PIPE FITTERS LOCAL NO. 533 HEALTH AND WELFARE PLAN

Combination Plan Document
and
Summary Plan Description

Effective March 1, 2023

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IMPORTANT NUMBERS

PIPE FITTERS LOCAL NO. 533 HEALTH AND WELFARE PLAN

CLAIMS ADMINISTRATOR AND PLAN ADMINISTRATOR

Solxsys Administrative Solutions, LLC
5600 New King Drive, Suite 330
Troy, MI 48098

Satellite Office Maintained At:
8600 Hillcrest Road, Suite A
Kansas City, MO 64138
Phone: (816) 361-0206
Fax: (816) 444-4275

PPO AND CASE MANAGEMENT PROVIDER

Blue Cross and Blue Shield of Kansas City
One Pershing Square
2301 Main Street
P.O. Box 419169
Kansas City, MO 64141-6169
Telephone: (816) 395-2222
Toll Free: (888) 989-8842 (Customer Contact Center)
You can locate a Preferred Provider by visiting: www.bluekc.com

TELEHEALTH PROVIDER

Blue KC Virtual Care
www.member.bluekc.com
(888) 658-6653 (Telehealth Support)

PRESCRIPTION BENEFIT MANAGER

Sav-Rx Prescription Services
224 North Park Avenue
Fremont, NE 68025

Mail Order Address:
P.O. Box 8
Freemont, NE 68026

Toll Free: (800) 228-3108
Fax: (888) 810-1394
www.savrx.com

DENTAL PROVIDER

Delta Dental of Missouri
P.O. Box 8690
St. Louis, MO 63126-0690
Main Phone: (314) 656-3000
Customer Service Phone: (314) 656-3001
Toll Free: (800) 392-1167 or Toll Free: (800) 335-8266
www.DeltaDentalMO.com

EMPLOYEE ASSISTANCE PROGRAM

LifeMatters
Empathia, Inc.
N17 W24100 Riverwood Drive, Suite 300
Waukesha, WI 53188
(800) 634-6433
https://members2.mylifematters.com/portal/welcome/sso

MEDICARE

Enrollment (through Social Security): (800) 772-1213

Other Questions: (800) MEDICARE / (800) 633-4227

www.medicare.gov

TIPS TO BE A SMART HEALTH CARE CONSUMER

The suggestions listed below will not only save the Plan money but will also save you money.

TOP TEN WAYS TO SAVE

1. Utilize providers in the Blue Cross and Blue Shield of Kansas City ("Blue KC") network whenever possible.

2. Enroll in Medicare as soon as you are eligible for Part A and Part B coverage.

3. Utilize the Sav-Rx Mail Order Pharmacy for maintenance drugs that you take on an on-going basis. You should also inquire about the cost of medications. Generic drugs often cost less than name brands and your Physician will prescribe them if you ask.

4. Review your copy of all provider billings to make sure you received the services for which they are billing. Question all discrepancies.

5. Utilize urgent care facilities and telehealth through Blue KC Virtual Care rather than the emergency department of a Hospital if you need non-emergency care outside the office hours of your Physician.

6. Maintain a healthy lifestyle. Many sicknesses and injuries can be prevented. Major illnesses such as heart disease are often connected with lifestyle. Smoking, excessive drinking of alcoholic beverages, improper diet, and stress are a few of the factors that can cause illness. By eating right, getting enough sleep, and exercising regularly, you can prevent many sicknesses.

7. When you get a referral from your Physician, ensure that the referred Physician is an in-network provider.

8. Establish a Relationship with a Primary Care Physician and utilize this Physician whenever possible.

9. Schedule a physical each year to identify and treat health issues before those issues become severe.

10. When you need services, such as lab tests, x-rays and outpatient surgeries, receive the services at in-network free-standing facilities rather than hospitals.

INTRODUCTION

The Board of Trustees of the Pipe Fitters Local No. 533 Health and Welfare Plan is pleased to provide you with this updated Combination Plan Document and Summary Plan Description ("SPD"). The Plan described in this SPD is effective March 1, 2023 and replaces all other Plan documents previously provided to you.

The Plan is established on a non-insured basis. This means that all liability for payment of benefits is assumed by the Plan. The Board of Trustees has the power and discretion to amend, change, add to, interpret, or terminate the Plan.

If something in this SPD is not clear, you should contact the Fund Office for more information. We have included a list of important numbers in the front of this SPD that you can refer to if you need information or clarification.

The Plan provides the following benefits:

- Comprehensive Medical Benefits;
- Prescription Drug Benefits;
- Dental Benefits;
- Vision Benefits;
- Death Benefits;
- Accidental Death and Dismemberment Benefits; and
- Accident and Sickness Loss of Time Benefits.

You should remember that by saving the Plan money, we are able to provide better benefits. Saving the Plan money also helps lessen the need to increase the hourly contribution rate, which may ultimately decrease your paycheck. There are certain things you can do to help in this effort, such as using in-network providers and using generic prescription drugs whenever possible. If you feel you were overcharged by a provider, please call the provider and ask for an itemized bill of your expenses.

In order to protect your family's rights, you should keep the Fund Office informed of any changes in the addresses of you and your family members. You should also keep a copy for your records of any notices that you send to the Fund Office.

Please take some time to review this SPD. If you are married, share this SPD with your spouse. We recommend that you keep this SPD with your important papers so that you can refer to it when needed.

We hope that you find this SPD useful, and we hope that you and your family will enjoy the Plan's benefits for years to come.

Sincerely,

Trustees of the Pipe Fitters Local No. 533 Health and Welfare Plan

IMPORTANT NOTICE

This SPD is intended to describe the Comprehensive Medical Benefits, Prescription Drug Benefits, Dental Benefits, Vision Benefits, Death Benefits, Accidental Death and Dismemberment Benefits, and Accident and Sickness Loss of Time Benefits provided by the Plan. Only the full Board of Trustees has the authority to interpret the benefits described in this SPD. Their interpretation will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. The Plan contains appeal procedures that may be used if you feel that benefits have been wrongfully denied. The Trustees' decision can be challenged in court only after those procedures are exhausted. No Employer or Union nor any representative of any Employer or Union, in such capacity, is authorized to interpret this Plan nor can any such person act as an agent of the Trustees.

The Board of Trustees has complete power and discretion to amend or terminate the Plan, in whole or in part, at any time. This means that the Trustees can reduce or eliminate benefits, terminate all benefits for certain Participants, or modify the availability, nature, and extent of benefits, and the conditions for and method of payment of benefits. The Trustees may also modify the eligibility and coverage requirements and the rules surrounding a Participant's hours of work in Covered Employment. The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time a claim occurs.

The Board has authorized the Fund Office to respond in writing to your written questions. If you have a question about your benefits, you should write to the Fund Office for a definitive answer. As a courtesy to you, the Fund Office may also respond informally to oral questions. However, oral information and answers are not binding upon the Board of Trustees and cannot be relied on in any dispute concerning your benefits.

Notice of Plan Changes

Notices of any changes to the Plan rules and benefits will be sent to each Participant's last known address. Please be sure to read all Plan announcement letters about benefit changes and keep them with this SPD. In order for you to be aware of the benefits available to you and your Dependents, please read this SPD carefully prior to obtaining medical care. If you have any questions about the benefits described in this SPD, please contact the Fund Office.

Notices of Plan changes will be sent to each Participant's last known address.

It is extremely important that you notify the Fund Office, in writing, of any address change!

Defined Terms

Certain words have specific meaning and are capitalized when used in the Plan. These words are listed in Article XV - Definitions. It is important to understand the meanings of the defined terms when using this SPD.

PREFERRED PROVIDER ORGANIZATION

The Fund offers the Blue Cross and Blue Shield ("BCBS") National Preferred Provider Organization network of Physicians, Hospitals, facilities, and other health care providers. BCBS contracts with these providers to offer medical treatment to Covered Persons at reduced rates. This network of providers is called a Preferred Provider Organization ("PPO") and the providers in the network are called in-network providers.

The Fund's Preferred Provider Organization is Blue Cross and Blue Shield National Preferred Provider Organization.

For up-to-date provider information, visit Blue Cross and Blue Shield's website at http://www.BlueKC.com

BlueCard PPO Program

The BlueCard PPO program is a national Preferred Provider program offered by Blue KC and other participating Blue Cross and/or Blue Shield Plans across the country. This program offers Participants and their Dependents access to a National PPO provider network so they can receive the highest level of Plan benefits when they obtain Covered Services from any Physician, Hospital, or other health care provider designated as a Preferred Provider in the BlueCard PPO Program. You are not required to use an in-network provider to receive benefits from the Plan. However, by using an in-network provider, you benefit from the following important advantages:

- You will pay a lower percentage of the Allowable Charges for most treatments; and
- You will not have to pay charges that exceed the Allowable Charges. The Plan specifically excludes payment for any part of a charge for treatment that exceeds the Allowable Charge. When you receive treatment from an in-network provider, you will not be billed for more than the total Allowable Charge. If you use an out-of-network provider, that provider could bill for more than the total Allowable Charge.

It is always a good idea to verify if your provider is in the PPO network before receiving treatment. Visit BCBS's website at http://www.BlueKC.com for the most up-to-date provider information. You can also call the Fund Office at (888) 989-8842.

No matter how you access a directory, it is recommended that you take the following steps: (1) verify your provider's participation in the network before seeking treatment; and (2) confirm PPO network participation with your provider when making an appointment.

To keep your costs as low as possible, YOU need to ask for in-network providers at every level of service. It is up to you to look out for your own interests. Do not assume that your in-network Doctor will be doing this for you. You can ask the Doctor, but (s)he may not know or may be misinformed. For more information about in-network providers, you can call the Fund Office at (888) 989-8842 or visit www.bcbskc.com.

NOTE: If you use an out-of-network provider, the Plan's eligible benefit amount will not be assignable (paid) directly to the provider. This means the Plan will directly pay you for out-of-network provider claims and you are responsible for paying the out-of-work provider. This policy is standard for all plans with BCBS, but only applies to out-of-network provider claims.

LIFE EVENTS AT A GLANCE

There are several significant events that may occur while you are covered under the Plan. Immediately contact the Fund Office, in writing, if any of the following occurs:

- **YOUR ADDRESS OR TELEPHONE NUMBER CHANGES**.
- **YOU MARRY OR DIVORCE**. You must also submit the appropriate legal documents (for example: marriage certificate or divorce decree).
- **YOU CHANGE YOUR BENEFICIARY**.
- **YOUR DEPENDENT CHILD NO LONGER QUALIFIES AS A DEPENDENT UNDER THE TERMS OF THE PLAN**.
- **YOU BECOME A PARENT**. You must also submit the child's state-certified birth certificate, a decree of adoption or placement for adoption, a Qualified Medical Child Support Order, or other legal documentation.
- **YOU GO INTO OR RETURN FROM MILITARY SERVICE**.
- **YOU BEGIN RECEIVING WORKERS' COMPENSATION BENEFITS**.
- **YOU ARE ABOUT TO TURN AGE 65 AND BECOME ELIGIBLE FOR MEDICARE. SEE SECTION 10.04 FOR MORE DETAILS**.
- **YOU RETIRE**.

EMPLOYEE ASSISTANCE PROGRAM

The Plan provides a free program to help Covered Persons cope with personal difficulties that can affect their lives both at home and at work. This free program is called the Employee Assistance Program ("EAP") and is available to all Covered Persons.

The Plan's EAP provider is Empathia Inc. ("Empathia"). Empathia provides an EAP referred to as the LifeMatters program ("LifeMatters"). LifeMatters is a free program and assists Covered Persons with a variety of life problems, including: alcohol and drug abuse; stress, anxiety, and depression; marital, family, and relationship discord; child and adolescent behavioral problems; domestic violence; child care; elder care; financial and legal concerns; and educational and career related problems. All contact with LifeMatters is confidential.

The Trustees encourage you to take advantage of the assessment and supportive counseling services offered by Empathia to help you determine the clinically appropriate level of care that you may need for your mental health or substance abuse condition.

