is terminated.

Your participation in this Plan is terminated upon the earliest of the following:

1. The date this Plan is terminated;
2. The date you notify the Fund Office in writing that you wish to cease participating in this Plan;
3. The date on which you meet all of the following criteria: you are not a Participant in the Health Plan; and the Fund has not received contributions on your behalf (or self-payments) during the preceding 180 days;
4. The date you become a Retiree.

If you Retire and then return to work on a later date, you will immediately become a participant in this Plan again.

C. Contributions

Only your employer may contribute to this Plan on your behalf, and only in the amount required by a Collective Bargaining Agreement or Participation Agreement. You may not contribute to this Plan. Your employer may not make salary reduction contributions or contributions over which you exercise control.

D. HRA Account

When you become a Participant in this Plan, a notional account ("HRA Account") will be established for you. The HRA Account is merely a record-keeping account – it is not a separate fund and no assets are segregated for any individual Participant.

The balance of your HRA Account on any date will equal the sum of all contributions received by the Plan on your behalf and any earnings allocated to you, less the sum of all benefits that have been paid to you and any Plan expenses that have been allocated to you.

The Board of Trustees will determine if and when Plan earnings or Plan expenses will be allocated among Participant accounts. If earnings are allocated among Participant accounts, they will be allocated pro-rata. If plan-level expenses are allocated among Participant accounts, they will be allocated per capita. Expenses that are directly attributable to a specific Participant, such as check fees, will be allocated to the specific Participant. Upon termination of your Participation in this Plan, you forfeit the balance of your HRA Account.

If you Retire and then return to work on a later date, the balance of your account on the date that you become a participant in this Plan again will be equal to the balance of your account under the U.A. Local 125 Retiree Health Reimbursement Arrangement on the date you ceased to be a Retiree.

E. Benefits

This Plan will reimburse you for Medical Care Expenses you incur for yourself or your Dependents while you are a Participant in this Plan so long as the Medical Care Expenses are not reimbursable from another source. The maximum reimbursable amount with respect to any Medical Care Expense is either the full amount of the Medical Care Expense or the balance of your HRA Account when you submit a Claim for reimbursement, whichever is less.

Benefits will not be paid unless you submit a Claim to the Fund Office providing all information the Fund Office deems necessary to determine that you are entitled to payment. You must submit a Claim for reimbursement to the Fund Office within one year of the date you incur a Medical Care Expense. Benefits will not be paid until you have incurred at least $25 in reimbursable Medical Care Expenses. For additional information on submitting Claims, see the "Payment, Claims, and Appeals" section of the Uniform Terms For Plans Maintained By The U.A. Local 125 Health and Welfare Fund.

"Medical Care Expenses" generally are expenses described under Code § 213 (d). Examples of Medical Care Expenses include amounts you pay toward a Deductible or Coinsurance under the Health Plan, amounts you are required to pay to maintain your eligibility for benefits from the Fund, and expenses for medically necessary healthcare that is not covered under the health plan. Any expenses you (or your Dependents) incur when not covered by a Minimum Value health plan (such as the U.A. Local 125 Health Plan) are not Medical Care Expenses. This Plan will not reimburse you for any expenses you or your Dependents incur while you or your Dependents, as applicable, are not covered by a Minimum Value health plan. A Medical Care Expense is incurred at the time the item or service giving rise to the expense is furnished, and not when you are formally billed for the item or services. Medical Care Expenses incurred before you become a Participant or after your participation is terminated are not reimbursable. A Medical Care Expense is only reimbursable to the extent the expense is not reimbursable from any other source.

If only a portion of a Medical Care Expense is reimbursable from another source, the remaining portion is reimbursable under this Plan.

F. Reimbursement of Dependent Medical Care Expenses

Upon your death, the Plan will continue to reimburse Medical Care Expenses for your Dependents until the earliest of the following:

- There is no balance remaining in your HRA Account; or
- Your Dependents cease to be eligible for benefits from the Fund.

G. Additional Plan Terms

This Plan is intended to qualify as an employer-provided medical reimbursement arrangement under Code §§ 105 and 106 and regulations issued thereunder, and as a Health Reimbursement Arrangement as defined under IRS Notice 2002-45, and will be interpreted to accomplish that objective. The Medical Care Expenses reimbursed under the Plan are intended to be eligible for exclusion from Participants' gross income under Code § 105(b). This Plan is intended to be "integrated" as described in Technical Release 2013-3. Reimbursements to highly compensated individuals may be limited or treated as taxable compensation to comply with Code §105(h), as may be determined by the Board of Trustees in its sole discretion. All of the amounts payable under this Plan shall be paid from the general assets of the Fund. Nothing herein will be construed to require the Board of Trustees to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Fund from which any payment under this Plan may be made. The provisions of the section of this Booklet entitled "Uniform Terms For Plans Maintained By The U.A. Local 125 Health and Welfare Fund" are incorporated into this Plan in their entirety.

10. U.A. LOCAL 125 RETIREE HEALTH REIMBURSEMENT ARRANGEMENT

This Plan provides benefits to reimburse you for Medical Care Expenses you or your Dependents incur that are not reimbursable by another source. The terms of this Plan are the same as those of the U.A. Local 125 Active Health Reimbursement Arrangement except as expressly stated in this Plan.

You become a Participant in this Plan when you become a Retiree. You cease to be a participant in this Plan on the earliest of the following: the date you cease to be a Retiree; the date that the balance of your account is $0; the date this Plan is terminated; the date you notify the Fund Office in writing that you wish to cease participating in this Plan.

No contributions may be made to this Plan by any person. Refunds of erroneously made payments and similar payments related to the administration of this Plan are not contributions.

The initial balance of your account is the amount that was in your account under the U.A. Local 125 Active Health Reimbursement Arrangement on the date you became a Retiree.

You (and your Dependents) do not need to be covered by a Minimum Value health plan to qualify for reimbursement under this Plan. The term Medical Care Expenses, as defined in the U.A. Local 125 Active Health Reimbursement Arrangement, will be construed accordingly for purposes of this Plan.

This Plan does not need to be integrated.

11. PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION OF THE U.A. LOCAL 125 DEATH BENEFITS PLAN

The Fund will pay a death benefit of $6,000 to your Beneficiary if you die while you are a Participant in this Plan. If you do not designate a Beneficiary, or if your designated Beneficiary does not survive you, benefits will be paid: to your surviving spouse; or if none, then to your surviving natural and adopted children; or if none, then to your surviving parent(s); or if none, then to your estate. Benefits will be paid equally among surviving children or surviving parents. Contact the Fund Office for a Beneficiary designation form if you wish to change your Beneficiary designation. Payment will be promptly made in a lump sum after the Fund Office receives a satisfactory application for benefits from your Beneficiary.

Only individuals who are Eligible for benefits from the Fund by virtue of collectively-bargained employment and not eligible for Medicare benefits may participate in this Plan. Individuals who are retired or who are eligible for benefits from the Fund by virtue of being a Dependent or by virtue of non-collectively-bargained employment may not participate in this Plan. Except if you decline to participate, you become a Participant in this Plan when you become eligible for benefits from the Fund (see the section of this Benefits Booklet entitled “Eligibility For Benefits” for information on when you become eligible for benefits from the Fund). Once you become a Participant, you remain a Participant until your participation is terminated. Your participation in this Plan is terminated when you cease to be Eligible for benefits from the Fund.

The provisions of the section of this Booklet entitled “Uniform Terms For Plans Maintained By The U.A. Local 125 Health and Welfare Fund” are incorporated into this Plan in their entirety.

12. UNIFORM TERMS FOR PLANS MAINTAINED BY THE U.A. LOCAL 125 HEALTH AND WELFARE FUND

A. Payment, Claims, and Appeals

1. Claims and Appeals Procedures, In General

Below is the standard claims and appeal procedure for all the Plans. The purposes of these procedures are to ensure that benefits are distributed promptly and in accordance with the Plans, and, to assist the Trustees in determining the Fund's financial state, to provide finality with respect to Fund liabilities for benefits within a reasonable period (generally, one year). If the Fund contracts with a PPO to provide claims or appeal adjudication services, that PPO's claims and appeals procedures will supplement the standard claims and appeal procedures. To the extent that a PPO's claims and appeals procedures are inconsistent with the standard claims and appeal procedures, the standard claims and appeals procedures will apply. A PPO appeal procedure that calls for two levels of appeal will not be considered inconsistent with the Plans' standard procedures. See the Important Contact Information section of this Booklet for information on filing claims and appeals. Notwithstanding anything to the contrary, the Plans' Claims and appeals will be administered in accordance with 29 C.F.R. § 2560.503-1.

2. What is a Claim?

A Claim is a request that satisfies all of the following:

- The request is from you or on your behalf for payment by the Fund of an expense you incurred, or for Prior Authorization, or for payment of a benefit to which you believe you are entitled;
- The request is in writing to the Fund Office and on the appropriate form provided by the Fund Office, or the request is formatted and submitted in the manner required by the claims procedures of the applicable PPO[16];
- The request provides the information necessary to determine whether the expense is payable under the applicable Plan, or whether Prior Authorization can be granted, or whether you are entitled to payment; and,
- The request is received by the Fund within one year of the date you incurred the expense or became entitled to the benefit and the request does not pertain to an expense or benefit for which you have previously filed a Claim.

Each year you must submit a completed family information form to the Fund Office. If you do not provide a complete and accurate family information form by the deadline stated on the form, any request for payment the Fund or a PPO receives will not be considered a Claim until you submit a satisfactory form. If the Fund or a PPO receives a request for payment of expenses you incurred as a result of an accident, the request will not be considered a Claim until you have submitted a completed subrogation form to the Fund Office. If the Fund receives a request for payment of expenses and there is reason to believe that that a person or entity other than you or the Fund may be liable for those expenses, the request will not

[16] If you are unsure which PPO is appropriate for your Claim, contact the Fund Office. See the Important Contact Information section of this Booklet for PPO appeal information.

be considered a Claim until you have submitted a completed subrogation agreement to the Fund Office. If you submit a request for payment but do not provide all of the required information, your request will not be considered a Claim until you provide all required information. If you do not perfect your Claim until after the timely filing period has elapsed, your Claim will be untimely even though you may have submitted a timely but imperfect request.