To utilize this program, please contact Empathia at (800) 634-6433. Information is also available at: https://members2.mylifematters.com/portal/welcome/sso

ARTICLE I - ELIGIBILITY

The following topics are discussed under this Article on Eligibility:

- 1.01 Definitions for this Article I Only
- 1.02 Initial Eligibility
- 1.03 Continuing Eligibility and Coverage
- 1.04 Eligibility and Coverage under a Participation Agreement
- 1.05 Reciprocity
- 1.06 Retiree Eligibility and Coverage
- 1.07 Retiree Premium
- 1.08 Termination of Coverage for Eligible Employees and Retirees
- 1.09 Reinstatement of Coverage as an Eligible Employee
- 1.10 Reinstatement of Coverage as a Retiree
- 1.11 Qualification as an Eligible Dependent Spouse of an Eligible Employee
- 1.12 Qualification as an Eligible Dependent Child of an Eligible Employee
- 1.13 Initial Date of Coverage for an Eligible Dependent Spouse of an Eligible Employee
- 1.14 Initial Date of Coverage for an Eligible Dependent Child of an Eligible Employee
- 1.15 Waiver of Coverage for an Eligible Dependent of an Eligible Employee
- 1.16 Termination of Coverage for a Spouse of an Eligible Employee
- 1.17 Termination of Coverage for a Child of an Eligible Employee
- 1.18 Reinstatement of Coverage for an Eligible Dependent Spouse of an Eligible Employee
- 1.19 Reinstatement of Coverage for an Eligible Dependent Child of an Eligible Employee
- 1.20 Qualification as an Eligible Dependent Spouse of a Retiree
- 1.21 Qualification as an Eligible Dependent Child of a Retiree
- 1.22 Coverage for an Eligible Dependent of a Retiree
- 1.23 Termination of Coverage for a Spouse and/or Child of a Retiree
- 1.24 Coverage for a Surviving Spouse of an Eligible Employee
- 1.25 Coverage for a Surviving Dependent Child of an Eligible Employee
- 1.26 Surviving Spouse Premium for the Surviving Spouse of an Eligible Employee
- 1.27 Coverage for a Surviving Spouse of a Retiree
- 1.28 Coverage for a Surviving Dependent Child of a Retiree
- 1.29 Surviving Spouse Premium for the Surviving Spouse of a Retiree
- 1.30 General Notice of COBRA Continuation Coverage Rights
- 1.31 Certificates of Creditable Coverage
- 1.32 Suspension of Certain Deadlines Due to COVID-19

To understand how coverage under the Plan works, you must understand the following key concepts: (1) how you initially become an Eligible Employee; and (2) how you remain an Eligible Employee. To understand these concepts, you must understand the meaning of the terms Qualifying Period and Coverage Period.

A Qualifying Period is a defined period of four calendar months during which you must work a specified minimum number of hours in Covered Employment to become and remain covered by the Plan (i.e., to become and remain an Eligible Employee). There are three Qualifying Periods:

- June 1 through September 30;
- October 1 through January 31; and
- February 1 through May 31.

A Coverage Period is a defined period of four calendar months during which you and your Dependents are eligible to receive benefits from the Plan based on work performed during a Qualifying Period (or Qualifying Periods). There are three Coverage Periods:

- November 1 through February 28 (if leap year, February 29);

- March 1 through June 30; and
- July 1 through October 31.

Section 1.01 - Definitions for this Article I Only

The following terms will have specific meaning when they are used within this Article:

(a) Alternate Recipient

"Alternate Recipient" means a person who is entitled to coverage under this Plan under a Qualified Medical Child Support Order.

(b) Coverage Period

"Coverage Period" means a specified period of four calendar months (November 1 through February 28/29, March 1 through June 30, and July 1 through October 31) during which an Eligible Employee and his/her Dependents are eligible to receive benefits under this Plan based on work performed during a corresponding Qualifying Period.

(c) Disabled Participant

"Disabled Participant" means a Participant that is receiving Social Security Disability Benefits or other benefits under the federal Social Security Act on account of his/her disability, when such determination is based on a finding by the Social Security Administration that the Participant is unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment.

(d) Exempt Coverage

"Exempt Coverage" means any of the following:

- COBRA coverage;
- Coverage that does not provide medical or prescription drug benefits (e.g., a dental plan or a vision plan); or
- Coverage that does not permit another health plan to pay benefits on a secondary basis (i.e., coverage that is not available to an Eligible Employee's spouse if the Eligible Employee's spouse has secondary coverage from another health plan). If the employer-sponsored coverage available to an Eligible Employee's spouse is a high-deductible health plan ("HDHP") combined with a Health Savings Account ("HSA"), the coverage is not considered Exempt Coverage. This means that if the employer-sponsored coverage available to an Eligible Employee's spouse is a HDHP combined with a HSA, the spouse is not eligible for coverage from the 533 Plan unless she is enrolled in her employer's HDHP. If the Eligible Employee's spouse is enrolled in her employer's HDHP, she is eligible for coverage from the 533 Plan regardless of whether or not she makes or receives employee and/or employer contributions to the HSA.

(e) Participation Agreement

"Participation Agreement" means any written agreement between the Fund and an Employer which requires the Employer to submit contributions to the Fund in an amount and manner acceptable to the Trustees.

(f) Qualifying Health Coverage

"Qualifying Health Coverage" means an employer-sponsored health plan that provides "minimum value" (as that term is defined by the Affordable Care Act), does not cost the Eligible Employee's

spouse more than $250 a month (i.e., the Eligible Employee's spouse does not have to pay more than $250 a month for the least expensive coverage option that is available from his or her employer), and is not Exempt Coverage (as that term is defined in Section 1.01(d)).

(g) Qualifying Period

"Qualifying Period" means a certain four-month block of time during which an Employee must work the required number of hours to become eligible for coverage under the Plan, and once the Employee is eligible it is the block of time during which the Employee must work the required number of hours to maintain eligibility for coverage.

(h) Reciprocity Agreement

"Reciprocity Agreement" means the United Association Health & Welfare Fund Reciprocal Agreement or any other agreement between the Plan and one or more unrelated health and welfare funds permitting the Plan to accept contributions for, or recognize hours of work in Covered Employment earned by, Participants for work performed in the plumbing and pipe fitting industry for an Employer that is obligated to make contributions to a health and welfare fund pursuant to a collective bargaining agreement.

(i) Working Spouse Rule

"Working Spouse Rule" means the rule described in Section 1.11(b) that generally provides that if your spouse is employed and she has Qualifying Health Coverage available from her employer, your spouse is not eligible for coverage from the Plan unless she is enrolled in her employer's health plan.

(j) Year of Service

"Year of Service" means the following:

(1) During a Plan Year that began prior to June 1, 1981, a year in which you worked at least one hour in Covered Employment; and

(2) During a Plan Year that began on or after June 1, 1981, a year in which you worked at least 800 hours in Covered employment.

Section 1.02 - Initial Eligibility

You will automatically be covered by the Plan (i.e., you will become an Eligible Employee) at 12:00 a.m. on the first day of the Coverage Period that begins one month after the first Qualifying Period in which you work at least 400 hours in Covered Employment.

The following chart illustrates how initial eligibility and coverage work:

If you work at least 400 hours in Covered Employment during the Qualifying Period of . . .	Your initial eligibility date is . . .	And your initial Coverage Period is . . .
June 1 through September 30	November 1	November 1 through February 28 (if leap year, February 29)
October 1 through January 31	March 1	March 1 through June 30
February 1 through May 31	July 1	July 1 through October 31

The following examples illustrate how initial eligibility and coverage work:

Example 1: On June 1, 2023, Joe begins to work in Covered Employment. Joe works 400 hours in Covered Employment during the June 1 through September 30, 2023 Qualifying Period. On November 1, 2023, Joe will become covered by the Plan (i.e., (s)he will become an Eligible Employee).

Example 2 On July 1, 2023, Joe begins to work in Covered Employment. Joe works 300 hours in Covered Employment during the June 1 through September 30, 2023 Qualifying Period. Joe also works 100 hours in Covered Employment in October 2023. On November 1, 2023, Joe will NOT become covered by the Plan (i.e., (s)he will NOT become an Eligible Employee) because (s)he did not work at least 400 hours in Covered Employment during the June 1 through September 30, 2023 Qualifying Period.

Section 1.03 - Continuing Eligibility and Coverage

As explained in Section 1.03(a) and Section 1.03(b), once you become an Eligible Employee, your coverage from the Plan will continue for each Coverage Period that your coverage is not terminated in accordance with Section 1.08 and you meet at least one of the following criteria:

- You work at least 250 hours in Covered Employment in the Qualifying Period immediately prior to the Coverage Period;
- You work at least 500 hours in Covered Employment in the two consecutive Qualifying Periods immediately prior to the Coverage Period; or
- You pay the self-payment premium in accordance with Section 1.03(b).

(a) Continuing Eligibility and Coverage through Hours Worked in Covered Employment

The following chart illustrates how you can continue your coverage under the Plan by working sufficient hours in Covered Employment (i.e., how you can continue your coverage by working sufficient hours in accordance with the first two bullet points of this Section 1.03):

If you work at least . . .	**You will have coverage during the Coverage Period of . . .**
250 hours in Covered Employment from June 1 through September 30 **OR** 500 hours in Covered Employment from February 1 through September 30	November 1 through February 28 (if leap year, February 29)
250 hours in Covered Employment from October 1 through January 31 **OR** 500 hours in Covered Employment from June 1 through January 31	March 1 through June 30
250 hours in Covered Employment from February 1 through May 31 **OR** 500 hours in Covered Employment from October 1 through May 31	July 1 through October 31

(b) Continuing Eligibility and Coverage Through Self-Payments

(1) Eligibility to make self-payments

If you do not work sufficient hours in Covered Employment to remain covered by the Plan in accordance with Section 1.03(a), you may pay a self-payment premium to remain covered by the Plan as an Eligible Employee if you meet all of the following criteria:

(i) You pay the appropriate self-payment premium in accordance with this Section 1.03(b);

(ii) You are covered by the Plan (i.e., you are an Eligible Employee) immediately prior to the calendar month that you pay the self-payment premium for coverage (i.e., you do not have a lapse in coverage); and

(iii) You are not receiving benefits from the Pension Plan or the Plumbers & Pipefitters National Pension Fund.

You may pay the self-payment premium to remain covered by the Plan in accordance with this Section 1.03(b) for a maximum of 18 consecutive months. If you fail to qualify for coverage based on hours worked in Covered Employment, pay the self-payment premium to remain covered, then again qualify for coverage based on hours worked in Covered Employment, the months you previously paid the self-payment premium will not affect the 18-month limit of future period(s) in which you pay the self-payment premium to remain covered (i.e., the 18-month limit is reset after you again qualify for coverage from the Plan based on hours worked in Covered Employment).

(2) Self-payment premium amount and due date

The self-payment premium amount is the dollar amount that you are required to pay to receive a month of coverage from the Plan as an Eligible Employee. The Board of Trustees has the authority to establish and change the self-payment premium amount from time to time, as it deems appropriate in its sole and exclusive discretion. Effective June 1, 2017, the self-payment premium amount is $400.00 per month regardless of whether or not you have any Dependents covered by the Plan (i.e., if you do not have any Dependents covered by the Plan, your self-payment premium amount is $400.00 per month. If you, your spouse, and/or your Dependent child are covered by the Plan, your self-payment premium amount is still $400.00 per month).

Your self-payment premium is due in full on the first day of the calendar month for which you intend to pay the self-payment premium to remain covered by the Plan. Unless there are extenuating circumstances, as determined solely by the Plan Administrator, your coverage from the Plan through self-payments will terminate if the Fund Office does not receive your self-payment premium in full by the fifth business day of the calendar month. If your coverage from the Plan is terminated, you will only regain coverage from the Plan if you work sufficient hours in Covered Employment in accordance with Section 1.09. If your coverage from the Plan through self-payments terminates, you may be eligible for COBRA continuation coverage. Refer to Section 1.30 for information about COBRA continuation coverage.