A Claim must be truthful and not misleading. If the Fund makes a payment to you or on your behalf based on a Claim and it is later determined that the Fund would have paid less or paid nothing had the Claim been truthful and not misleading, you will be liable to the Fund for the amount of the payments that should not have been made to you or on your behalf plus interest and all collection expenses the Fund incurs. The Fund may take any legal action necessary to collect, including, without limitation, offsetting any benefits that are owed to you and filing a lawsuit.

3. How to Obtain Prior Authorization

Prior Authorization is a condition of coverage for certain healthcare items and services under which the items and services are excluded from coverage unless you obtain approval from the Fund Office or the applicable PPO before you incur charges for the items or services. If you do not obtain Prior Authorization when it is required, the Fund will not pay benefits for the items and services you received without Prior Authorization. You only need Prior Authorization when it is expressly stated in a Plan's SPD or in the applicable PPO's coverage criteria. Prior Authorization is not available for any item or service for which Prior Authorization is not required. You may not appeal a denial of your request for Prior Authorization when the reason for denial is that Prior Authorization is not required. See the section of this Booklet entitled Important Contact Information for information about who to contact for Prior Authorization.

4. How Benefits are Paid and How to File a Claim.

When you incur Covered Expenses and you file a Claim, the Fund will reimburse you for those Covered Expenses to extent provided by the applicable Plan. In many cases, your Healthcare Provider will file a Claim on your behalf using the information on your ID card.[17] In such cases, you will not need to personally file a Claim.[18] If you wish, you may notify the Fund Office in writing that all reimbursements should be disbursed directly to you. If you have not elected to receive reimbursements directly and a Healthcare Provider submits a Claim that is determined to be payable, you be will presumed to have directed the Fund to pay your reimbursement directly to the Healthcare Provider on your behalf. The Fund will then pay your reimbursement to the Healthcare Provider in full satisfaction of the Fund's obligation to reimburse you. If you incur Covered Expenses and another person or entity does not file a Claim on your behalf, you must file the Claim. Obtain the appropriate form by contacting the Fund Office.[19]

You may appoint a representative to act on your behalf with respect to one or more Claims by filing a written form with the Fund Office. Contact the Fund Office to obtain the appropriate form. The terms of the form constitute a part of this Benefits Booklet. For most Claims, you may appoint any person or entity to represent you except the person or entity with which you incurred the expenses that are at issue in

[17] Note that, although a Healthcare Provider may file a Claim on your behalf, you cannot assign your right to receive payment from a Plan (or any rights associated with your right to payment) to any person or entity.

[18] You are, however, still responsible for ensuring that the Healthcare Provider files a timely, complete, and accurate Claim.

[19] Contact information for the Fund Office is in the "Important Contact Information" section of this Booklet.

your Claim (e.g., your healthcare provider or your healthcare provider's company).[20] Solely in the case of an appeal of an Urgent Care Claim, as defined by 29 C.F.R. 2560.503-1(m)(1), you may appoint your healthcare professional (the actual person, not the professional's employer or company) as your representative.

If a Healthcare Provider does not file a Claim on your behalf and you believe you are entitled to benefits, you, your Beneficiary, or your representative must file a written Claim for benefits with the Fund Office using the appropriate form. Contact the Fund Office for the appropriate form.

If the Fund attempts to pay you or a Healthcare Provider on your behalf and the payment is not accepted (e.g., by failure to cash the check) within 180 days, the Fund will void the payment. If you or the Healthcare provider does not contact the Fund to request a re-issue of payment within one year of the date that the Fund first attempted payment, the payment is forfeited to the Fund. The Fund may waive forfeiture upon satisfactory evidence that the failures to accept payment and to request re-issue of payment were due exclusively to administrative error on the Fund's behalf.

If you, or another person on your behalf, attempts to file a Claim but does not provide all information required to process your Claim, you will be notified. If your attempt to make a Claim relates to Prior Authorization, you will be notified within five days (or 24 hours, if the Prior-Authorization is for Urgent Care). If you (or another person on your behalf) do not file a Claim for benefits within one year of the date of the date you became entitled to benefits, you forfeit any right to benefits that would have been payable had a timely Claim been filed. For purposes of the preceding sentence, the date you become entitled to benefits is the date you incur an expense that is reimbursable under a Plan or, for death benefits, the date of your death.

5. How The Fund Decides Whether To Pay Your Claim, and How You Can Appeal

When the Fund (or the applicable PPO) receives a Claim, a decision will be made regarding whether or to what extent the Claim is payable under the terms of the applicable Plan. You will be notified of that decision in writing. With respect to a claim for health benefits, you will generally be notified via a form called an "Explanation of Benefits". This form may be from the Fund Office or a PPO. If the decision is to deny your Claim in whole or in part, the notice will be provided in a culturally and linguistically appropriate manner and will provide the following (to the extent applicable):

- If the denied Claim is for health benefits, information sufficient to identify the Claim involved (including the date of service, the Healthcare Provider, the Claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

- The specific reason or reasons for the denial;

[20] If a dispute arises regarding coverage, your healthcare provider has a conflict of interest with you on the key issue of the extent of your liability to the provider. Your representative should exclusively represent your interests both with respect to the Fund's obligations to reimburse you and your obligation to pay your healthcare provider. Accordingly, to the maximum extent permitted by law, if you choose to appoint a representative, the Fund will not accept the appointment of your healthcare provider as your representative.

- Reference to the specific Plan provisions on which the denial was based;
- If your Claim was denied because more information was needed to process your Claim, the notice will describe the information needed and the reasons it is needed;
- A description of the appeal procedures, including, if the denied claim was for Urgent Care, a description of the expedited appeal procedure for Urgent Care claims;
- A statement that you have a right to bring a civil action under ERISA Section 502(a) after you have exhausted your appeal rights; and,
- If the denied Claim is for health benefits, contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and appeals and external review processes.

If you disagree with the decision to deny your Claim, you have 180 days to appeal in writing.[21] For all appeals, your request for appeal must include the specific reasons you feel the determination or the Claim denial was improper. You may submit any documents, materials and information you feel appropriate or would like to be considered as part of the decision. You may request copies of documents relevant to your Claim from the Fund Office or the applicable PPO (there is no charge for copies). The Fund will provide you free of charge any new or additional rationale or evidence considered, relied upon, or generated by or on behalf of the Fund in the appeal process as soon as possible. If you receive notice of such new or additional evidence or rationale, you will be provided a reasonable opportunity to respond before a final decision is made on your appeal. If the new evidence or rationale arises with insufficient time to give you a reasonable opportunity to respond before a decision on your appeal is due, the deadline for the decision will be will be tolled while you are given an opportunity to respond. You may not file a lawsuit or take other action until you have appealed and either the appeal has been decided or you have not received a decision within the required time-frame.

Generally, the Board of Trustees will decide appeals, but the Board may delegate the authority to decide appeals to another person or entity. Decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) will not be made based upon the likelihood that the individual will support the denial of benefits. If the Trustees decide your appeal, their decision will generally be made at the next regularly scheduled Board meeting that is more than 30 days from the receipt of the appeal request. You may not appear in person before the Board. Appeal decisions will be based solely on documentary evidence.

On appeal, the initial decision to deny your Claim or to determine your eligibility will not be afforded deference. Everything you submitted relating to your Claim will be taken into account regardless of whether anything you submitted was considered or submitted in the initial decision to deny your Claim

[21] For an Urgent Care Claim, your request for appeal need not be in writing. In addition to a denial of a Claim, you may also appeal a rescission of coverage under the same rules that apply to a Claim.

or to determine your eligibility. You will be provided notice of the decision within five days after your appeal was considered.

If your appeal is denied (in whole or in part) the notice of decision on appeal will (to the extent applicable):

- If the appeal relates to a health benefit, provide information sufficient to identify the Claim involved (including the date of service, the Healthcare Provider, the Claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- State the specific reason(s) for the decision;
- Refer to the specific Fund provision(s) on which the decision is based;
- State that you are entitled to receive reasonable access to and copies of all documents relevant to your Claim, upon request and free of charge;
- State that you have a right to bring a civil action under ERISA Section 502(a) and that you have one year to bring such an action;
- Provide contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and appeals and external review processes; and,
- State that "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

If applicable PPO procedures call for two levels of appeal, the first-level of appeal will be decided by the applicable PPO and the second level of appeal will be decided by the Board of Trustees. You have 180 days from the date you receive notice of the first-level decision to file a second-level appeal with the Fund Office. You will be notified of the decision on a first-level appeal of a Post-Service Claim for health benefits within 15 days of the date the applicable PPO receives your Claim. If you disagree with the Trustees' decision[22] and wish to file a lawsuit in federal court under ERISA section 502, you may do so within one year of the date you receive notice of the Trustees' decision. You may not initiate a lawsuit until you have exhausted your administrative remedies under the applicable plan. You may not initiate a lawsuit on or after the first anniversary of the date you received notice of the Trustees' decision on appeal.

The time-frames for each step in the Claim and appeal process depend on the type of Claim at issue. The time-frames are as described below.

6. External Appeals

If the Board of Trustees denies your appeal, you may further elect to have the adverse appeal determination reviewed by an independent review organization ("IRO") if an IRO determines that the claim involved a medical judgment, a rescission of coverage, or a determination that the No Surprises Act does not apply to a specific

[22] A decision on a first-level appeal that is not made by the Trustees is not final. The Trustees must deny your appeal before you may file a lawsuit.

item or service you received. [23]

To initiate external review, you must file a written request for an external review of an adverse internal appeal decision with the Fund Office within four months after the date of receipt of a notice of an adverse benefit determination on internal appeal. Contact the Fund Office to obtain the appropriate forms.

Within six business days after receipt of your request, the Fund will issue a notification in writing to you regarding whether your claim is eligible for external review. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification shall describe the information or materials needed to make the request complete and the Fund will allow you to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later. If the request is complete and eligible for review, the Fund will assign the matter for external review as described below.

The Fund will assign an IRO to conduct the external review. The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit additional information in writing to the IRO within 10 business days that the IRO must consider when conducting the external review. The Fund Office will provide documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO. The IRO will review all of the information and documents timely received and is not bound by the Fund's prior determination.

The IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision.

If there is a reversal of the Fund's decision, upon receipt of the notice of final external review decision reversing the adverse benefit determination, the Fund will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim. If the Fund disagrees with the IRO's determination, it may sue you or your representative to recover the benefits paid after the IRO's determination.