The following examples illustrate how continued eligibility and coverage work (i.e., continuation of coverage based on hours worked in Covered Employment and/or self-payments):

Example 1: Joe is covered by the Plan as an Eligible Employee on June 1, 2023. Joe works 250 hours in Covered Employment during the June 1 through September 30, 2023 Qualifying Period. Joe remains covered by the Plan for the November 1 through February 28, 2024 Coverage Period (i.e., (s)he remains an Eligible Employee during the period of November 1 through February 28, 2024).

Example 2: Joe is covered by the Plan as an Eligible Employee on February 1, 2023. Joe works 500 hours in Covered Employment during the period of February 1 through September 30, 2023. Joe remains covered by the Plan for the November 1 through February 28, 2024 Coverage Period (i.e., (s)he remains an Eligible Employee during the period of November 1 through February 28, 2024).

Example 3: Joe is covered by the Plan as an Eligible Employee on February 1, 2023. Joe works 250 hours in Covered Employment during the period of February 1 through May 31, 2023. Joe also works 240 hours in Covered Employment during the period of June 1 through September 30, 2023. Joe is only eligible for coverage from the Plan during the November 1 through February 28, 2024 Coverage Period if (s)he pays the self-payment premium (i.e., (s)he will only remain an Eligible Employee during the period of November 1 through February 28, 2024 if (s)he pays the self-payment premium).

Example 4 Joe is covered by the Plan as an Eligible Employee on October 1, 2023. Joe does not work sufficient hours in Covered Employment to remain covered by the Plan during the Coverage Period that begins on November 1, 2023. On November 1, 2023, Joe pays the self-payment premium and (s)he remains covered by the Plan. In November 2023, December 2023, and January 2024, Joe pays the self-payment premium and works 100 hours each month in Covered Employment. On February 1, 2024, Joe loses his/her job in Covered Employment. On March 1, 2024, Joe is automatically covered by the Plan through June 30, 2024 based on the hours that (s)he worked in Covered Employment during the October 1, 2023 through January 31, 2024 Qualifying Period.

From March 1, 2024 through June 30, 2024, Joe does not work in any type of employment. On July 1, 2024, Joe pays the self-payment premium (i.e., as of July 1, 2024, (s)he is no longer automatically covered by the Plan because (s)he did not work sufficient hours in Covered Employment during the prior Qualifying Periods). Joe may continue to self-pay for coverage for 18-conseuctive months (i.e., because (s)he again qualified for coverage based on the hours worked in Covered Employment, his/her 18-month limit of self-payment coverage was reset and (s)he may self-pay for coverage until December 31, 2025 so long as his/her coverage is not otherwise terminated).

(c) Continuing Eligibility and Coverage While on Leave Pursuant to the Family and Medical Leave Act

An Eligible Employee on qualified leave pursuant to the Family and Medical Leave Act of 1993 ("FMLA") will not lose health benefits under this Plan as a result of such leave. The determination of whether an Eligible Employee is entitled to FMLA-qualified leave shall be made by the Eligible Employee's Employer. Generally, to qualify for FMLA benefits, an Eligible Employee must meet all of the following criteria:

(1) He works for an Employer;

(2) He has worked for an Employer for at least 12 months;

(3) He has worked at least 1,250 hours over the previous 12 months; and

(4) He works at a location where at least 50 employees are employed by the Employer within 75 miles.

An Eligible Employee will also qualify for FMLA benefits if his/her Employer is required by state or other law, or any applicable Collective Bargaining Agreement, to maintain his/her health coverage for additional periods.

The qualifying Eligible Employee's Employer must make contributions to the Plan on the Eligible Employee's behalf as if the Eligible Employee had continued to work during the FMLA leave. Contributions will be paid in an amount equal to the average number of hours the Eligible Employee worked in each of the six consecutive weekly pay periods immediately prior to the week in which the leave began multiplied by the hourly contribution rate set by the applicable Collective Bargaining Agreement. The Plan will accept contributions for such hours as if the Eligible Employee had actually worked those hours. The Plan will credit the Eligible Employee with all hours for which contributions are received pursuant to this Section 1.03(c) as if the Eligible Employee had actually worked such hours.

(d) Continuing Eligibility and Coverage While Away from Work Due to an Injury or Sickness

An Eligible Employee will be credited with 16 hours per week for each week that (s)he meets both of the following criteria:

(1) He is absent from work because (s)he is completely unable to perform any work in the plumbing and pipe fitting industry due to injury or Sickness; and

(2) He is receiving Accident and Sickness Loss of Time Benefits from the Plan or (s)he is receiving benefits under workers' compensation (or a similar law or program) during the period that (s)he is unable to work.

If an Eligible Employee meets both of the criteria above for a period that includes a partial week, (s)he will be credited with a prorated number of hours, calculated by multiplying the 16 hours of weekly credit by a fraction, the numerator of which is the number of days during the partial week for which the Eligible Employee meets the criteria above, and the denominator of which is seven. An Eligible Employee will not be credited with any hours during a period that benefits under workers' compensation (or a similar law or program) are paid based on a partial disability.

(e) Eligibility and Coverage During and After Service in the Uniformed Services

Under the Uniformed Services Employment and Re-employment Rights Act of 1994 ("USERRA") or other applicable federal law, an Employee and his/her Dependents may be entitled to continued eligibility and coverage from the Plan during certain periods of service in the United States Uniformed Services. This coverage, referred to as USERRA continuation coverage, is nearly identical to COBRA continuation coverage. An Employee should contact the Fund Office immediately upon receiving notification that (s)he is being called to duty in the Uniformed Services. The Board of Trustees has established a written USERRA Policy that describes the Plan's procedures when an Employee serves in the Uniformed Services. This USERRA Policy is consistent with the following general principles:

(1) "Uniformed Services" refers to the Armed Forces; the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty; the commissioned corps of the Public Health Service; any other category of persons designated by the President in time of war or national emergency; and any other category of persons as may be designated by Congress. An Employee performs service in the Uniformed Services if (s)he performs duty on a voluntary or involuntary basis in a Uniformed Service under competent authority. Such service includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, a period for which the Employee is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty, and a period for which the Employee is absent from employment for the purpose of performing funeral honors duty as authorized by Section 12503 of Title 10, U.S.C. or Section 115 of Title 32, U.S.C.

(2) An Employee must provide advance written or oral notice to his/her Employer and the Fund Office of his/her service in the Uniformed Services, unless the giving of such notice is precluded by military necessity or, under all of the relevant circumstances, the giving of such notice is otherwise impossible or unreasonable. Military necessity shall be determined with respect to regulations prescribed by the Secretary of Defense.

(3) Continuation of eligibility and coverage shall be available to an Employee whose cumulative absence from employment with an Employer for the purpose of performing service in the Uniformed Services does not exceed five years, subject to certain exceptions as may be required by federal law. All periods of absence for the purpose of performing service in the Uniformed Services shall be aggregated for the purpose of determining the five year maximum.

(4) An Employee must return to Covered Employment, or must re-apply for Covered Employment (by notifying his/her last Employer and/or the Union and requesting either reinstatement or listing on the out-of-work list and providing a copy of his/her Form DD-214, if applicable) within the following maximum time frames:

  (i) If the absence due to service in the Uniformed Services was for less than 31 days, not later than the first business day following completion of the period of service (completion of the period of service is deemed to occur upon the completion of eight hours following a period allowing for the safe transportation of the person from the place of service to his/her place of residence following discharge);

  (ii) If the absence due to service in the Uniformed Services was for more than 30 days but less than 181 days, within 14 days following discharge; or

  (iii) If the absence due to service in the Uniformed Services was for more than 180 days, within 90 days following discharge.

(5) The hours that an Employee works before leaving Covered Employment for service in the Uniformed Services shall be "frozen" from the date the Employee leaves Covered Employment for service in the Uniformed Services until the date the Employee returns to Covered Employment or signs the out-of-work list with the Union, as applicable, if (s)he meets all of the following criteria:

  (i) He is covered by the Plan (i.e., (s)he is an Eligible Employee) immediately prior to the date (s)he begins service in the Uniformed Services;

(ii) He does not elect to use hours worked in Covered Employment prior to service in the Uniformed Services to continue receiving coverage from the Plan;

(iii) He is absent from Covered Employment as a result of his/her service in the Uniformed Services;

(iv) He provides advance notice in accordance with Section 1.03(e)(2);

(v) His cumulative absence from Covered Employment as a result of his/her service in the Uniformed Services does not exceed five years, subject to certain exceptions specified in federal law and/or the Plan's USERRA Policy;

(vi) His service in the Uniformed Services is not terminated for dishonorable or other undesirable conduct; and

(vii) He returns to Covered Employment or signs the out-of-work list with the Union, as applicable, within the timeframe described in Section 1.03(e)(4).

(6) The Employee shall be offered USERRA continuation of coverage for up to 24 months from the date the Employee's coverage from the Plan is terminated in accordance with Section 1.08(a)(5), pursuant to the rules governing COBRA continuation coverage explained in Section 1.30. An Employee that elects USERRA continuation coverage is generally required to pay a premium for that coverage. However, if the Employee's period of service in the Uniformed Services is less than 31 days, no premium shall be required. In addition, no premium shall be required with respect to Dependents of a member of the military reserves for the period beginning on the date the Employee leaves Covered Employment for active duty service in the reserves until the date on which the Employee's Dependents are eligible for dependent health care coverage through the military. USERRA continuation coverage shall terminate at 12:00 a.m. on the earliest of the following days:

(i) The first day of the calendar month following the calendar month that the Employee has received USERRA continuation coverage for 24 consecutive months;

(ii) The day the Employee's eligibility and coverage from the Plan are reinstated (i.e., the day the Employee becomes an Eligible Employee again) in accordance with the terms of the Plan's USERRA Policy;

(iii) The first day of the calendar month following the last day that the Employee may return to Covered Employment or sign the out-of-work list with the Union, as applicable, in accordance with Section 1.03(e)(4);

(iv) The first day of the calendar month in which the Employee does not pay the premium for USERRA continuation coverage in accordance with the Plan and the Plan's USERRA Policy; or

(v) The first day of the calendar month following the Employee's death.

(7) In appropriate circumstances, as determined by the Plan Administrator, the Plan may recognize a family member or other person as the personal representative of an Employee performing service in the Uniformed Services. Any action taken by such deemed personal representative shall be binding on the Employee and any affected Dependents.

Section 1.04 - Eligibility and Coverage under a Participation Agreement

An Employee who qualifies for coverage from the Plan (i.e., becomes an Eligible Employee) through a Participation Agreement, as well as any Dependents of such Employee, will be treated the same as other Eligible Employees and eligible Dependents.

For Employees who qualify for coverage from the Plan by reason of a Participation Agreement, the rules regarding contributions that are remitted to the Plan, including, but not limited to, the due date of the contributions and the consequences for failure to timely remit contributions, shall be governed by the applicable Participation Agreement.

Section 1.05 - Reciprocity

The Plan has entered into a Reciprocity Agreement. Pursuant to the Reciprocity Agreement, an employer that is not otherwise obligated to contribute to the Plan will remit contributions to the Plan on an Employee's behalf when the Employee works outside of the Union's jurisdiction. An Employee who has contributions remitted to the Plan on his/her behalf through the Reciprocity Agreement will gain initial eligibility (i.e., (s)he will become an Eligible Employee) by meeting the initial eligibility criteria explained in Section 1.02. Once the Employee qualifies for coverage from the Plan, (s)he will continue to receive coverage from the Plan by meeting the continuing eligibility criteria explained in Section 1.03. For purposes of determining whether or not an Employee has met the criteria explained in Section 1.02 or Section 1.03, as applicable, the hours that the Employee worked in another Union's jurisdiction will be prorated and converted to hours in Covered Employment based on the contribution rate in effect in the jurisdiction in which the Employee worked. For example, if the Plan's contribution rate is $10 an hour, and $5 an hour is remitted to the Plan for an Employee's work outside of the Union's jurisdiction, the Plan will credit the Employee with one hour in Covered Employment for every two hours that the Employee works outside of the Union's jurisdiction.

Except as specifically provided in this Section 1.05, an Employee who qualifies for coverage from the Plan (i.e., becomes an Eligible Employee) based on contributions remitted in accordance with the Reciprocity Agreement, as well as any Dependents of such Employee, will be treated the same as other Eligible Employees and eligible Dependents.

Section 1.06 - Retiree Eligibility and Coverage

To receive coverage from the Plan as a Retiree, you must meet all of the following criteria:

(a) You are age 55 or older or a Disabled Participant as that term is defined in Section 1.01(c);

(b) You meet at least one of the following criteria:

    (1) You are covered by the Plan as an Eligible Employee or a Retiree for a minimum of 36 of the 60 months immediately prior to the date you intend to begin receiving coverage as a Retiree. Months you are covered by COBRA continuation coverage do not count towards this criteria; or

    (2) You work in Covered Employment for at least 400 hours in at least three Qualifying Periods that begin and/or end during the 24-month period immediately prior to the date you begin receiving benefits from the Pension Plan;

(c) You have not worked sufficient hours in Covered Employment in accordance with Section 1.03(a) to remain eligible for coverage from the Plan as an Eligible Employee;

(d) You are receiving benefits from the Pension Plan;

(e) You make an appropriate Retiree health coverage election at the time you submit an application for benefits to the Pension Plan;

(f) You are covered by the Plan the month immediately prior to the date you intend to begin receiving coverage as a Retiree or you are covered by the Plan on the first day of the calendar month that you begin receiving benefits from the Pension Plan (i.e., the first day of the calendar month that you actually receive payment from the Pension Plan); and

(g) You pay the appropriate Retiree premium in accordance with Section 1.07.

If you are covered by the Plan as an Eligible Employee on the date you begin receiving benefits from the Pension Plan, your Retiree coverage will begin at 12:00 a.m. on the day following the last day you are covered by the Plan as an Eligible Employee. If you are not covered by the Plan as an Eligible Employee on the date you begin receiving benefits from the Pension Plan, your Retiree coverage will begin at 12:00 a.m. on the first day of the calendar month that you begin receiving monthly benefits from the Pension Plan (i.e., the first day of the calendar month that you actually receive payment from the Pension Plan). For example, if you are not covered by the Plan on February 1, 2023, you submit an application for benefits to the Pension Plan on February 15, 2023, and you receive benefits from the Pension Plan on April 1, 2023 that are retroactive to February 1, 2023, your Retiree coverage will begin at 12:00 a.m. on April 1, 2023.

NOTE: If you are receiving benefits from the Pension Plan and subsequently stop receiving those benefits, you will meet the criteria of Section 1.06(e) if you make an appropriate Retiree health coverage election at the time you submit an application to resume benefits from the Pension Plan. Further, you will meet the criteria of Section 1.06(f) if you are either covered by the Plan during the calendar month immediately prior to the date you intend to resume receiving coverage as a Retiree or you are covered by the Plan on the first day of the calendar month that you resume receiving benefits from the Pension Plan.

The following example illustrates how Retiree eligibility and coverage work:

Example: On February 1, 2023, Joe is 62 years old, (s)he is covered by the Plan as an Eligible Employee, and (s)he is not working in any type of employment. On March 1, 2023, Joe starts receiving benefits from the Pension Plan. From February 1, 2023 through June 30, 2023, Joe does not work in any type of employment and (s)he remains covered by the Plan as an Eligible Employee based on the hours that (s)he worked in Covered Employment during the period of June 1, 2022 through January 31, 2023. On July 1, 2023, Joe does not have enough hours to remain covered by the Plan as an Eligible Employee (i.e., (s)he did not work sufficient hours in Covered Employment during the prior Qualifying Periods). On July 1, 2023, Joe's coverage from the Plan as an Eligible Employee is terminated. On July 1, 2023, Joe pays the Retiree premium in accordance with Section 1.07 and (s)he becomes covered by the Plan as a Retiree.

Section 1.07 - Retiree Premium

The Retiree premium amount is the dollar amount that you are required to pay to receive a month of coverage from the Plan as a Retiree. As explained in Section 1.07(a) and Section 1.07(b), the manner in which your Retiree premium amount is calculated depends on whether you began receiving benefits from the Pension Plan prior to June 1, 2008 (see Section 1.07(a)) or on or after June 1, 2008 (see Section 1.07(b)). The Board of Trustees has the authority to establish and change the Retiree premium amount from time to time, as it may deem appropriate in its sole and exclusive discretion.

For your first month of coverage as a Retiree, your Retiree premium is due in full on the first day of the calendar month for which you intend to begin receiving coverage from the Plan as a Retiree (e.g., if you intend to begin receiving coverage as a Retiree on January 1, 2023, your first Retiree premium payment is due on January 1, 2023). Your first Retiree premium payment will satisfy the payment requirement for both your first and third months of coverage as a Retiree (e.g., your January 1, 2023 payment will satisfy the Retiree premium payment requirement for both January 2023 and March 2023).

For your second month of coverage as a Retiree, your Retiree premium is due in full on the first day of the second calendar month for which you intend to continue receiving coverage from the Plan as a Retiree (e.g., if you started receiving coverage as a Retiree on January 1, 2023 and you intend to continue receiving coverage as a Retiree on February 1, 2023, your second Retiree premium payment is due on February 1, 2023). Your second Retiree premium payment will satisfy the payment requirement for both your second and fourth months of coverage as a Retiree (e.g., your February 1, 2023 payment will satisfy the Retiree premium payment requirement for both February 2023 and April 2023).

Starting with your fifth month of coverage, your Retiree premium is due in full on the first day of the calendar month two months prior to the calendar month for which you intend to continue receiving coverage from the Plan as a Retiree (e.g., your Retiree premium payment for the month of May 2023 is due on March 1, 2023).

Your coverage from the Plan as a Retiree will terminate if the Fund Office does not receive your Retiree premium payment in full by the 15th calendar day of the calendar month for which you are required to pay the Retiree premium to receive coverage from the Plan as a Retiree (e.g., if your Retiree premium for the month of May 2023 is not paid by March 15, 2023, your coverage from the Plan as a Retiree will terminate on May 1, 2023).

(a) Retiree Premium Amount for Retirees Who Began Receiving Benefits from the Pension Plan Prior to June 1, 2008

If you are a Retiree and you began receiving benefits from the Pension Plan prior to June 1, 2008, your Retiree premium amount will be determined by a number of factors, including the age you attained and the number of hours that you worked in Covered Employment on the date that you started receiving coverage from the Plan as a Retiree. For more information about the Retiree premium amount for Retirees who began receiving benefits from the Pension Plan prior to June 1, 2008, contact the Fund Office.

NOTE: If you are a Retiree, you began receiving benefits from the Pension Plan prior to June 1, 2008, your coverage from the Plan as a Retiree is terminated in accordance with Section 1.08(b), and subsequently your coverage from the Plan as a Retiree is reinstated in accordance with Section 1.10, your Retiree premium amount on the date that your coverage as a Retiree is reinstated will depend on whether or not you stopped receiving benefits from the Pension Plan on or after June 1, 2008. If you did not stop receiving benefits from the Pension Plan at any time on or after June 1, 2008, your Retiree premium amount will be calculated in accordance with this Section 1.07(a) (i.e., you will be treated as though you started receiving benefits from the Pension Plan prior to June 1, 2008). If you stopped receiving benefits from the Pension Plan on or after June 1, 2008, your Retiree premium amount will be calculated in accordance with Section 1.07(b) (i.e., you will be treated as though you started receiving benefits from the Pension Plan on or after June 1, 2008).

(b) Retiree Premium Amount for Retirees Who Began Receiving Benefits from the Pension Plan On or After June 1, 2008

If you are a Retiree and you began receiving benefits from the Pension Plan on or after June 1, 2008, your initial Retiree premium amount (i.e., the premium amount that you are required to pay on the date that you begin receiving coverage from the Plan as a Retiree) will be calculated in accordance with Section 1.07(b)(1). After your initial Retiree premium amount is calculated, your Retiree premium amount will subsequently be recalculated in accordance with the following rules:

- If you have single coverage (i.e., you do not have any Dependents that are covered by the Plan) and subsequently your Dependent spouse and/or child becomes covered by the Plan in accordance with Section 1.22 (i.e., subsequently at least one of your Dependents becomes

covered by the Plan), your Retiree premium amount will be recalculated in accordance with Section 1.07(b)(2)(i) on the date that your Dependent spouse and/or child becomes covered by the Plan;

- If you have family coverage (i.e., you have at least one Dependent that is covered by the Plan) and subsequently your Dependent's (or Dependents' if more than one Dependent is covered by the Plan) coverage from the Plan is terminated in accordance with Section 1.23 (i.e., subsequently you no longer have any Dependents that are covered by the Plan), your Retiree premium amount will be recalculated in accordance with Section 1.07(b)(2)(ii) on the date that your Dependent's (or Dependents', as applicable) coverage from the Plan is terminated;

- If you and/or your covered Dependent becomes eligible for Medicare, your Retiree premium amount may be recalculated in accordance with Section 1.07(b)(2)(iii) on the date that you and/or your Dependent becomes eligible for Medicare; and

- If you are covered by the Plan as a Retiree on May 31 of a calendar year and on June 1 of that calendar year your Retiree premium amount is not recalculated in accordance with any of the bullet points above (i.e., on June 1 of that calendar year you do not change from single coverage to family coverage, you do not change from family coverage to single coverage, you do not become eligible for Medicare, and your Dependent does not become eligible for Medicare), your Retiree premium amount will be recalculated in accordance with Section 1.07(b)(2)(iv) on June 1 of that calendar year (i.e., on June 1 of each calendar year your Retiree premium amount is recalculated. The manner in which your Retiree premium amount is recalculated depends on whether or not any of the events described in the bullet points above occurred on June 1 of that calendar year. If none of the events described in the bullet points above occurred on June 1, then your Retiree premium amount is recalculated in accordance with Section 1.07(b)(2)(iv)).

NOTE: Throughout this Section 1.07(b), examples are used to illustrate how your Retiree premium amount is calculated. These examples are rounded to the nearest cent ($0.01). Additionally, the Contribution Rate used in these examples is a hypothetical number used solely for the purpose of illustrating how your Retiree premium amount is calculated. The Contribution Rate used in these examples does not reflect the actual Contribution Rate. For information about the actual Contribution Rate, contact the Fund Office.

(1) Calculation of initial Retiree premium amount

If you are a Retiree and you began receiving benefits from the Pension Plan on or after June 1, 2008, your initial Retiree premium amount (i.e., the premium amount that you are required to pay on the date that you begin receiving coverage from the Plan as a Retiree) will be calculated in accordance with the following rules:

(i) **Step 1**: Your base rate is calculated by multiplying the Contribution Rate in effect on the date that you began receiving coverage from the Plan as a Retiree by 140. For example, if the Contribution Rate is $10.00 on the date that you began receiving coverage from the Plan as a Retiree, your base rate would equal $1,400.00 ($10.00 x 140 = $1,400.00).

(ii) **Step 2**: Your adjusted base rate is calculated by either increasing or decreasing your base rate based on whether you have single coverage (i.e., you do not have any Dependents that are covered by the Plan) or family coverage (i.e., you have at least one Dependent that is covered by the Plan). If you have single coverage, your adjusted base rate is calculated by reducing your base rate by 33% (i.e., the amount that was calculated in accordance with Section 1.07(b)(1)(i) is reduced by 33%). If you have family coverage, your adjusted base rate is calculated by increasing your

base rate by 33% (i.e., the amount that was calculated in accordance with Section 1.07(b)(1)(i) is increased by 33%). For example, if your base rate is $1,400.00 and you have single coverage, your adjusted base rate would equal $938.00 ($1,400.00 - 33% of $1,400.00 = $938.00). If your base rate is $1,400.00 and you have family coverage, your adjusted base rate would equal $1,862.00 ($1,400.00 + 33% of $1,400.00 = $1,862.00).