	Post-Service	Prior Authorization	Urgent Care Claim
Initial Decision[24]	Within 30 days of Claim receipt	Within 15 days of Claim receipt	Within 72 hours of Claim receipt (24 hours if more

[23] An IRO's authority is confined to deciding disputes on these subjects on these subjects only. An IRO does not have authority, for instance, to overturn a determination that you were not eligible for benefits or that your claim was untimely. An IRO is bound by the terms of the Plan. To the extent that an IRO's decision exceeds its authority, the Fund will disregard the IRO's decision.

[24] This is when you will receive notice of the decision.

	Post-Service	Prior Authorization	Urgent Care Claim
			information needed to process claim)[25]
Extension Period[26]	15 days	15 days	None
Appeal Request	Within 180 days	Within 180 days	Within 180 days
Appeal Decision[27]	5 days after the first Board meeting that is more than 30 days from receipt of appeal request (or within 30 days for a first level of appeal).	Within 30 days (or 15 days if there are two levels of appeal)	Within 72 hours
Extension Period[28]	2 extensions, each till the next Board meeting	None	None
External Appeal Request (Optional)[29]	Within four months after the date of receipt of a notice of a final internal adverse benefit determination	Within four months after the date of receipt of a notice of a final internal adverse benefit determination	Within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination
External Appeal Decision	Within 45 days after the IRO receives the request for external review	Within 45 days after the IRO receives the request for external review	No later than 72 hours after the IRO receives the request for external review
File Lawsuit	Within one year of receipt of the internal appeal decision	Within one year of receipt of the internal appeal decision	Within one year of receipt of appeal decision

[25] 24 hours if the Claim pertains to a cessation of coverage of an ongoing course of treatment.
[26] You will be advised in writing in advance if an extension will be necessary.

[27] This is when you will receive notice of the decision.
[28] You will be advised in writing in advance if an extension will be necessary.
[29] External appeal is optional. You may also file a lawsuit after receiving final internal adverse benefit determination.

7. Tips For A Successful Appeal

Appealing a benefit determination can be complex. Significant sums may be at stake. You may wish to retain an attorney to assist you. You may appoint any person or entity to represent you in an appeal except the person or entity with which you incurred the expenses that are at issue in your Claim. Contact the Fund Office for the appropriate forms to appoint a representative for your appeal.

As a participant in the Plan, you are entitled to receive benefits in accordance with the terms of the Plan, applicable law, and the prevailing circumstances (all as determined by the Trustees). If the initial determination on your Claim was consistent with the Plan, the law, and the prevailing circumstances, the Trustees must rule against your appeal. A successful appeal will therefore assert that the initial determination on your Claim was contrary to the Plan, the law, the prevailing circumstances, or some combination thereof. If your written request for appeal does not articulate any cognizable reason for your appeal, it will not be treated as an appeal. If you do not perfect your appeal by the deadline for appeal, your request will be disregarded as untimely.

The Trustees cannot make your argument on appeal for you. The Trustees will only consider the arguments you make. State the specific circumstances, terms of the Plan, or terms of the law you believe were violated. The explanation of benefits ("EOB") you received on your Claim will assist you. The EOB tells you why your Claim was denied. It cites to a specific term (or terms) of the Plan that limit or exclude coverage of the Claim. If you have questions about what your EOB means, contact the Fund Office. Your appeal should explain why the determination in your EOB was incorrect. Along with your written appeal, provide documentation supporting your assertions. Your healthcare provider or your attorney may help you find relevant documentation. If you do not successfully argue that the basis for denial conveyed in your EOB was contrary to the Plan, the law, or the prevailing circumstances, your appeal is unlikely to succeed.

Example 1: A participant's EOB states that coverage is excluded; the drug obtained was experimental or investigational because it was not FDA-approved for the intended use. The appeal asserts that the basis for denial in the EOB is factually incorrect. The participant provides documentation demonstrating that the drug obtained is FDA-approved for the intended use. It is likely that the Trustees will rule that there was error in the initial determination on this Claim. This appeal will probably succeed.

Example 2: A participant's EOB states that coverage is excluded; the drug obtained was experimental or investigational because it was not FDA-approved for the intended use. The appeal asserts that the drug was medically necessary. It does not attempt to demonstrate that the drug is not experimental or investigational. It is likely that the Trustees will rule that there was no error in the initial determination on this Claim. This appeal will probably fail.

Example 3: A participant's EOB states that coverage is excluded; the drug obtained was experimental or investigational because it was not FDA-approved for the intended use. The appeal asserts that the participant's doctor recommended the drug and it should therefore be covered. The appeal does not attempt to demonstrate that the drug is not experimental or investigational. It is likely that the Trustees will rule that there was no error in the initial determination on this Claim. This appeal will probably fail.

If you initiated your appeal by notifying the Trustees that the payment offered for your Claim was insufficient, your EOB will not state a reason for denial of your Claim. Because the Plan did not deny your Claim, it will be your responsibility to identify the circumstances, the terms of the Plan, or the terms of the law at issue in your appeal. Your notice (which also serves as your written appeal) should explain specifically why the payment was contrary to the specific circumstances, the terms of the Plan, or the terms of the law.

When the Trustees consider your appeal, they will review the initial benefit determination de novo. This means the Trustees will evaluate your appeal without deference to the initial benefit determination. Even if the Trustees find that the initial determination on your Claim was in error, they may find that there are other reasons to limit or exclude coverage. Regardless of the initial determination with respect to payment your Claim (partial, full, or none), the Trustees may find your Claim payable in full, or in part, or not payable at all. If the Trustees find that there is a reason to rule against your appeal not articulated in your EOB, they will notify you in writing, citing specific provisions of the Plan, and provide you opportunity to respond. Treat this correspondence as new EOB; if possible, explain why there is an error in the specific reason for denial given in the correspondence.

If the Trustees rule against your appeal, you may challenge the Trustees' decision in Federal Court (by filing a timely lawsuit). The Trustees have total discretion in connection with administering the Plan. Your challenge will therefore be limited to the assertion that the Trustees' decision on appeal was arbitrary or capricious based on the information and documents that the Trustees had at the time of the decision. As a result, you should not hold anything back in your appeal to the Trustees. Present every argument, document, or other piece of information you can. A Federal Court will disregard anything that was not before the Trustees on appeal because it is not relevant to whether the Trustees' decision on appeal was arbitrary or capricious based on the information and documents that the Trustees had at the time of the decision.

If you believe the Plan should cover your Claim even though it is unambiguously excluded from coverage, you have the option to request that the Trustees amend the Plan. Such requests will not be treated as appeals. They will, however, be considered at the first regularly-schedule Trustee meeting that is at least 30 days after receipt of your request. If you submit such a request, explain in detail why you believe the Trustees should amend the Plan. In all other respects, the Trustees will decide how to handle requests to amend the Plan on a case-by-case basis. Note, however, that the Trustees have sole and final discretion to amend the Plan – they retain the authority to reject any requested amendment for any reason or no reason at all.

For the avoidance of doubt, the provisions of this section "Tips for a Successful Appeal" are (like all other text in this Booklet) a part of the Plans. In this section, all references to "you" include a Healthcare Provider with which you or your Dependent incurred expenses at issue in the applicable Claim and your duly appointed representative, if any, with respect to the Claim; an act by any one of the foregoing with respect to a Claim is imputed to all. A reference to the "Trustees" includes, to the extent consistent with context, any person or entity to which the Trustees delegated the power to decide benefit appeals.

8. Paid Claims Are Final, Effect of Acceptance of Payment

When the Fund directly or indirectly tenders payment to you or on your behalf in response to a Claim, this constitutes an initial determination on the Claim. Acceptance of the payment fully and permanently extinguishes the Plan's liability with respect to the subject of the Claim and all connected matters. Once

payment has been accepted with respect to a Claim, further requests for payment based on the same event(s) will be disregarded. If payment is tendered in an amount you believe is less than the amount payable under the terms of the Plan, or you otherwise object to the payment, you must treat the tender of payment as a denial of your Claim. You must not accept the tendered payment and you must appeal the initial determination in accordance with the Plan's appeal procedures. In such cases, the date payment is tendered is the date of the Plan's initial determination on your Claim for purposes of the deadline to appeal. By accepting payment tendered in response to a Claim:

1. You irrevocably agree that your Claim was adjudicated fully in compliance with the terms of the Plan and the law;

2. You irrevocably agree that the payment is in full and final satisfaction of the Fund's (and Plan's) obligations with respect to the event(s) underlying the Claim;

3. You irrevocably waive all rights against the Fund, the Plan (and their Trustees, fiduciaries, vendors, agents, advisers, and similar) in connection with the event(s) (including, without limitation, expenses, losses, etc.) underlying the Claim; and

4. You irrevocably agree to indemnify the Fund (and Plan) against any expense, cost, damage, penalty, or other loss that the Fund (and Plan) subsequently suffers in connection with your Claim including, without limitation, the costs (including attorney's fees, expert fees, court costs, and related) of defending against any allegation that you are entitled to further payment in connection with your Claim.

For purposes of this section, all references to "you" include a Healthcare Provider with which you or your Dependent incurred expenses at issue in the applicable Claim and your duly appointed representative, if any, with respect to the Claim; an act by any one of the foregoing with respect to a Claim is imputed to all.

B. Coordination Of Benefits With Other Plans

The Fund does not provide benefits for items and services to a greater extent than you are responsible for the cost of those items and services. If you are covered by another plan or plans then benefits under this Fund will be coordinated with other sources of compensation so that the combined payments do not total more than the amount you actually incurred. The Fund will coordinate benefits in accordance with the model rules established by the National Association of Insurance Commissioners in effect at the time you incur Covered Expenses.[30] The Fund may: release to or obtain from any other plan any necessary claim information; recover any overpayment from any other person or plan; and pay any other plan any amount the Fund should have paid.

[30] Contact the Fund Office for a copy of the NAIC model rules.