(iii) **Step 3**: Your Plan subsidy is determined based on the age that you attained and the Years of Service that you earned on the date that you began receiving coverage from the Plan as a Retiree. For purposes of this Section 1.07(b)(1)(iii), your Years of Service are calculated in accordance with the following rules:

- If you worked at least one hour in Covered Employment during a Plan Year that began prior to June 1, 1981, you are credited with one Year of Service for that Plan Year; and
- If you worked at least 800 hours in Covered Employment during a Plan Year that began on or after June 1, 1981, you are credited with one Year of Service for that Plan Year.

The following chart illustrates how your Plan subsidy is calculated:

If you began receiving coverage from the Plan as a Retiree when you were . . .	And on the date that you began receiving coverage from the Plan as a Retiree you had . . .	Your Plan subsidy is . . .
55 or 56 years old	at least 15 Years of Service	1.33% per Year of Service, up to 30 years, plus 0.25% for each Year of Service over 30, up to 35 years.
	less than 15 Years of Service	zero.
57, 58, or 59 years old	at least 15 Years of Service	1.66% per Year of Service, up to 30 years, plus 0.25% for each Year of Service over 30, up to 35 years.
	less than 15 Years of Service	zero.
at least 60 years old or a Disabled Participant	at least 10 Years of Service	2.00% per Year of Service, up to 30 years, plus 0.25% for each Year of Service over 30, up to 35 years.
	less than 10 Years of Service	zero.

For example, if you began receiving coverage from the Plan as a Retiree when you were 56 years old and had 20 Years of Service, your Plan subsidy would be 26.6% (1.33% x 20 = 26.6%).

(iv) **Step 4**: Your subsidized base rate is calculated by reducing your adjusted base rate by your Plan subsidy (i.e., the amount that was calculated in accordance with Section 1.07(b)(1)(ii) is reduced by the percentage that was calculated in accordance with Section 1.07(b)(1)(iii)). For example, if your adjusted base rate is $938.00 and your Plan subsidy is 26.6%, your subsidized base rate would equal $688.49 ($938.00 - 26.6% of $938.00 = $688.49). If your adjusted base rate is $1,862.00 and your Plan subsidy is 26.6%, your subsidized base rate would equal $1,366.71 ($1,862.00 - 26.6% of $1,862.00 = $1,366.71).

(v) **Step 5**: Your initial Retiree premium amount is determined based on whether or not you and/or your covered Dependents are eligible for Medicare in accordance with the following rules:

- If you have single coverage and you are not eligible for Medicare, your initial Retiree premium amount equals your subsidized base rate (i.e., your initial Retiree premium amount equals the amount that was calculated in accordance with Section 1.07(b)(1)(iv)). For example, if your subsidized base rate is $688.49, you have single coverage, and you are not eligible for Medicare, your initial Retiree premium amount would equal $688.49.
- If you have single coverage and you are eligible for Medicare, your initial Retiree premium amount equals 76% of your subsidized base rate (i.e., your initial Retiree premium amount equals 76% of the amount that was calculated in accordance with Section 1.07(b)(1)(iv)). For example, if your subsidized base rate is $688.49, you have single coverage, and you are eligible for Medicare, your initial Retiree premium amount would equal $523.35 (76% of $688.49 = $523.35).
- If you have family coverage and neither you nor any of your covered Dependents are eligible for Medicare, your initial Retiree premium amount equals your subsidized base rate (i.e., your initial Retiree premium amount equals the amount that was calculated in accordance with Section 1.07(b)(1)(iv)). For example, if your subsidized base rate is $1,366.71, you have family coverage, and neither you nor any of your covered Dependents are eligible for Medicare, your initial Retiree premium amount would equal $1,366.71.
- If you have family coverage, you are eligible for Medicare, and at least one of your covered Dependents is not eligible for Medicare, your initial Retiree premium amount equals 76% of your subsidized base rate (i.e., your initial Retiree premium amount equals 76% of the amount that was calculated in accordance with Section 1.07(b)(1)(iv)). For example, if your subsidized base rate is $1,366.71, you have family coverage, you are eligible for Medicare, and at least one of your covered Dependents is not eligible for Medicare, your initial Retiree premium amount would equal $1,038.70 (76% of $1,366.71 = $1,038.70).
- If you have family coverage, you are not eligible for Medicare, and at least one of your covered Dependents is eligible for Medicare, your initial Retiree premium amount equals 76% of your subsidized base rate (i.e., your initial Retiree premium amount equals 76% of the amount that was calculated in accordance with Section 1.07(b)(1)(iv)). For example, if your subsidized base rate is $1,366.71, you have family coverage, you are not eligible for Medicare, and at least one of your covered Dependents is eligible for Medicare, your initial Retiree premium amount would equal $1,038.70 (76% of $1,366.71 = $1,038.70).

- If you have family coverage, you are eligible for Medicare, and all of your covered Dependents are also eligible for Medicare, your initial Retiree premium amount equals 54% of your subsidized base rate (i.e., your initial Retiree premium amount equals 54% of the amount that was calculated in accordance with Section 1.07(b)(1)(iv)). For example, if your subsidized base rate is $1,366.71, you have family coverage, you are eligible for Medicare, and all of your covered Dependents are also eligible for Medicare, your initial Retiree premium amount would equal $738.02 (54% of $1,366.71 = $738.02).

(2) Recalculation of Retiree premium amount

After your initial Retiree premium amount is calculated in accordance with Section 1.07(b)(1), your Retiree premium amount will subsequently be recalculated in accordance with the rules described in this Section 1.07(b)(2).

(i) Recalculation of your Retiree premium amount when you change from single coverage to family coverage

If you are a Retiree, you began receiving benefits from the Pension Plan on or after June 1, 2008, you have single coverage (i.e., you do not have any Dependents that are covered by the Plan), and subsequently your Dependent spouse and/or child becomes covered by the Plan in accordance with Section 1.22 (i.e., subsequently at least one of your Dependents becomes covered by the Plan), your Retiree premium amount will be recalculated on the date that your Dependent spouse and/or child becomes covered by the Plan in accordance with the following rules:

(A) **Step 1**: Your base rate is calculated by multiplying the Contribution Rate in effect on the date that your Dependent spouse and/or child became covered by the Plan by 140 (i.e., the Contribution Rate in effect on the date that you changed from single coverage to family coverage is multiplied by 140). For example, if the Contribution Rate is $10.00 on the date that you changed from single coverage to family coverage, your base rate would equal $1,400.00 ($10.00 x 140 = $1,400.00).

(B) **Step 2**: Your adjusted base rate is calculated by increasing your base rate by 33% (i.e., the amount that was calculated in accordance with Section 1.07(b)(2)(i)(A) is increased by 33%). For example, if your base rate is $1,400.00, your adjusted base rate would equal $1,862.00 ($1,400.00 + 33% of $1,400.00 = $1,862.00).

(C) **Step 3**: Your subsidized base rate is calculated by reducing your adjusted base rate by your Plan subsidy (i.e., the amount that was calculated in accordance with Section 1.07(b)(2)(i)(B) is reduced by the percentage that was calculated in accordance with Section 1.07(b)(1)(iii)). For example, if your adjusted base rate is $1,862.00 and your Plan subsidy is 26.6%, your subsidized base rate would equal $1,366.71 ($1,862.00 - 26.6% of $1,862.00 = $1,366.71).

(D) **Step 4**: Your new Retiree premium amount is determined based on whether or not you and/or your covered Dependents are eligible for Medicare in accordance with the following rules:

- If neither you nor any of your covered Dependents are eligible for Medicare, your new Retiree premium amount equals your subsidized base rate (i.e., your new Retiree premium amount equals the amount that

was calculated in accordance with Section 1.07(b)(2)(i)(C)). For example, if your subsidized base rate is $1,366.71 and neither you nor any of your covered Dependents are eligible for Medicare, your new Retiree premium amount would equal $1,366.71.

- If you are eligible for Medicare and at least one of your covered Dependents is not eligible for Medicare, your new Retiree premium amount equals 76% of your subsidized base rate (i.e., your new Retiree premium amount equals 76% of the amount that was calculated in accordance with Section 1.07(b)(2)(i)(C)). For example, if your subsidized base rate is $1,366.71, you are eligible for Medicare, and at least one of your covered Dependents is not eligible for Medicare, your new Retiree premium amount would equal $1,038.70 (76% of $1,366.71 = $1,038.70).

- If you are not eligible for Medicare and at least one of your covered Dependents is eligible for Medicare, your new Retiree premium equals 76% of your subsidized base rate (i.e., your new Retiree premium equals 76% of the amount that was calculated in accordance with Section 1.07(b)(2)(i)(C)). For example, if your subsidized base rate is $1,366.71, you are not eligible for Medicare, and at least one of your covered Dependents is eligible for Medicare, your new Retiree premium amount would equal $1,038.70 (76% of $1,366.71 = $1,038.70).

- If you are eligible for Medicare and all of your covered Dependents are also eligible for Medicare, your new Retiree premium amount equals 54% of your subsidized base rate (i.e., your new Retiree premium amount equals 54% of the amount that was calculated in accordance with Section 1.07(b)(2)(i)(C)). For example, if your subsidized base rate is $1,366.71, you are eligible for Medicare, and all of your covered Dependents are also eligible for Medicare, your new Retiree premium amount would equal $738.02 (54% of $1,366.71 = $738.02).

(ii) Recalculation of your Retiree premium amount when you change from family coverage to single coverage

If you are a Retiree, you began receiving benefits from the Pension Plan on or after June 1, 2008, you have family coverage (i.e., you have at least one Dependent that is covered by the Plan), and subsequently your Dependent's (or Dependents', as applicable) coverage from the Plan is terminated in accordance with Section 1.23 (i.e., subsequently you no longer have any Dependents that are covered by the Plan), your Retiree premium amount will be recalculated on the date that your Dependent's (or Dependents', as applicable) coverage from the Plan is terminated in accordance with the following rules:

(A) **Step 1**: Your base rate is calculated by multiplying the Contribution Rate in effect on the date that your Dependent's (or Dependents' if more than one Dependent is covered by the Plan) coverage from the Plan was terminated by 140 (i.e., the Contribution Rate in effect on the date that you changed from family coverage to single coverage is multiplied by 140). For example, if the Contribution Rate is $10.00 on the date that you changed from family coverage to single coverage, your base rate would equal $1,400.00 ($10.00 x 140 = $1,400.00).

(B) **Step 2**: Your adjusted base rate is calculated by reducing your base rate by 33% (i.e., the amount that was calculated in accordance with Section 1.07(b)(2)(ii)(A) is reduced by 33%). For example, if your base rate is $1,400.00, your adjusted base rate would equal $938.00 ($1,400.00 - 33% of $1,400.00 = $938.00).

(C) **Step 3**: Your subsidized base rate is calculated by reducing your adjusted base rate by your Plan subsidy (i.e., the amount that was calculated in accordance with Section 1.07(b)(2)(ii)(B) is reduced by the percentage that was calculated in accordance with Section 1.07(b)(1)(iii)). For example, if your adjusted base rate is $938.00 and your Plan subsidy is 26.6%, your subsidized base rate would equal $688.49 ($938.00 - 26.6% of $938.00 = $688.49).

(D) **Step 4**: Your new Retiree premium amount is determined based on whether or not you are eligible for Medicare in accordance with the following rules:

- If you are not eligible for Medicare, your new Retiree premium amount equals your subsidized base rate (i.e., your new Retiree premium amount equals the amount that was calculated in accordance with Section 1.07(b)(2)(ii)(C)). For example, if your subsidized base rate is $688.49 and you are not eligible for Medicare, your new Retiree premium amount would equal $688.49.
- If you are eligible for Medicare, your new Retiree premium amount equals 76% of your subsidized base rate (i.e., your new Retiree premium amount equals 76% of the amount that was calculated in accordance with Section 1.07(b)(2)(ii)(C)). For example, if your subsidized base rate is $688.49 and you are eligible for Medicare, your new Retiree premium amount would equal $523.25 (76% of $688.49 = $523.25).