C. First Priority Right of Subrogation and Reimbursement[31]

1. First Priority Right of Subrogation

The Fund has a first priority subrogation right for all benefits paid on your behalf and all benefits paid to you arising out of or relating to an Injury or Illness for which any individual or entity may be responsible. This first priority right of subrogation includes claims you may have against any individual, entity, or employer, and claims against any insurance policy including but not limited to all first-party insurance coverage (e.g. no-fault, underinsured, uninsured), third-party insurance coverage, general liability, employment practices, premises insurance coverage, etc.[32] The first priority right of subrogation includes all work-related claims you may have arising out of or relating to employment and employment related activities. The first priority right of subrogation includes all claims against any responsible or potentially responsible individual, entity, employer or insurer whether arising out of statute, regulation, contract or common law. The Fund may pursue a claim or cause of action in its own name or in your name against the liable or potentially liable individual, entity, employer or insurer. The Fund's subrogation claim will be paid in full before any amounts are paid to you, your attorney, or any other party. The subrogation right will be paid in full before any amounts are paid to a trust on your behalf.

2. First Priority Right of Reimbursement

The Fund also has a first priority right of reimbursement. The first priority right of reimbursement includes all amounts paid by the Fund to you or paid on your behalf as determined by the Trustees as set forth below. The reimbursement right extends to all amounts you receive or have the right to receive relating to or arising out of any Injury or Illness no matter how the recovery is characterized and regardless of whether the amount represents reimbursement for medical claims, lost wages, loss of consortium, future losses, pain and suffering, property loss, etc. You are required to reimburse the Fund in full before any amounts are paid to you, to your attorney or to any other individual, entity, including any trust. Any state law requiring you to be made whole before the Fund are fully reimbursed is preempted by ERISA. The amount of the right to subrogation and reimbursement includes all amounts the Fund paid to you and all amounts paid on your behalf. The amount of the right also includes all amounts the Fund incurs for attorneys' fees and costs enforcing subrogation or reimbursement rights. The first priority right of subrogation and first priority right of reimbursement will not be reduced by any attorneys' fees or costs that you incur. The Fund will not pay any portion of your attorneys' fees or costs. The Trustees have the sole discretion to determine which benefits the Fund has paid relate to or arise out of the Injury or Illness for which you are receiving or are entitled to receive a recovery.

3. Establishment of a Constructive Trust

A constructive trust is automatically established for the benefit of the Fund and the Participants in all amounts you receive or become entitled to receive in connection with an Injury or Illness, including all amounts whether the amount represents reimbursement for medical claims, lost wages, loss of consortium, future losses, pain and suffering, property loss, etc.

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[31] Throughout this section, the term "you" means you or your Dependent jointly and severally, including you on behalf of your minor Dependent.

[32] Any entity responsible for paying claims against any insurance policy including but not limited to all first-party insurance coverage (e.g. no-fault, underinsured, uninsured), third-party insurance coverage, general liability, employment practices, premises insurance coverage, etc. is hereinafter referred to as an "insurer."

4. Duty to Cooperate and Assist the Fund

You will assist the Fund in protecting its rights to recovery, and you will assist the Fund in any action it brings. You will do nothing to prejudice the rights of the Fund with respect to the Fund's subrogation and reimbursement rights and are required to do everything necessary to secure such rights to the Fund. If the Fund believes that you have suffered an Injury or Illness for which there is potentially another individual, entity, employer, or insurer responsible, the Fund will forward forms to you to complete. The Fund may withhold benefits otherwise payable until you execute all documents required by the Fund.

With regard to any Injury or Illness that any individual, entity, employer, or insurer may be liable for or required to make payments with regard to (whether or not the individual, entity, employer, or insurer actually caused such Injury or Illness), you must:

- Do whatever is needed to secure the Fund's recovery rights, including signing all necessary forms (if any) and documents and an agreement to reimburse the Fund to the extent of benefits paid by the Fund (plus reasonable costs of collection, including reasonable attorneys' fees) and providing the Fund with a lien to the extent of benefits provided to you by the Fund (plus reasonable costs of collection, including reasonable attorneys' fees);

- Promptly inform the Fund Administrator of all potential or actual claims, actions, lawsuits, demands, rights to payment, or benefits, that you have or may have against any individual entity, employer, or insurer and to inform the Fund Office before you agree to any settlement or compromise; and

- Identify to the Fund Office any and all individuals, entities, employers, or insurers against whom you may have a claim for damages, benefits, or payments and the date on which the Injury or Illness occurred or arose.

Your failure to sign any form, acknowledgment of the Fund's rights or an agreement to reimburse the Fund, shall be grounds for the Fund's refusal to pay any benefits on your behalf. In addition, the Fund will be entitled to enforce all of these rights regardless of whether you sign any form, acknowledgment or agreement. The Fund's subrogation and reimbursement rights are not waived if benefits were paid prior to obtaining your signature on any required form, acknowledgment or agreement. If you have retained an attorney, such attorney is required to sign an acknowledgment, stating his or her willingness to comply with the Fund's subrogation and reimbursement rights.

The Fund may exercise its subrogation and reimbursement rights against any potentially responsible individual, entity, employer, or insurer to recover all of the benefits it has paid or may pay in the future to you, whether or not you have recovered all damages and regardless of the nature of the benefit, damages, or payments received by you from any potentially responsible individual, entity, employer, or insurer.

In furtherance of its subrogation and reimbursement rights, the Fund may recover an amount equal to all benefits of any type that it has paid or may pay in the future with regard to any Injury or Illness. If you fail to cooperate or assist the Fund or otherwise take action which prejudices the Fund's rights, the Fund will offset all claims for you until such time as the Fund has recovered the full amount of its subrogation and reimbursement interest. The Fund Trustees, at their sole discretion, have the right to waive part or all of the Fund's subrogation or reimbursement interest.

By accepting benefits from the Plan, you agree that if you or your Dependent does not reimburse the Fund from a third party or insurer recovery then the Fund may offset any future claims otherwise payable with interest at the rate of 10% per annum. If the Fund prevails in a lawsuit to enforce its rights, the Fund will be entitled to recover benefits paid on your behalf or your Dependent's behalf, together with interest at 10% per annum, plus reasonable attorney's fees and costs incurred by the Fund.

D. Continuation of Coverage, Family and Medical Leave, Military Leave[33]

COBRA, USERRA, and FMLA do not apply to all Fund benefits. COBRA, USERRA, and FMLA apply only to the U.A. Local 125 Health Plan, the U.A. Local 125 Dental Plan, the U.A. Local 125 Vision Plan, and the U.A. Local 125 Health Reimbursement Arrangement.

If your participation in an applicable Plan is terminated, you may qualify to continue your participation under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA Coverage will begin on the day that coverage under the Plan would otherwise have been lost. Under COBRA Coverage, your benefits will be the same as those of a similarly situated Participant who does not have COBRA Coverage. However, you must pay a monthly premium for COBRA Coverage. For more information about COBRA Coverage, contact the Fund Office.

Notwithstanding any provision to the contrary in an applicable Plan, if you go on a qualifying leave under the Family and Medical Leave Act ("FMLA"), the Families First Coronavirus Relief Act ("FFCRA"), or the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), then to the extent necessary to permit your employer to comply with FMLA or USERRA, as applicable, the Fund will continue to maintain your benefits on the same terms and conditions that would apply if you were still an employee.

For each workday that a collectively-bargained employee takes leave under the FMLA or FFCRA, the employer must report 6.825 hours to the Fund and pay to the Fund an amount equal to 6.825 multiplied by the then-applicable hourly contribution rate for health coverage. No HRA contributions are required with respect to any hours reported for FMLA/FFCRA leave. FMLA/FFCRA contributions must be reported separately from regular working hours on the remittance report. Accordingly, if an employee has both FFCRA hours and regular working hours in a month, the employee should appear twice on the remittance report. The 6.825 hour per workday contribution results in a total contribution that is the minimum amount needed to maintain health coverage as required by the FMLA/FFCRA. The 6.825 hour contribution is based on the assumption that there are five workdays per week. For any period of FMLA/FFCRA leave, "workdays" are Monday through Friday – regardless of the days that the employee was actually scheduled to work.

E. Privacy of Your Health Information

HIPAA requires the Fund to protect the confidentiality and security of your private health information. A description of your rights under HIPAA can be found in the Fund's Notice of Privacy Practices, which you can find with your Benefits Booklet.

The Fund will not use or disclose your protected health information except as necessary for treatment, payment, and health plan operations, or as permitted or required by law. The Fund will implement

[33] Throughout this section, the term "you" means a Member and not a Dependent.

administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of your protected health information. The Fund requires all of its business associates to enter written contracts with the Fund requiring them to protect the confidentiality and security of your private health information to the same degree as the Fund. The Fund will not, without your written authorization, use or disclose your protected health information for employment-related actions and decisions.

The Fund will generally de-identify your protected health information (that is, the Fund will strip away all the information that could be used to identify you) before providing it to the Board of Trustees for health plan operations purposes, such as appeals. The Fund will disclose your protected health information without de-identification to the Board of Trustees only after receiving a certification from the Board of Trustees in accordance with 45 C.F.R. § 164.504(f)(2)(ii). If the Fund provides your protected health information to the Board of Trustees, the Board of Trustees will adhere to the same policies and procedures as the Fund regarding the use, disclosure, confidentiality, and security of your protected health information. The Board of Trustees will not disclose your protected health information to any person or entity other than the Fund, and the Board of Trustees will report to the Fund any security incident of which it becomes aware.

You have the right to see and copy your protected health information, to receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Fund or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated. Contact the Fund Office for a copy of the Notice of Privacy Practice, for answers to your questions about the privacy of your health information; or if you wish to file a complaint under HIPAA.

F. Genetic Information Nondiscrimination Act

Generally, the Plans will not require you or your family members to provide genetic information or undergo genetic testing. However, a Plan may condition coverage of certain items or services on whether you have the appropriate genetic makeup. If you request coverage of such items or services, the applicable Plan will request the relevant genetic information. Any genetic information the Plan receives will be used or disclosed by the Plan only as permitted by the Plan's Privacy Practices. If you decline to provide the information, the Plan will deny coverage.

G. Newborns Act

Under federal law, the U.A. Local 125 Health Plan may not restrict a hospital stay for childbirth to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section delivery. However, federal law allows the mother's or newborn's attending provider, after consulting with the mother, to discharge the mother or newborn earlier than 48 hours (or 96 hours for a cesarean section). The Plan may not require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours for a cesarean section).

H. Women's Health and Cancer Rights Act

The Plans comply with the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage is 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 is performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; treatment of physical complications of the mastectomy, including lymphedema. Plan limits, deductibles, copayments, and coinsurance apply to these benefits.

I. Section 1557 of the Affordable Care Act

Section 1557 of the Affordable Care Act prohibits certain discrimination. However, health plans that do not receive Federal financial assistance are not required to comply with Section 1557. None of the Fund's Plans receive or intend to begin accepting federal financial assistance as defined in 45 C.F.R. § 92.4. Therefore, the Plans are not subject to Section 1557.

J. Section 2706 of the Affordable Care Act

To the extent required to comply with 42 U.S.C. § 300gg–5, the Plans will not discriminate against any Healthcare Provider who is acting within the scope of that provider's license or certification under applicable State law.

K. Mental Health Parity and Addiction Equity Act

The Trustees have made efforts with the care, skill, prudence, and diligence under the prevailing circumstances that a prudent person acting in a like capacity and familiar with such matters would use to ensure that the terms of the Plan comply with the Mental Health Parity and Addiction Equity Act, as amended, and the regulations promulgated thereunder (together, the "MHPAEA"). Due to the extreme complexity and automation of the processes for adjudicating Claims, the almost infinite circumstances under which benefits may be payable under the Plan, the rapid pace at which the healthcare system and related medical consensus develops, and the significant ambiguities in the requirements under the MHPAEA, the Trustees cannot be absolutely certain that the Plan complies with MHPAEA with respect to every possible Claim. Notwithstanding anything to the contrary, this Plan in intended to comply with the MHPAEA. With respect to any one Claim, any term of the Plan that would, if applied at the time the Claim is adjudicated, cause the Plan to violate the MHPAEA does not apply to that Claim.

L. No Surprises Act

To the extent required by law, the Health Plan will comply with the No Surprises Act and the regulations promulgated thereunder (together, the "NSA"). "Balance bills" are what Out-of-Network providers or facilities charge you even after both you and the Plan have paid the amounts due under the Plan. Providers balance bill when the prices they charge exceed the Allowed Amounts under the Plan. Balance billing never occurs when you visit In-Network providers. The No Surprises Act prohibits Out-of-Network providers and facilities from balance billing you in limited circumstances. You are protected from balance billing for Protected Services (Out-of-Network Emergency Services and Hidden Out-Of-Network Services). The Health Plan does not cover air ambulance services. The NSA therefore does not protect you from balance billing for air ambulance services. When balance billing Is not allowed under the NSA, you will pay only In-Network cost-sharing amounts, your cost-sharing will be based on the amount the Plan would pay in-network, and your cost-sharing will count toward your in-network deductible and out-of-pocket limit.

If an in-network provider or facility leaves the PPO network, you may be able to receive care as if the provider or facility was still In-Network for up to 90 days so that you have time to transition to an in-network provider. You will have this option if you are inpatient, scheduled for nonelective surgery, or receiving care for a pregnancy, serious and complex condition, or terminal illness when your provider or facility becomes out-of-network. If you can show that you received inaccurate information from the Health Plan's medical or prescription drug PPO that a provider was In-Network on a particular claim, then you will pay In-Network cost-sharing for that claim. The Out-of-Network provider may still balance bill you for that claim.

You may appeal a determination that the NSA does not protect you from balance billing with respect to a specific item or service you received. If the Board denies your appeal, you may request external review of that decision. All terms of the Health Plan will be interpreted so as to give effect to this Section of the Benefits Booklet. To the extent of any conflict of terms, this Section will prevail.

M. Information About The Plans

1. Resolution of Restatement

Exercising the authority granted by section 6(a)(9) of the Agreement and Declaration of Trust of the U.A. Local 125 Health and Welfare Fund (the "Fund"), the Fund's Trustees resolved to amend and restate the Plan Document And Summary Plan Description Of The U.A. Local 125 Health Plan, the Plan Document And Summary Plan Description Of The U.A. Local 125 Dental Plan, the Plan Document And Summary Plan Description Of The U.A. Local 125 Vision Plan, the Plan Document And Summary Plan Description Of The U.A. Local 125 Active Health Reimbursement Arrangement, Plan Document And Summary Plan Description Of The U.A. Local 125 Retiree Health Reimbursement Arrangement; and the Plan Document And Summary Plan Description Of The U.A. Local 125 Death Benefits Plan (the "Plans") as follows:

> Each Plan is restated in its entirety. Each restated Plan, as provided in the 2022 Edition of the Benefits Booklet of the U.A. Local 125 Health and Welfare Fund, supersedes all plan documents and summary plan descriptions that were previously issued with respect to any and all matters pending final determination on or arising after the date of restatement.

In connection with the Plan restatement(s) described above, the Trustees approved the 2022 Edition of the Benefits Booklet of the U.A. Local 125 Health and Welfare Fund.

Effective date of action: May 1, 2022

Resolved on: _____

Resolution executed on: _____

_____ _____

_____ _____

_____ _____

_____ _____

2. Name Of Fund And Plans

The Fund is known as the U.A. Local 125 Health and Welfare Fund. The Fund has established and maintains: the U.A. Local 125 Health Plan; the U.A. Local 125 Dental Plan; the U.A. Local 125 Vision Plan; the U.A. Local 125 Health Reimbursement Arrangement; and the U.A. Local 125 Death Benefits Plan.

3. Agent For Service Of Legal Process

The Fund Office is the Fund's agent for service of legal process. Any legal documents pertaining to the Fund or the Plans must be served at:

1831 16th Avenue SW
Cedar Rapids, Iowa 52404

4. Plan Sponsor And Plan Administrator

The Board of Trustees is both the plan sponsor and plan administrator, as those terms are defined by ERISA, of each Plan.

5. Identification Numbers

The number assigned to this Fund by the Internal Revenue Service is 42-6247352. The number assigned by the Trustees is 501.

6. Type Of Plans

The Plans are maintained to provide: benefits for treatment of accidental injury and illness; limited scope dental benefits; limited scope vision benefits; health reimbursement benefits; and death benefits.

7. Fiscal Year

The fiscal year of the Fund and each Plan begins on May 1 and ends on April 30.

8. Trust Fund

All assets are held in trust by the Board of Trustees for the purpose of providing benefits to Plan Participants and their Dependents and defraying reasonable administrative expenses. The Fund's assets and reserves are invested by the Board of Trustees in certificates of deposit, government securities, corporate bonds, corporate stocks, and other investment vehicles. All benefits of all Plans are paid directly from the assets of the Fund. The Fund is exempt from tax under § 501(c)(9) of the Internal Revenue Code.

9. Source Of Contributions

Contributions to the Fund are made by Contributing Employers in accordance with their Collective Bargaining Agreements or by written agreement with the Board of Trustees. The Fund Office will provide, upon written request, information as to whether a Contributing Employer is actually contributing to this Fund. The Collective Bargaining Agreements require fixed contributions to the Fund at fixed rates per hour worked. Participation agreements establish the basis upon which contributions are made to the Fund for Participants who are not covered by a Collective Bargaining Agreement.

10. Board Of Trustees

The Board of Trustees is responsible for the operation of this Fund. The Board of Trustees consists of an equal number of employer and union representatives, selected by the Contributing Employers and the Union who have entered into Collective Bargaining Agreements or participation agreements. You may contact the Board of Trustees at the address and phone number listed in your Benefits Booklet. The Board of Trustees has the responsibility of determining rules for participation in the Fund's Plans and for

determining the benefits to be offered. The Board of Trustees will exercise complete and sole discretionary authority to interpret and apply all of the terms of the Plan Document and Summary Plan Description of each of the Plans. The Board of Trustees will exercise complete and sole discretionary authority to determine all facts relevant to interpreting and applying the terms of the Plans. All acts by the Board of Trustees with respect to or in connection with the Plans will be final and binding on all persons and, if reviewed, will be afforded the maximum deference permitted by law. The Fund Office has non-discretionary authority to process claims, determine eligibility, and perform other ministerial functions on behalf of the Fund and its Plans. Certain PPOs may be delegated authority to adjudicate certain Claims and appeals. If at any time, the Fund Office or a PPO is in doubt as to the proper interpretation of a Plan, the Fund Office or PPO will notify the Board of Trustees, which will determine the proper interpretation. The Board of Trustees will exercise complete and sole discretionary authority to review all appealed Claim denials except to the extent that the Board expressly delegates this authority. A decision on appeal by a person or entity acting under delegated authority of the Board of Trustees will have the same effect as a decision by the Board of Trustees. The current Trustees are:

Mike Sadler II
1839 16th Ave. SW
Cedar Rapids, IA 52404

Bret Brecke
3066 104th Street
Urbandale, IA 50322

Dustin Ashmore
1839 16th Ave. SW
Cedar Rapids, IA 52404

Tammy Musser
3066 104th Street
Urbandale, IA 50322

Bruce Beckman
1839 16th Ave. SW
Cedar Rapids, IA 52404

Ken Burns
3066 104th Street
Urbandale, IA 50322

Bill Hudson
1839 16th Ave. SW
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Mike Machula
3066 104th Street
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Matt Kranzler, Alternate
1839 16th Ave. SW
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Scott Stoltenberg, Alternate
3066 104th Street
Urbandale, IA 50322

Larry Husemann, Alternate
1839 16th Ave. SW
Cedar Rapids, IA 52404

Mike Smith, Alternate
3066 104th Street
Urbandale, IA 50322

11. Amendment Of The Plans, Termination Of The Fund

The Board of Trustees intends to continue the Fund indefinitely. The Trustees retain the right to amend the Plans at any time, prospectively or retrospectively to the extent permitted by law. Any amendment to a Plan will be binding on all covered persons on the effective date of the amendment. The Trustees also retain the right to terminate a Plan or the Fund. In this event, the assets of the Plan or Fund will be applied to all existing benefit obligations. Any balance that cannot be so applied will be applied to other uses as,

in the opinion of the Trustees, will best service the intentions of the Fund. Upon the disbursement of the entire Fund, the Fund will then terminate.

12. Benefits Are Not Vested

You are not vested in any benefits under any of the Fund's Plans. The Fund's Plans may be amended at any time to modify or eliminate benefits. Any benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the year in which the benefit became payable will be forfeited to the Fund.