(iii) Recalculation of your Retiree premium amount when you and/or your covered Dependent becomes eligible for Medicare

If you are a Retiree, you began receiving benefits from the Pension Plan on or after June 1, 2008, and you and/or your covered Dependent, as applicable, becomes eligible for Medicare, your Retiree premium amount will be recalculated in accordance with this Section 1.07(b)(2)(iii) if all of the criteria in at least one of the following bullet points are met:

- You have single coverage and you become eligible for Medicare;
- You have family coverage, none of your covered Dependents are eligible for Medicare, and you become eligible for Medicare;
- You have family coverage, you are not eligible for Medicare, and your covered Dependent becomes eligible for Medicare;
- You have family coverage because you and one Dependent are covered by the Plan (i.e., you only have one Dependent covered by the Plan), you are eligible for Medicare, and your Dependent becomes eligible for Medicare; or
- You have family coverage because you and more than one Dependent are covered by the Plan (i.e., you have at least two Dependents covered by the Plan), you and your covered Dependent spouse are eligible for Medicare, and your

Dependent child's coverage from the Plan is terminated (i.e., you have family coverage and you no longer have any covered Dependents who are not eligible for Medicare).

If all of the criteria in at least one of the bullet points above are met, your Retiree premium amount will be recalculated on the date that you and/or your Dependent, as applicable, meets such criteria in accordance with the following rules:

(A) **Step 1**: Your base rate is calculated by multiplying the Contribution Rate in effect on the date that you and/or your Dependent, as applicable, met one of the criteria of this Section 1.07(b)(2)(iii) by 140 (i.e., the Contribution Rate in effect on the date that you and/or your Dependent met the criteria of one of the bullet points that is listed at the beginning of this Section 1.07(b)(2)(iii) is multiplied by 140). For example, if you become eligible for Medicare and the Contribution Rate is $10.00 on the date that you become eligible for Medicare, your base rate would equal $1,400.00 ($10.00 x 140 = $1,400.00).

(B) **Step 2**: Your adjusted base rate is calculated by either increasing or decreasing your base rate based on whether you have single coverage (i.e., you do not have any Dependents that are covered by the Plan) or family coverage (i.e., you have at least one Dependent that is covered by the Plan). If you have single coverage, your adjusted base rate is calculated by reducing your base rate by 33% (i.e., the amount that was calculated in accordance with Section 1.07(b)(2)(iii)(A) is reduced by 33%). If you have family coverage, your adjusted base rate is calculated by increasing your base rate by 33% (i.e., the amount that was calculated in accordance with Section 1.07(b)(2)(iii)(A) is increased by 33%). For example, if your base rate is $1,400.00 and you have single coverage, your adjusted base rate would equal $938.00 ($1,400.00 - 33% of $1,400.00 = $938.00). If your base rate is $1,400.00 and you have family coverage, your adjusted base rate would equal $1,862.00 ($1,400.00 + 33% of $1,400.00 = $1,862.00).

(C) **Step 3**: Your subsidized base rate is calculated by reducing your adjusted base rate by your Plan subsidy (i.e., the amount that was calculated in accordance with Section 1.07(b)(2)(iii)(B) is reduced by the percentage that was calculated in accordance with Section 1.07(b)(1)(iii)). For example, if your adjusted base rate is $938.00 and your Plan subsidy is 26.6%, your subsidized base rate would equal $688.49 ($938.00 - 26.6% of $938.00 = $688.49). If your adjusted base rate is $1,862.00 and your Plan subsidy is 26.6%, your subsidized base rate would equal $1,366.71 ($1,862.00 - 26.6% of $1,862.00 = $1,366.71).

(D) **Step 4**: Your new Retiree premium amount is determined based on whether or not you and/or your covered Dependents are eligible for Medicare in accordance with the following rules:

- If you have single coverage and you are eligible for Medicare, your new Retiree premium amount equals 76% of your subsidized base rate (i.e., your new Retiree premium amount equals 76% of the amount that was calculated in accordance with Section 1.07(b)(2)(iii)(C)). For example, if your subsidized base rate is $688.49, you have single coverage, and you are eligible for Medicare, your new Retiree premium amount would equal $523.25 (76% of $688.49 = $523.25).

- If you have family coverage, you are eligible for Medicare, and at least one of your covered Dependents is not eligible for Medicare, your new Retiree premium amount equals 76% of your subsidized base rate (i.e., your new Retiree premium amount equals 76% of the amount that was calculated in accordance with Section 1.07(b)(2)(iii)(C)). For example, if your subsidized base rate is $1,366.71, you have family coverage, you are eligible for Medicare, and at least one of your covered Dependents is not eligible for Medicare, your new Retiree premium amount would equal $1,038.70 (76% of $1,366.71 = $1,038.70).

- If you have family coverage, you are not eligible for Medicare, and at least one of your covered Dependents is eligible for Medicare, your new Retiree premium amount equals 76% of your subsidized base rate (i.e., your new Retiree premium amount equals 76% of the amount that was calculated in accordance with Section 1.07(b)(2)(iii)(C)). For example, if your subsidized base rate is $1,366.71, you have family coverage, you are not eligible for Medicare, and at least one of your covered Dependents is eligible for Medicare, your new Retiree premium amount would equal $1,038.70 (76% of $1,366.71 = $1,038.70).

- If you have family coverage, you are eligible for Medicare, and all of your covered Dependents are also eligible for Medicare, your new Retiree premium amount equals 54% of your subsidized base rate (i.e., your new Retiree premium amount equals 54% of the amount that was calculated in accordance with Section 1.07(b)(2)(iii)(C)). For example, if your subsidized base rate is $1,366.71, you have family coverage, you are eligible for Medicare, and all of your covered Dependents are also eligible for Medicare, your new Retiree premium amount would equal $738.02 (54% of $1,366.71 = $738.02).

(iv) Recalculation of your Retiree Premium amount on June 1

If you are a Retiree, you began receiving benefits from the Pension Plan on or after June 1, 2008, you are covered by the Plan as a Retiree on May 31 of a calendar year, and on June 1 of that calendar year your Retiree premium amount is not recalculated in accordance with Sections 1.07(b)(2)(i)-(iii)) (i.e., on June 1 of that calendar year you do not change from single coverage to family coverage, you do not change from family coverage to single coverage, you do not become eligible for Medicare, and your Dependent does not become eligible for Medicare), your Retiree premium amount will be recalculated on June 1 of that calendar year in accordance with the following rules:

(A) **Step 1**: Your base rate is calculated by multiplying the Contribution Rate in effect on June 1 of the calendar year by 140. For example, if the Contribution Rate is $10.00 on June 1 of the calendar year, your base rate would equal $1,400.00 ($10.00 x 140 = $1,400.00).

(B) **Step 2**: Your adjusted base rate is calculated by either increasing or decreasing your base rate based on whether you have single coverage (i.e., you do not have any Dependents that are covered by the Plan) or family coverage (i.e., you have at least one Dependent that is covered by the Plan). If you have single coverage, your adjusted base rate is calculated by reducing your base rate by 33% (i.e., the amount that was calculated in accordance with Section 1.07(b)(2)(iv)(A) is reduced by 33%). If you have family

coverage, your adjusted base rate is calculated by increasing your base rate by 33% (i.e., the amount that was calculated in accordance with Section 1.07(b)(2)(iv)(A) is increased by 33%). For example, if your base rate is $1,400.00 and you have single coverage, your adjusted base rate would equal $938.00 ($1,400.00 - 33% of $1,400.00 = $938.00). If your base rate is $1,400.00 and you have family coverage, your adjusted base rate would equal $1,862.00 ($1,400.00 + 33% of $1,400.00 = $1,862.00).

(C) **Step 3**: Your subsidized base rate is calculated by reducing your adjusted base rate by your Plan subsidy (i.e., the amount that was calculated in accordance with Section 1.07(b)(2)(iv)(B) is reduced by the percentage that was calculated in accordance with Section 1.07(b)(1)(iii)). For example, if your adjusted base rate is $1,862.00 and your Plan subsidy is 26.6%, your subsidized base rate would equal $1,366.71 ($1,862.00 - 26.6% of $1,862.00 = $1,366.71).

(D) **Step 4**: Your preliminary Retiree premium amount is determined based on whether or not you and/or your covered Dependents are eligible for Medicare in accordance with the following rules:

- If you have single coverage and you are not eligible for Medicare, your preliminary Retiree premium amount equals your subsidized base rate (i.e., your preliminary Retiree premium amount equals the amount that was calculated in accordance with Section 1.07(b)(2)(iv)(C)). For example, if your subsidized base rate is $688.49, you have single coverage, and you are not eligible for Medicare, your preliminary Retiree premium amount would equal $688.49.

- If you have single coverage and you are eligible for Medicare, your preliminary Retiree premium amount equals 76% of your subsidized base rate (i.e., your preliminary Retiree premium amount equals 76% of the amount that was calculated in accordance with Section 1.07(b)(2)(iv)(C)). For example, if your subsidized base rate is $688.49, you have single coverage, and you are eligible for Medicare, your preliminary Retiree premium amount would equal $523.25 (76% of $688.49 = $523.25).

- If you have family coverage and neither you nor any of your covered Dependents are eligible for Medicare, your preliminary Retiree premium amount equals your subsidized base rate (i.e., your preliminary Retiree premium amount equals the amount that was calculated in accordance with Section 1.07(b)(2)(iv)(C)). For example, if your subsidized base rate is $1,366.71, you have family coverage, and neither you nor any of your covered Dependents are eligible for Medicare, your preliminary Retiree premium amount would equal $1,366.71.

- If you have family coverage, you are eligible for Medicare, and at least one of your covered Dependents is not eligible for Medicare, your preliminary Retiree premium amount equals 76% of your subsidized base rate (i.e., your preliminary Retiree premium amount equals 76% of the amount that was calculated in accordance with Section 1.07(b)(2)(iv)(C)). For example, if your subsidized base rate is $1,366.71, you have family coverage, you are eligible for Medicare, and at least one of your covered Dependents is not eligible for Medicare, your preliminary Retiree premium amount would equal $1,038.70 (76% of $1,366.71 = $1,038.70).

- If you have family coverage, you are not eligible for Medicare, and at least one of your covered Dependents is eligible for Medicare, your preliminary Retiree premium amount equals 76% of your subsidized base rate (i.e., your preliminary Retiree premium amount equals 76% of the amount that was calculated in accordance with Section 1.07(b)(2)(iv)(C)). For example, if your subsidized base rate is $1,366.71, you have family coverage, you are not eligible for Medicare, and at least one of your covered Dependents is eligible for Medicare, your preliminary Retiree premium amount would equal $1,038.70 (76% of $1,366.71 = $1,038.70).

- If you have family coverage, you are eligible for Medicare, and all of your covered Dependents are also eligible for Medicare, your preliminary Retiree premium amount equals 54% of your subsidized base rate (i.e., your preliminary Retiree premium amount equals 54% of the amount that was calculated in accordance with Section 1.07(b)(2)(iv)(C)). For example, if your subsidized base rate is $1,366.71, you have family coverage, you are eligible for Medicare, and all of your covered Dependents are also eligible for Medicare, your preliminary Retiree premium amount would equal $738.02 (54% of $1,366.71 = $738.02).

(E) **Step 5**: Your new Retiree premium amount is determined by comparing your preliminary Retiree premium amount (i.e., the Retiree premium amount calculated in accordance with Section 1.07(b)(2)(iv)(D)) to the Retiree premium amount that you paid in May of the same calendar year (i.e., the Retiree premium amount that you paid the prior calendar month) in accordance with the following rules:

- If your preliminary Retiree premium amount is not more than 5% greater than the Retiree premium amount that you paid in May of the same calendar year (i.e., if the amount calculated in accordance with Section 1.07(b)(2)(iv)(D) is not more than 5% higher than the Retiree premium amount that you paid the prior calendar month), then your new Retiree premium amount equals your preliminary Retiree premium amount (i.e., your new Retiree premium amount equals the amount that was calculated in accordance with Section 1.07(b)(2)(iv)(D)). For example, if your Retiree premium amount in May 2023 was $1,000.00 and your preliminary Retiree premium amount is $1,045.00, then your new Retiree premium amount on June 1, 2023 would equal $1,045.00 ($1,045.00 is only 4.5% greater than $1,000.00).