13. Reliance On Information

The Board of Trustees may rely upon the information submitted by you as being accurate and not misleading, and will not be responsible for any act or failure to act due to inaccurate or misleading information you provided or due to your direction or lack of direction. The Board of Trustees will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Fund or the Board of Trustees. No person dealing with the Fund or a Plan may rely on an oral statement made by any person in connection with the Fund or the Plans. Any person seeking to rely on a determination with respect to the Fund or the Plans must obtain such a determination in writing from the Fund Office or the Board of Trustees.

14. Effect Of Mistake

In the event of a mistake by the Fund as to your Eligibility or benefits, the Fund will endeavor to correct the mistake by placing persons and entities affected by the mistake in the positions they would have held had the mistake not been made to the extent that it deems administratively possible and legally permissible. If a mistake resulted in an overpayment by the Fund, the Fund may take any appropriate action to collect the overpayment, including, without limitation, adjusting your account, offsetting your benefits, or filing suit.

15. Fraud, Intentional Misrepresentation

If, as a result of your fraud or intentional misrepresentation of a material fact, the Fund makes payments to you or on your behalf that would not otherwise have been made, you will be liable to the Fund in the amount of the payments plus interest and all collection expenses the Fund incurs including, without limitation, attorney's fees. The Fund may take any legal action necessary to collect, including, without limitation, offsetting any benefits that are owed to you and filing a lawsuit.

16. Provider Billing Errors, Excesses, and Fraud

Healthcare Providers, like any business, may make errors in billing. Common errors include incorrect charges, duplicate charges, and duplicate invoices. Some Out-of-Network Providers may intentionally bill in a manner designed to substantially inflate the cost of the services provided beyond the intrinsic value. They may also fraudulently bill for services that were not provided. Read the explanations of benefits you receive from the Fund. If you identify errors, excesses, or fraud, contact the Fund Office.

17. No Guarantee Of Tax Consequences

The Fund does not guarantee that any amounts paid to or for your benefit by the Fund will be excludable from your gross income for federal state or local income tax purposes. You must determine when each payment from the Fund is excludable from your gross income for federal, state and local income tax

purposes, and notify the Board of Trustees if you have any reason to believe that the payment is not excludable.

18. Indemnification Of Fund And Plan(s)

If you receive one or more payments or reimbursements from this Fund and the payments do not qualify for tax-exempt treatment under the Code, you will indemnify and reimburse the Fund for any liability it may incur for failure to withhold federal income taxes, social security taxes, or any other taxes.

19. No Third-Party Beneficiaries

The Plans are agreements between you and the Fund. They are not for the benefit of any third party, and no third party may make any claims against the Fund in connection with the Plans.

20. Non-Assignability Of Rights

You may not assign your right to benefits under a Plan or your right to payment from the Fund. You may not assign any right associated with your right to benefits under a Plan or your right to payment from the Fund. Except as required by law, the Fund will not recognize any assignment of your benefits or right to payment, or any attempt by another person to assert rights pertaining to your benefits or right to payment, or any claims by your creditors. Only you may bring an action against the Fund or the Trustees that involves a Plan or the Fund.

21. Incompetence, Disappearance, or Death

If any benefit cannot be paid to you due to your incompetence, disappearance, or death, the Fund may make payment of the benefits due in accordance with your Beneficiary designation. Payments made under this section will constitute full and final discharge of all obligations of this Fund to the extent of such payments.

22. Incorporation of Vendor Policies and Procedures

To the extent not inconsistent with the applicable Plan, each Plan incorporates the policies (and procedures, manuals, handbooks, etc.; all "policies" for purposes of this section) of its vendors that pertain to or affect the adjudication and payment of Claims, including, without limitation; clinical policies (policies containing exclusions or limitations on coverage based on medical or related factors); claims, payment, banking and similar policies; and policies regarding the development, implementation, and maintenance of incorporated policies. Incorporation of vendor policies into a Plan may limit or exclude reimbursement of an expense that would be reimbursable without reference to vendor policies. For information regarding policies affecting your Claim, contact the Fund Office. You may access clinical policies directly at the website(s) of the applicable vendor(s) listed in the Important Contact Information section at the beginning of this Booklet. For purposes of this section, "vendor" means any person or entity providing services to a Plan.

23. Miscellaneous

You may not file a lawsuit against the Fund, a Plan, or the Trustees after the earlier of the following: the first anniversary of the date on which your cause of action accrues; the first date on which an applicable statute of limitations bars your action. In the case of an action based on a denial of benefits, your cause of action does not accrue until you receive notice of a final denial of benefits on appeal. In any other case, your cause of action accrues on the date you become aware, or, by reasonable diligence, should have become aware, of the facts forming the basis of your claim. To the extent not preempted by federal law, Iowa law will govern all disputes under the Plans and all such disputes will be heard in the United States

District Court for the Southern District of Iowa, which will have exclusive personal and subject matter jurisdiction. The Trustees' delay in enforcement of any term of a Plan for any period will not operate as a waiver of the right to enforce every term of every Plan. If any term of a Plan is determined to be void or invalid, that term will be severed from the Plan and the remaining terms will remain in effect. Headings in this Benefits Booklet are for convenience only and do not form part of the Plans.

N. Your Rights Under ERISA

As a Participant in the Plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that you will be entitled to:

- Examine, without charge, at the Fund Office and other specified locations, such as worksites and union halls all documents governing the Plan, including insurance contracts, Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain upon written request to the Fund Office copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Fund Office may make a reasonable charge for the copies.

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

If your claim for a benefit is denied in whole or in part, you have the right know why to this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Fund's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, listed in your telephone directory, or the Division of Technical

Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

O. Definitions

1. Allowed Amount

The Allowed Amount is a dollar amount applicable to a particular item or service rendered under specific circumstances that the Fund will use, in conjunction with other information, to determine the amount of benefits payable under a Plan with respect to the item or service. Benefits under a Plan will never exceed the Allowed Amount. The Allowed Amount is not determined by reference to, or intended to reflect, any usual, customary, or reasonable amount. For expenses incurred In-Network, the Allowed Amount is the negotiated amount under the Fund's network agreement that the provider agrees to accept as payment in full. The In-Network Allowed Amount is subject to the applicable policies and procedures of the applicable PPO. Cost-sharing with respect to an In-Network expense will be determined based on the Allowed Amount as of the date the claim is adjudicated – subsequent adjustments to the Allowed Amount will have no effect on cost-sharing. For expenses incurred Out-Of-Network, the Allowed Amount is 140% of the amount that Medicare would reimburse for the item or service. If Medicare generally provides coverage for an item or service but the circumstances of Medicare coverage differ from the circumstances of the relevant claim, the Fund will determine the Allowed Amount as 140% of the amount Medicare would pay under the most closely analogous circumstances. In the rare case that Medicare totally excludes coverage of an item or service for which the Plan provides coverage, the Out-of-Network Allowed Amount is the median charge determined by the Fair Health database for the applicable charge, setting, and geographic location. If Medicare excludes the item or service and the Fair Health Database does not provide price data, the Out-of-Network Allowed Amount is 50% of the invoiced amount.

For purposes of determining an Out-of-Network Allowed Amount, the Fund will determine what constitutes an item or service and how the invoiced and Allowed Amount should be calculated based on the totality of the facts and circumstances. The Fund is not bound in any way by a provider's choices regarding how to invoice an item or service. The Fund may bundle unbundled line items (i.e., disregard individual procedure codes or similar and determine the Allowed Amount based on a code that describes all the individual procedures together). The Fund may combine invoices, or portions of invoices, that were issued separately but relate to the same item, service, or encounter. The Fund may separate invoices that relate to different items, services, or encounters. In determining the appropriate manner to calculate an Allowed Amount when the Fund considers a provider's invoice to be inaccurate, duplicative, devised so as to inflate the value of the items or services provided beyond the intrinsic value, or subject to Medicare reference based pricing, the Fund may consider methods used by its PPO in calculating Allowed Amounts for In-Network providers, methods used by Medicare to calculate Allowed Amounts, constraints Medicare places on provider invoicing practices, other standards and practices used by like entities in like circumstances, and anything else the Trustees deem relevant to determining what an accurate invoice for the actually provided items and services should contain. The following is an example of these principles. A provider conducts a laboratory test and generates an invoice stating that two tests, A and B, were performed. The Fund determines that test A is a necessary and integral part of performing test B. In-network providers performing the same test invoice only test B. Medicare prohibits providers from billing

for test A when test B is performed. The invoiced amount for test B is comparable to the amount that In-Network providers bill for test B, which encompasses both test A and B. The Fund determines that the provider has inappropriately unbundled test A and B. It therefore determines the Allowed Amount on the invoice by disregarding the test A line item.

2. Apprentice

An employee of a Contributing Employer with respect to whom the Contributing Employer is required by a Collective Bargaining Agreement to contribute to the Fund at the rate for apprentices. A person who is a member of the U.A. Local 125 and enrolled in the U.A. Local 125 Apprenticeship Training Program.

3. Beneficiary

A person (or persons) you designate to receive benefits payable on account of your death. If you do not designate a Beneficiary, or if your designated Beneficiary does not survive you, benefits will be paid: to your surviving spouse; or if none, then to your surviving natural and adopted children; or if none, then to your surviving parent(s); or if none, then to your estate. Benefits will be paid equally among surviving children or surviving parents.

4. Benefits Booklet (Booklet)

The set of documents that describes the Fund's benefits plans. The Fund Office will provide you these documents when you become Eligible for benefits and upon request.

5. Board Of Trustees (Trustees)

The trustees of the U.A. Local 125 Health and Welfare Fund.

6. Child

A person under the age of 26 who is: your natural child; your stepchild; your adopted child; a person who is placed with you in anticipation of adoption; or a person for whom you are a court-appointed guardian or conservator. A "natural child" is a biological child who lives with you or otherwise maintains a relationship with you; a biological child who has been adopted by another person and has no relationship with you is not a "natural child" for the purposes of this section. "Child" does not include a foster child.

7. Claim

See the section of this Benefits Booklet entitled "What is a Claim?" under "Payment, Claims, and Appeals".

8. Code

The Internal Revenue Code.

9. Coinsurance

See the section of the U.A. Local 125 Health Plan entitled "Coinsurance" under "Your Cost For Covered Expenses".

10. Collective Bargaining Agreement

An agreement between the Union and one or more Employers or an association representing Employers that requires contributions to the Fund.