- If your preliminary Retiree premium amount is more than 5% greater than the Retiree premium amount that you paid in May of the same calendar year (i.e., if the amount calculated in accordance with Section 1.07(b)(2)(iv)(D) is more than 5% higher than the Retiree premium amount that you paid the prior calendar month), then your new Retiree premium amount equals 5% more than the Retiree premium amount that you paid in May of that calendar year (i.e., your new Retiree premium amount equals 5% more than the Retiree premium amount that you paid the prior calendar month). For example, if your Retiree premium amount in May 2023 was $1,000.00 and your preliminary Retiree premium amount is $1,100.00, then your new Retiree premium amount on June 1, 2023, would equal $1,050.00 ($1,050.00 is 5% greater than $1,000.00).

Section 1.08 - Termination of Coverage for Eligible Employees and Retirees

The Plan is intended to exist and provide benefits to Participants indefinitely. However, under certain circumstances, coverage may terminate for specific individuals, for all Participants, or for any group of Participants. The Board of Trustees reserves the right to amend the Plan at any time, and such amendments may eliminate certain benefits for all Participants or terminate all benefits for certain Participants, such as Retirees. The Board of Trustees also reserves the right to terminate the Plan in accordance with Article XIII, Section 13.10. If the Board of Trustees terminates the Plan, all Participants will lose coverage from the Plan.

In addition, a Participant's coverage from the Plan will terminate in accordance with Sections 1.08(a) or 1.08(b), as applicable.

(a) Termination of Coverage as an Eligible Employee

You will no longer be covered by the Plan as an Eligible Employee (i.e., you will have your coverage as an Eligible Employee terminated and you will no longer be considered an Eligible Employee) at 12:00 a.m. on the earliest of the following days:

(1) The first day of the calendar month in which you have not worked sufficient hours to remain covered by the Plan in accordance with Section 1.03(a) and you do not pay the self-payment premium in accordance with Section 1.03(b);

(2) The first day of the calendar month following the 18th consecutive month that you received coverage from the Plan by paying the self-payment premium in accordance with Section 1.03(b);

(3) The first day of the calendar month that you receive benefits from the Pension Plan and you do not work sufficient hours in Covered Employment to remain covered by the Plan in accordance with Section 1.03(a);

(4) The first day of the calendar month that you receive benefits from the Plumbers & Pipefitters National Pension Fund and you do not work sufficient hours in Covered Employment to remain covered by the Plan in accordance with Section 1.03(a);

(5) The first day of the calendar month following the calendar month that you left Covered Employment to begin service in the Uniformed Services, so long as you are still in the Uniformed Services on the last day of that calendar month and you did not elect to use your hours to remain covered by the Plan in accordance with Section 1.03(e) (e.g., if you enter the Uniformed Services on June 7, 2023, your coverage from the Plan would terminate on July 1, 2023 so long as you are still in the Uniformed Services on June 30, 2023 and you did not elect to use your hours to remain covered by the Plan in accordance with Section 1.03(e));

(6) The first day that you perform work in the plumbing and pipe fitting industry for an employer that is not obligated to contribute to the Plan; or

(7) The first day of the calendar month following your death.

If your coverage is terminated in accordance with this Section 1.08(a), you will only regain coverage from the Plan as an Eligible Employee if your coverage is reinstated in accordance with Section 1.09.

NOTE: If an Employee's (or former Employee's) coverage as an Eligible Employee is terminated in accordance with this Section 1.08(a), the Employee (or former Employee) may be eligible for coverage from the Plan as a Retiree. Further, if an Employee's (or former Employee's) coverage is terminated in accordance with this Section 1.08(a), the Employee (or former Employee) may be eligible for COBRA continuation coverage or USERRA continuation coverage. Refer to Section 1.06 for information about Retiree coverage; Section 1.30 for information about COBRA continuation coverage; and Section 1.03(e) for information about USERRA continuation coverage.

(b) Termination of Coverage as a Retiree

You will no longer be covered by the Plan as a Retiree (i.e., you will have your coverage as a Retiree terminated and you will no longer be considered a Retiree) at 12:00 a.m. on the earliest of the following days:

(1) The first day of the calendar month for which you did not pay the appropriate Retiree premium in accordance with Section 1.07;

(2) The first day of the Coverage Period following a Qualifying Period(s) in which you worked sufficient hours in Covered Employment to have your coverage as an Eligible Employee reinstated in accordance with Section 1.09;

(3) The first day of the calendar month that you no longer receive benefits from the Pension Plan; or

(4) The first day of the calendar month following your death.

If your coverage is terminated in accordance with this Section 1.08(b), you will only regain coverage from the Plan as a Retiree if your coverage is reinstated in accordance with Section 1.10.

NOTE: If a Retiree's coverage as a Retiree is terminated in accordance with this Section 1.08(b), the Retiree may be eligible for coverage from the Plan as an Eligible Employee. Refer to Section 1.09 for information about coverage from the Plan as an Eligible Employee.

Section 1.09 - Reinstatement of Coverage as an Eligible Employee

As explained in Sections 1.09(a) and 1.09(b), if your coverage from the Plan is terminated in accordance with Section 1.08, the number of hours that you are required to work in Covered Employment before your coverage as an Eligible Employee is reinstated (i.e., the number of hours you are required to work in Covered Employment before you become an Eligible Employee again) depends on the reason that your coverage is terminated and the number of consecutive months in which you were not covered by the Plan as an Eligible Employee. If your coverage as an Eligible Employee is reinstated in accordance with this Section 1.09, your coverage from the Plan will continue for each Coverage Period that you meet the criteria of Section 1.03 and your coverage is not terminated in accordance with Section 1.08(a) (i.e., once your coverage is reinstated, the determination as to whether or not you will remain covered by the Plan as an Eligible Employee is based on the rules described in Sections 1.03 and 1.08(a)).

(a) Reinstatement of Coverage as an Eligible Employee Following Termination of Coverage in Accordance with Section 1.08(a) (i.e., reinstatement of coverage as an Eligible Employee for an Employee who was covered by the Plan as an Eligible Employee on the day before his/her coverage is terminated)

(1) Reinstatement of coverage as an Eligible Employee for an Employee who was covered by the Plan as an Eligible Employee during at least one of the past 12 consecutive months (i.e., reinstatement of coverage as an Eligible Employee during the 12 consecutive months after the date that coverage as an Eligible Employee is terminated)

If your coverage from the Plan is terminated in accordance with Section 1.08(a) (i.e., if your coverage as an Eligible Employee is terminated) and you were covered by the Plan as an Eligible Employee during at least one of the past 12 consecutive months, your coverage from the Plan as an Eligible Employee will be reinstated (i.e., you will become an Eligible Employee again) at 12:00 a.m. on the first day of the Coverage Period following a Qualifying Period in which you work at least 250 hours in Covered Employment.

(2) **Reinstatement of coverage as an Eligible Employee for an Employee who was not covered by the Plan as an Eligible Employee during at least one of the past 12 consecutive months** (i.e., reinstatement of coverage as an Eligible Employee 12 or more consecutive months after the date that coverage as an Eligible Employee is terminated)

If your coverage from the Plan is terminated in accordance with Section 1.08(a) (i.e., if your coverage as an Eligible Employee is terminated) and you were not covered by the Plan as an Eligible Employee during at least one of the past 12 consecutive months, your coverage from the Plan as an Eligible Employee will be reinstated (i.e., you will become an Eligible Employee again) at 12:00 a.m. on the first day of the Coverage Period following a Qualifying Period in which you work at least 400 hours in Covered Employment.

(b) **Reinstatement of Coverage as an Eligible Employee Following Termination of Coverage in Accordance with Section 1.08(b)** (i.e., reinstatement of coverage as an Eligible Employee for an Employee who is covered by the Plan as a Retiree on the day before his/her coverage is terminated)

(1) **Reinstatement of coverage as an Eligible Employee following termination of coverage in accordance with Section 1.08(b)(3)** (i.e., reinstatement of coverage as an Eligible Employee for an Employee whose coverage is terminated because (s)he no longer receives benefits from the Pension Plan)

If your coverage from the Plan is terminated in accordance with Section 1.08(b)(3) (i.e., your coverage as a Retiree is terminated because you no longer receive benefits from the Pension Plan), your coverage from the Plan as an Eligible Employee will be reinstated (i.e., you will become an Eligible Employee again) if you make a self-payment in accordance with Section 1.09(b)(1)(i) or work sufficient hours in Covered Employment in accordance with Section 1.09(b)(1)(ii).

(i) **Reinstatement of coverage as an Eligible Employee by making self-payments**

Your coverage from the Plan as an Eligible Employee will be reinstated (i.e., you will become an Eligible Employee again) on the same day that your coverage from the Plan as a Retiree is terminated if you meet all of the following criteria:

(A) You pay the self-payment premium in accordance with this Section 1.09(b)(1)(i);

(B) You do not have a lapse in coverage (i.e., you are covered by the Plan as a Retiree on the day before your coverage as an Eligible Employee is reinstated); and

(C) You are not receiving benefits from the Plumbers & Pipefitters National Pension Fund.

The Board of Trustees has the authority to establish and change the self-payment premium amount from time to time, as it deems appropriate in its sole and exclusive discretion. Effective June 1, 2017, the self-payment premium amount is $400.00 per month regardless of whether or not you have any Dependents covered by the Plan. Your self-payment premium is due in full on the first day of the calendar month for which you intend to have your coverage from the Plan as an Eligible Employee reinstated. Your coverage from the Plan as an Eligible Employee will not be reinstated in accordance with this Section 1.09(b)(1)(i) if the Fund Office does not receive your self-payment premium in full by the fifth business day after the date that your coverage from the Plan as a Retiree is terminated.

(ii) Reinstatement of coverage as an Eligible Employee by working in Covered Employment

If your coverage is not reinstated in accordance with Section 1.09(b)(1)(i), your coverage from the Plan as an Eligible Employee will be reinstated (i.e., you will become an Eligible Employee again) in accordance with the following rules:

(A) If your coverage from the Plan is terminated in accordance with Section 1.08(b)(3), your coverage is not reinstated in accordance with Section 1.09(b)(1)(i), and you were covered by the Plan as an Eligible Employee during at least one of the past 12 consecutive months, your coverage from the Plan as an Eligible Employee will be reinstated (i.e., you will become an Eligible Employee again) at 12:00 a.m. on the first day of the Coverage Period following a Qualifying Period in which you work at least 250 hours in Covered Employment; or

(B) If your coverage from the Plan is terminated in accordance with Section 1.08(b)(3), your coverage is not reinstated in accordance with Section 1.09(b)(1)(i), and you were not covered by the Plan as an Eligible Employee during at least one of the past 12 consecutive months, your coverage from the Plan as an Eligible Employee will be reinstated (i.e., you will become an Eligible Employee again) at 12:00 a.m. on the first day of the Coverage Period following a Qualifying Period in which you work at least 400 hours in Covered Employment.

(2) Reinstatement of coverage as an Eligible Employee following termination of coverage in accordance with Section 1.08(b)(1) (i.e., reinstatement of coverage as an Eligible Employee for an Employee whose coverage is terminated because (s)he did not pay the Retiree premium in accordance with Section 1.07)

If your coverage from the Plan is terminated in accordance with Section 1.08(b)(1) (i.e., your coverage as a Retiree is terminated because you did not pay the Retiree premium in accordance with Section 1.07), your coverage from the Plan as an Eligible Employee will be reinstated (i.e., you will become an Eligible Employee again) in accordance with the following rules:

(i) Reinstatement of coverage as an Eligible Employee for an Employee who was covered by the Plan as an Eligible Employee during at least one of the past 12 consecutive months (i.e., reinstatement of coverage as an Eligible Employee during the 12 consecutive months after the date that coverage as a Retiree began)

If your coverage from the Plan as a Retiree is terminated in accordance with Section 1.08(b)(1) and you were covered by the Plan as an Eligible Employee during at least one of the past 12 consecutive months, your coverage from the Plan as an Eligible Employee will be reinstated (i.e., you will become an Eligible Employee again) at 12:00 a.m. on the first day of the Coverage Period following a Qualifying Period in which you work at least 250 hours in Covered Employment.