11. Collectively Bargained Employee

An Employee on whose behalf a Contributing Employer is required to contribute to the U.A. Local 125 Health and Welfare Fund by a Collective Bargaining Agreement.

12. Copayment

See the section of the U.A. Local 125 Health Plan entitled “Copayment” under “Your Cost For Covered Expenses”..

13. Contributing Employer

An employer obligated to contribute to the Fund for its employees pursuant to a Collective Bargaining Agreement or Participation Agreement.

14. Contribution

A payment to the Fund by a Contributing Employer in accordance with a Collective Bargaining Agreement; a payment by a person or entity to the Fund under a Participation Agreement, a reciprocity agreement, an agreement of merger or transfer; or a payment by a Participant to the Fund in accordance with the Plan.

15. Covered Expense

See the section of the U.A. Local 125 Health Plan entitled “Covered Expenses”.

16. Custodial Care

Means treatment, services or confinement, regardless of who recommends, prescribes or performs them, or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, and that are designed mainly to help the patient with daily living activities. Custodial Care includes (without limitation): personal care such as help in: walking, getting in and out of bed, bathing, eating (including tube gastrostomy), exercising, dressing, using the toilet or administration of an enema; homemaking such as preparing meals or special diets; moving the patient; acting as a companion or sitter; supervising medication that can usually be self-administered; chronic health care not anticipated to improve the medical condition such as respite care provided to assist regular care givers; and repetitive and duplicative care that does not require the assistance of a skilled medical professional. This care does not seek to cure, but to stabilize and assist with daily living activities.

17. Dependent

A Member’s Spouse, or Child, or a person the Member is required to provide with health care coverage under a Qualified Medical Child Support Order. The Fund Office may require written documentation demonstrating that a person is or remains a Dependent. If documentation is required to substantiate the existence of a Dependent, a person will not be considered a Dependent until the Fund Office receives satisfactory documentation. If documentation is required to demonstrate that a person remains a Dependent, the Fund Office may cease treating a person as a Dependent if the Member does not provide satisfactory documentation in a timely manner.

18. Deductible

A Deductible is an aggregate amount you must pay toward Covered Expenses in a calendar year before a Plan will reimburse you. There is generally a Deductible per individual and per family. A Plan begins paying benefits with respect to an individual when the individual has incurred Covered Expenses equal to the individual Deductible. A Plan begins paying with respect to all individuals in a family when the aggregate Covered Expenses of all individuals in the family equal the family Deductible. There may also be Deductibles for specific benefits. The foregoing is a general description of Deductibles. For information on the Deductibles in a particular Plan, see the Plan’s SPD.

19. Eligible

The status of having met the applicable conditions to receive benefits from the Fund and having not met the conditions to cease receiving benefits from the Fund. The relevant conditions are described in the section of this Benefits Booklet entitled “Eligibility For Benefits”.

20. Eligibility Quarter

The following three-month periods for Eligibility for benefits: February 1 through April 30; May 1 through July 31; August 1 through October 31; and November 1 through January 31.

21. Emergency

You are experiencing an emergency if the absence of immediate medical attention would be reasonably expected to: seriously jeopardize your life, health, or ability to regain maximum function; or, subject you to severe and unmanageable pain.

22. Emergency Services

Services as defined by 29 C.F.R. § 2590.715-2719A(b)(4)(ii). Generally, this means a medical screening examination for an emergency medical condition provided by an emergency department of a hospital and such further medical examination and treatment at the hospital that is necessary to stabilize the patient. Solely for purposes of applying the No Surprises Act, if a Participant is furnished Emergency Services by an out-of-network provider or facility, the term Emergency Services will also include post-stabilization services unless (or until) the treating provider or facility determines the Participant is able to travel using nonmedical transportation or nonemergency medical transportation to an available In-Network provider located within a reasonable travel distance, the Out-of-Network provider satisfies the notice and consent criteria of Public Health Service Act section 2799B–2(d), the Participant is in a condition to receive the notice and provide informed consent; and the Out-of-Network satisfies any additional requirements or prohibitions imposed under state or federal law.

23. Employee

An individual who is employed by a Contributing Employer that is classified as a common-law employee, not including the following: any leased employee including but not limited to those individuals defined as leased employees in Code §414(n); any individual who performs services for the employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the employer; any employee covered under a collective bargaining agreement that does not provide for contributions to this Plan; any self-employed individual; any partner in a partnership; and any more-than 2% shareholder in a Subchapter S corporation, including those deemed to be a more than 2% shareholder by virtue of the Code §318 ownership attribution rules.

24. ERISA

The Employee Retirement Income Security Act of 1974, as amended.

25. Experimental or Investigative

An item or service that: has not been approved by the appropriate governmental authority, or that has been approved for an intended use that differs from the manner in which it was used; that does not have reliable evidence to establish a consensus conclusion among relevant experts recognizing the safety and effectiveness of the item or service under the conditions in which it is used; that is the subject of on-going research or investigational studies regarding the relevant intended use; with respect to which there is

scientific evidence that the item or service is not safe and effective for the relevant intended use; or that is considered Experimental and Investigative under the relevant PPO's coverage criteria (to the extent that such criteria are not inconsistent with the relevant Plan). The Trustees have the authority to determine, in their discretion, whether an item or service is Experimental or Investigative regardless of whether a Healthcare Provider has prescribed, ordered, recommended, or approved it. To the extent necessary to comply with 42 U.S.C. § 300gg–8, routine patient costs for a qualified individual to participate in an approved clinical trial with respect to the treatment of a cancer or other life-threatening disease or condition will not be considered "Experimental or Investigative".

26. Essential Health Benefits

The benefits described under 42 U.S.C. § 18022 (generally: 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; pediatric services, including oral and vision care). The Trustees have exclusive authority to determine whether any particular item or service is, or is not, an Essential Health Benefit. Contact the Fund Office for information regarding particular items or services. Being self-insured, the Fund's Plans are not required to cover Essential Health Benefits.

27. Formulary

A list of FDA-approved prescription drugs adopted by the Board of Trustees. The Formulary may change at any time. Contact the Fund Office for the current Formulary.

28. Fund Office

The person or entity to which the Board of Trustees delegates non-discretionary authority to process claims, determine eligibility, and perform other ministerial functions on behalf of the Fund and its Plans.

29. Fund

The U.A. Local 125 Health and Welfare Fund.

30. Healthcare Provider

A person or entity that is licensed under applicable law to treat Illnesses and Injuries.

31. Hidden Out-Of-Network Services

Items and services (other than Emergency Services) furnished by an Out-of-Network provider with respect to a visit at an In-Network Hospital, Hospital outpatient department, critical access Hospital, or ambulatory surgical center if such items and services would be covered by the Plan if furnished by an In-Network provider. For the purposes of this definition, in addition to items and services furnished by an Out-of-Network provider at the facility, a "visit" includes the furnishing of equipment and devices, telemedicine services, imaging services, laboratory services, and pre-operative and post-operative services, regardless of whether the Out-of-Network provider furnishing such items or services is physically at the facility.

32. HIPAA

The Health Insurance Portability and Accountability Act of 1996, as amended.

33. Hospital

A facility that: is licensed (if required) as a hospital; and is open at all times; and is operated mainly to diagnose and treat illness on an inpatient basis; and has a staff of one or more doctors on call at all times; and has 24-hour nursing services by registered nurses; and is not mainly a Skilled Nursing Facility, clinic, nursing home, rest home, convalescence home or like place; and has organized facilities for major surgery or is an approved ambulatory surgical center.

34. Hour Bank

See the section of this Benefits Booklet entitled "Hour Bank".

35. Illness Or Injury

A condition of the body or mind that is recognized by a consensus of appropriate medical and scientific experts as being harmful to an individual's health or ability to function normally. The Trustees have the authority to determine, in their discretion, whether a condition constitutes an Illness or Injury regardless of your Healthcare Provider's conclusion. Notwithstanding anything to the contrary, pregnancy is considered an Illness or Injury.

36. Inpatient Stay

Means a stay in a Hospital, Skilled Nursing Facility or licensed residential treatment center that exceeds a period of 24 hours.

37. In-Network

A Healthcare Provider that is part of a PPO with which the Fund has a contract.

38. Journeymen

An employee of a Contributing Employer with respect to whom the Contributing Employer is required by a Collective Bargaining Agreement to contribute to the Fund at the rate for journeymen.

39. Maximum Out-Of-Pocket

The maximum amount you must pay toward Covered Expenses in a calendar year, determined on an individual and family basis. A Maximum Out-Of-Pocket resets each calendar year. The foregoing is a general description of a Maximum Out-of-Pocket. For information on the Maximum Out-of-Pocket in a particular Plan, see the Plan's SPD.

40. Medically Necessary

An item or service that is:

- Provided or prescribed by a Healthcare Provider exercising prudent clinical judgment, acting in accordance with generally accepted standards of medical practice[34], and acting within the scope of his or her license to practice;
- Provided or prescribed for the purpose of diagnosing or treating an Illness or Injury;[35]

[34] "Generally accepted standards of medical practice" means the standards relied upon by the applicable PPO clinical policy, if there is an applicable policy, or, if not, standards that are based on credible scientific evidence published in peer-reviewed, medical literature that is generally recognized by the relevant medical community.

[35] An expense incurred for sterilization is deemed to satisfy this requirement.

- Clinically appropriate, in terms of type, frequency, extent, site, and duration;
- Considered safe and effective for diagnosis or treatment of the patient's Illness or Injury;
- Not primarily for the convenience of the patient or Healthcare Provider, or another Healthcare Provider[36]; and,
- Not more costly than an alternative that is likely to produce similar therapeutic or diagnostic results.

41. Medical Care Expenses

See the section entitled "Benefits" under the Plan Document and Summary Plan Description of the U.A. Local 125 Health Reimbursement Arrangement.

42. Member

An individual who is Eligible for benefits from the Fund by virtue of employment (rather than or in addition to being Eligible as a Dependent).

43. Misidentified Provider Service

An item or service furnished to a Participant by an Out-of-Network provider, if such item or service would be covered under the Plan if furnished by an In-Network provider and the Participant received through the PPO provider directory or a written response from the Plan information indicating that the provider was an In-Network provider for furnishing such item or service.

44. Mental Health Benefits and Substance Use Disorder Benefits

Items or services furnished for the diagnosis or treatment of an Illness or Injury most appropriately described by an International Classification of Diseases Tenth Revision Clinical Modification (ICD-10-CM) diagnosis code beginning with "F". Items or services furnished for the diagnosis or treatment of an Illness or Injury most appropriately described by ICD-10-CM diagnosis code beginning with any letter other than "F" are medical/surgical benefits. The Trustees have the authority to determine, in their discretion, whether an Illness or Injury is most appropriately described by an "F" code regardless of your Healthcare Provider's conclusion.

45. Minimum Value Coverage

Coverage under a group health plan or health insurance policy that satisfies the requirements of 26 U.S.C. § 36B(c)(2)(C)(ii).

46. Motorized Vehicle

A Motorized Vehicle refers to any vehicle which is a self-propelled road vehicle and off-road vehicle, wheeled or with treads, except an automobile.

47. Out-Of-Network

A Healthcare Provider that is not part of a PPO with which the Fund has a contract.

[36] An expense incurred for sterilization is deemed to satisfy this requirement.

48. Participant

An individual: who is or was Eligible for benefits from the Fund; and, who is or was permitted to participate in the applicable Plan under the terms of the Plan; and whose participation in the applicable Plan has not been terminated under the terms of the applicable Plan.

49. Plan (Plans)

The U.A. Local 125 Health Plan, the U.A. Local 125 Dental Plan, the U.A. Local 125 Vision Plan, the U.A. Local 125 Health Reimbursement Arrangement, or the U.A. Local 125 Death Benefit Plan, as indicated by context.

50. Plan Year

The 12-month period commencing May 1 and ending on April 30.

51. Post-Service Claim

A Claim for reimbursement of an expense that you have already incurred when you file the Claim.

52. Preferred Provider Organization (PPO)

An entity having a network of Healthcare Providers, through which a Plan contracts for services by HealthCare Providers within the network to be rendered to Participants at a discounted rate. A PPO may also adjudicate Claims and provide some customer service. See the Important Contact Information section of this Booklet for information about who to contact for Claims or customer service.

53. Prescription Drug

A drug that may not be legally sold in the United States to a person without a valid prescription from a Healthcare Provider who is licensed under applicable law to write the prescription.

54. Pre-Service Claim

A request for Prior Authorization.

55. Preventive Care

Healthcare items and services as described by 42 U.S.C. § 300gg-13. For a current list of items and services that are Preventive Care, see https://www.healthcare.gov/coverage/preventive-care-benefits/.

56. Prior Authorization

Prior Authorization is a condition of coverage for certain healthcare items and services under which the items and services are excluded from coverage unless you obtain approval from the Fund Office or the applicable PPO before you incur charges for the items or services. If you do not obtain Prior Authorization when it is required, the Fund will not pay benefits for the items and services you received without Prior Authorization. You only need Prior Authorization when it is expressly stated in a Plan's SPD or in the the PPO's coverage criteria. Prior Authorization is not available for any item or service for which Prior Authorization is not required. You or your Healthcare Provider may be required to obtain Prior Authorization for certain services. Your physician will coordinate the authorization process for any services which must first be authorized. See the section of this Booklet entitled Important Contact Information for information about who to contact for Prior Authorization. A PPO may have a procedure that is called "prior authorization" but that is not required as a condition of coverage under the applicable Plan. In such cases, this definition is not applicable and a Claim in such a case will not be considered a Pre-Service Claim.

57. Protected Services

Emergency Services furnished by an Out-of-Network provider, Hidden Out-of-Network Services, and Misidentified Provider Services. However, the term "Protected Services" will not include items and services if the Out-of-Network provider satisfies the notice and consent criteria of Public Health Service Act section 2799B–2(d) and its implementing regulations with respect to such items and services, and the Participant consents to receive the items or services from the Out-of-Network provider.

58. Qualified Medical Child Support Order

A judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction requiring that the Fund recognize an Employee's or Spouse's Child as an alternate recipient as defined by ERISA Section 609(a). Such order must be approved in accordance with procedures adopted by the Board of Trustees.

59. Retiree

A Member who has Retired.

60. Retired

A Member who has ceased to engage in any employment or self-employment and has filed an affidavit with the Fund Office using the form provided by the Fund Office.

61. Specialty Drug

A prescription drug that is available through the Fund's designated specialty pharmacy (see "Important Contact Information" for pharmacy contact information).

62. Spouse

An individual with whom you validly entered a formal legal relationship, denominated under the law of the state or foreign jurisdiction where the relationship was entered as a "marriage" (e.g., a marriage under Iowa Code § 595.1 et seq. and analogous statutes of other states), which has not been legally dissolved, annulled, subject to separation, or otherwise terminated by any governmental authority. For the avoidance of doubt, a common-law marriage is not a formal legal relationship and an individual to whom you are married by operation of common-law will not be considered your Spouse.

63. Summary Plan Description Or SPD

One or more sections of this Booklet whose titles begin with "Plan Document and Summary Plan Description", as indicated by context. Each Summary Plan Description and Plan Document is intended to satisfy both the requirement under ERISA to have a written plan document and the requirement under ERISA to have a written summary plan description.

64. Total Disability or Totally Disabled

A Member's inability to engage in the Member's occupation on account of an Injury or Illness within the two years following the Injury or Illness. Thereafter, a Member is Totally Disabled if the Member is unable to engage in any employment on account of the Injury or Illness.

65. Urgent Care Claim

A Claim under circumstances where application of the Fund's normal claims procedure would result in a delay in administering an item or service that could seriously jeopardize your life, health, or ability to regain maximum function, or where the delay would subject you to severe and unmanageable pain.

U.A. LOCAL 125 HEALTH AND WELFARE FUND
BENEFITS BOOKLET (2022 Edition)

SCHEDULE OF AMENDMENTS TO THE BENEFITS BOOKLET (2022 and later)

1. Effective May 1, 2022, the Benefits Booklet was amended to ensure compliance with the No Surprises Act.

2. Effective May 1, 2022, the Benefits Booklet was amended to provide a definition of mental health and substance use disorder benefits for purposes of applying the Mental Health Parity and Addiction Equity Act.

U.A. LOCAL 125 HEALTH AND WELFARE FUND
BENEFITS BOOKLET (2022 Edition)

TEMPORARY OTC COVID-19 TESTING ADDENDUM

This Temporary OTC COVID-19 Testing Addendum ("Addendum") temporarily modifies the terms of the U.A. Local 125 Health Plan ("Health Plan") as follows:

1. Definitions.

    a. Capitalized terms used but not defined in this Addendum have the meaning given by the Health Plan.

    b. The "Termination Date" of this Addendum is the date that the Department of Health and Human Services' declaration of public health emergency expires without renewal.

    c. "Special Coverage COVID-19 Testing Expenses" means expenses for in vitro diagnostic COVID-19 tests obtained without the involvement of a health care provider where the FDA labelling for such tests permits administration of the tests without a healthcare provider's order, i) that have been approved, authorized, or cleared by the Food and Drug administration, ii) that otherwise meet the statutory criteria under section 6001(a)(1) of the Families First Coronavirus Relief Act, and iii) for which Plan participants incur expenses during the period beginning on January 15, 2022 and ending on the Termination Date. Special Coverage COVID-19 Testing Expenses does not include COVID-19 tests obtained with the involvement of a health care provider.

2. Purpose. This Addendum was adopted by the Board of Trustees for the purpose of complying with "FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART 51" (the "FAQ") issued by the Department of Labor et al on January 10, 2022. Nothing in this Addendum will require the Plan to provide coverage in any greater extent than that required by the FAQ.

3. Effective Period. This Addendum is effective solely with respect to COVID-19 testing expenses that Participants and Dependents incur during the period beginning on January 15, 2022 and ending on the Termination Date.

4. Temporary COVID-19 Testing Coverage. Subject to the limitations and exclusions under this Addendum, the Plan will cover Special Coverage COVID-19 Testing Expenses without imposing any cost-sharing requirements, prior authorization, or other medical management requirements.

TEMPORARY OTC COVID-19 TESTING ADDENDUM

5. Exclusions and Limitations.

    a. The Plan excludes and will not cover expenses incurred for tests obtained without the involvement of a healthcare provider that do not qualify as Special Coverage COVID-19 Testing Expenses.

    b. The Plan excludes and will not cover Special Coverage COVID-19 Test Expenses that are incurred for use by an individual other than a Participant or Dependent, that are incurred for purposes of resale, that are reimbursable by a party other than the Plan, or for which a Participant or Dependent will not be held liable in the absence of reimbursement by the Plan.

    c. The Plan excludes and will not cover Special Coverage COVID-19 Test Expenses that are incurred for tests where the Participant or Dependent fails to provide adequate proof-of-purchase consisting of a receipt and the test packaging.

    d. The Plan limits coverage of Special Coverage COVID-19 Test Expenses to the expenses for eight such tests per Participant (or Dependent) per calendar month (e.g., the monthly limit for a household consisting of a Participant and one Dependent is sixteen tests). Unused portions of the monthly limit do not accumulate (e.g., a Participant who purchases four tests in January can have eight, as opposed to twelve), tests covered in February. The limit cannot be used in advance (e.g., a Participant who purchases sixteen tests in January and no tests in February can only receive coverage for eight tests for the two-month period). The Plan excludes and will not cover Special Coverage COVID-19 Test Expenses that are incurred for tests in excess of the monthly limit.

    e. Beginning on the date that the Plan arranges for direct coverage of OTC COVID-19 tests through both its pharmacy network and a direct-to-consumer shipping program in accordance with the requirements under Q2 of the FAQ, the Plan will limit reimbursement for Special Coverage COVID-19 Test Expenses incurred with out-of-network providers to the lesser of actual price or twelve dollars per test. Once effective, the limit under this subparagraph will remain in effect until the Termination Date or the date that the Plan can no longer provide direct coverage, if earlier.

6. Miscellaneous. To the extent that any provision of this Addendum directly conflicts with a pre-existing term or terms of the Health Plan, this Addendum will prevail. Except as

expressly affected by this Addendum, all terms of the Health Plan remain in effect including, without limitation, those terms that govern the adjudication of claims for COVID-19 testing expenses. Headings in this Addendum are for convenience and are to be disregarded in interpreting the Addendum.