(ii) Reinstatement of coverage as an Eligible Employee for an Employee who was not covered by the Plan as an Eligible Employee during at least one of the past 12 consecutive months (i.e., reinstatement of coverage as an Eligible Employee 12 or more consecutive months after the date that coverage as a Retiree began)

If your coverage from the Plan as a Retiree is terminated in accordance with Section 1.08(b)(1) and you were not covered by the Plan as an Eligible Employee during at least one of the past 12 consecutive months, your coverage from the Plan as an Eligible Employee will be reinstated (i.e., you will become an Eligible Employee again) at 12:00 a.m. on the first day of the Coverage Period following a Qualifying Period in which you work at least 400 hours in Covered Employment.

The following examples illustrate how termination and reinstatement of coverage as an Eligible Employee work:

Example 1: Joe is covered by the Plan as an Eligible Employee on February 1, 2023. Joe did not work sufficient hours in Covered Employment to remain covered by the Plan during the Coverage Period that begins on March 1, 2023. On March 1, 2023, Joe does not pay the self-payment premium and his/her coverage from the Plan is terminated. Joe works 250 hours in Covered Employment during the February 1 through May 31, 2023, Qualifying Period. On July 1, 2023, Joe's coverage from the Plan is reinstated and (s)he is an Eligible Employee.

Example 2: Joe is covered by the Plan as an Eligible Employee on February 1, 2023. Joe did not work sufficient hours in Covered Employment to remain covered by the Plan during the Coverage Period that begins on March 1, 2023. On March 1, 2023, Joe does not pay the self-payment premium and his/her coverage from the Plan is terminated. From February 1, 2023 through January 31, 2024, Joe does not work in any type of employment. On February 1, 2024, Joe returns to Covered Employment. Joe works 300 hours in Covered Employment during the February 1 through May 31, 2024 Qualifying Period. On July 1, 2024, Joe will NOT become covered by the Plan as an Eligible Employee (i.e., his/her coverage as an Eligible Employee will NOT be reinstated on July 1, 2024) because (s)he was not covered by the Plan as an Eligible Employee for more than 12 consecutive months and (s)he did not work at least 400 hours in Covered Employment during the February 1 through May 31, 2024 Qualifying Period.

Example 3: Joe is covered by the Plan as an Eligible Employee on February 1, 2023. Joe did not work sufficient hours in Covered Employment to remain covered by the Plan during the Coverage Period that begins on March 1, 2023. On March 1, 2023, Joe does not pay the self-payment premium and his/her coverage from the Plan is terminated. From February 1, 2023, through January 31, 2024, Joe does not work in any type of employment. On February 1, 2024, Joe returns to Covered Employment. Joe works 400 hours in Covered Employment during the February 1 through May 31, 2024, Qualifying Period. On July 1, 2024, Joe's coverage from the Plan is reinstated and (s)he is an Eligible Employee.

Example 4: On November 1, 2023, Joe is 62 years old, (s)he is covered by the Plan as a Retiree, and (s)he does not work in any type of employment. On December 1, 2023, Joe returns to Covered Employment. In December 2023, Joe works 40 hours in Covered Employment and stops receiving benefits from the Pension Plan. On December 1, 2023, Joe's coverage from the Plan as a Retiree is terminated in accordance with Section 1.08(b)(3). On that same date (i.e., December 1, 2023), Joe pays the self-payment premium in accordance with Section 1.09(b)(1)(i) and his/her coverage as an Eligible Employee is reinstated (i.e., his/her coverage as an Eligible Employee is reinstated at the same time that his/her coverage as a Retiree is terminated).

Example 5: On November 1, 2023, Joe is 62 years old, (s)he is covered by the Plan as a Retiree, and (s)he does not work in any type of employment. On December 1, 2023, Joe returns to Covered Employment. In December 2023, Joe works 40 hours in Covered Employment and stops receiving benefits from the Pension Plan. On December 1, 2023, Joe's coverage from the Plan as a Retiree is terminated in accordance with Section 1.08(b)(3). On December 1, 2023, Joe does not pay the self-payment premium and his/her coverage as an Eligible Employee is NOT reinstated. Because Joe's coverage as an Eligible Employee was not reinstated on December 1, 2023, Joe will not have coverage from the Plan until and unless (s)he works enough hours in Covered Employment to have his/her coverage as an Eligible Employee reinstated in accordance with Section 1.09(b)(1)(ii) (i.e., because his/her coverage as an Eligible Employee was not reinstated on the same date that his/her coverage as a Retiree was terminated, (s)he cannot have his/her coverage as an Eligible Employee reinstated by making a self-payment in accordance with Section 1.09(b)(1)(i)).

Example 6: On February 1, 2023, Joe is 62 years old, (s)he is covered by the Plan as an Eligible Employee, and (s)he is not working in any type of employment. On March 1, 2023, Joe starts receiving benefits from the Pension Plan. On July 1, 2023, Joe has not worked enough hours to remain covered by the Plan as an Eligible Employee (i.e., (s)he did not work sufficient hours in Covered Employment during the prior Qualifying Periods). From February 1, 2023, through June 30, 2023, Joe does not work in any type of employment and (s)he remains covered by the Plan as an Eligible Employee based on the hours that (s)he worked in Covered Employment during the period of June 1, 2022 through January 31, 2023. On July 1, 2023, Joe does not have enough hours to remain covered by the Plan as an Eligible Employee. On July 1, 2023, Joe's coverage from the Plan as an Eligible Employee is terminated. Joe meets the requirements of Section 1.06 and makes an appropriate election to begin coverage as a Retiree on July 1, 2023. From July 1, 2023, through October 31, 2023, Joe pays the Retiree premium and (s)he remains covered by the Plan as a Retiree. On November 1, 2023, Joe does not pay the Retiree premium and his/her coverage from the Plan is terminated. After January 2024, Joe is no longer eligible for coverage from the Plan as a Retiree and (s)he will not have coverage from the Plan again unless (s)he works enough hours in Covered Employment to have his/her coverage as an Eligible Employee reinstated in accordance with Section 1.09(b)(2).

Section 1.10 - Reinstatement of Coverage as a Retiree

If your coverage from the Plan as a Retiree is terminated in accordance with Section 1.08(b), your coverage from the Plan as a Retiree will be reinstated (i.e., you will become a Retiree again) at 12:00 a.m. on the first day of the calendar month following the date that you have met all the criteria of Section 1.06.

Section 1.11 - Qualification as an Eligible Dependent Spouse of an Eligible Employee

If you are an Eligible Employee, your spouse is only eligible for coverage from the Plan if your spouse is considered an eligible Dependent. Your spouse is considered an eligible Dependent if your spouse meets the criteria of Section 1.11(a) and Section 1.11(b).

(a) Your Spouse Must Be Your Lawful Spouse

Your spouse is considered your lawful spouse if you and your spouse are legally married under the laws of the United States or a foreign jurisdiction that has the legal authority to sanction marriages, regardless of where you and your spouse live and regardless of whether you and your spouse are of the same or opposite gender.

(b) Your Spouse Must Either Satisfy the Working Spouse Rule or Be Exempt from the Working Spouse Rule

The Working Spouse Rule generally provides that if your spouse is employed and she has Qualifying Health Coverage (as that term is defined in Section 1.01(f)) available from her employer, your spouse is not eligible for coverage from the Plan unless she is enrolled in her employer's health plan. Section 1.11(b)(1) and Section 1.11(b)(2) provide a detailed explanation of how Working Spouse Rule works. Your spouse satisfies the Working Spouse Rule if she meets the criteria of Section 1.11(b)(1). Your spouse is exempt from the Working Spouse Rule if she meets the criteria of Section 1.11(b)(2).

(1) Satisfaction of the Working Spouse Rule

Your spouse satisfies the Working Spouse Rule if she is enrolled in her employer's Qualifying Health Coverage.

(2) Exemption from the Working Spouse Rule

As explained in Section 1.11(b)(2)(i) and Section 1.11(b)(2)(ii), the determination as to whether or not your spouse is exempt from the Working Spouse Rule during a calendar year depends on whether or not you and your spouse are married on January 1 of that year.

(i) Exemption from the Working Spouse Rule for a spouse that is married to an Eligible Employee on January 1 of the calendar year

If you are married to your spouse on January 1 of the calendar year and at least one of the following criteria is met, your spouse will be exempt from the Working Spouse Rule during the period that begins on April 1 of that calendar year and ends on March 31 of the following calendar year (for example, if you and you and your spouse are married on January 1, 2023 and at least one of the following criteria is met on January 1, 2023 or March 31, 2023, as applicable, then your spouse will be exempt from the Working Spouse Rule during the period that begins on April 1, 2023 and ends on March 31, 2024):

(A) Your spouse does not have Qualifying Health Coverage available from her employer on March 31 of that year;

(B) Your spouse is not employed on January 1 of that year;

(C) You are not an Eligible Employee on January 1 of that year;

(D) Your spouse is employed on January 1 of that year and her employment is terminated prior to March 31 of that year; or

(E) Your spouse is under the age of 26, she has health coverage from her parent's employer's health plan, and her parent's employer's health plan is her Primary Plan (as that term is defined in Article X) on March 31 of that year.

If you are married to your spouse on January 1 of the calendar year, your spouse does not meet one of the criteria listed in Sections 1.11(b)(2)(i)(A)-(E), and your spouse loses eligibility for Qualifying Health Coverage after March 31 of that year, your

spouse will be exempt from the Working Spouse Rule during the period that begins on the first day of the calendar month following the date that your spouse is no longer eligible for Qualifying Health Coverage and ends on March 31 of the following calendar year.

(ii) Exemption from the Working Spouse Rule for a spouse that is not married to an Eligible Employee until after January 1 of the calendar year

If you are not married to your spouse until after January 1 of the calendar year and at least one of the following criteria is met, your spouse will be exempt from the Working Spouse Rule during the period that begins on the date of your marriage and ends on March 31 of the following calendar year (for example, if you get married to your spouse on May 1, 2023 and at least one of the following criteria is met on May 1, 2023, then your spouse will be exempt from the Working Spouse Rule during the period that begins on May 1, 2023 and ends on March 31, 2024):

(A) Your spouse does not have Qualifying Health Coverage available from her employer on the date of your marriage;

(B) Your spouse is not employed on the date of your marriage;

(C) You are not an Eligible Employee on the date of your marriage; or

(D) Your spouse is under the age of 26, she has health coverage from her parent's employer's health plan, and her parent's employer's health plan is her Primary Plan (as that term is defined in Article X) on the date of your marriage.

If you are not married to your spouse until after January 1 of the calendar year, your spouse does not meet one of the criteria listed in Sections 1.11(b)(2)(ii)(A)-(D), and your spouse loses eligibility for Qualifying Health Coverage after the date of your marriage, your spouse will be exempt from the Working Spouse Rule during the period that begins on the first day of the calendar month following the date that your spouse is no longer eligible for Qualifying Health Coverage and ends on March 31 of the following calendar year.

Section 1.12 - Qualification as an Eligible Dependent Child of an Eligible Employee

If you are an Eligible Employee, your child is only eligible for coverage from the Plan if your child is considered an eligible Dependent. Your child is considered an eligible Dependent if your child meets the criteria of Section 1.12(a) and Section 1.12(b).

(a) Your Child Must Be Related to You in at Least One of the Following Ways:

(1) He is your son, daughter, stepson, or stepdaughter;

(2) He is your eligible foster child;

(3) He is legally adopted or lawfully placed with you for adoption prior to his/her 18th birthday; or

(4) He is a child for whom you have a legal responsibility by virtue of a court order for custody and support or maintenance (including a legal guardianship), or who is the subject of a Qualified Medical Child Support Order ("QMCSO").

NOTE: A child is considered an eligible foster child if the child is placed with the Eligible Employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

A child is considered an eligible Dependent if the Plan receives a QMCSO from the court ordering the Plan to provide coverage to the child as the Alternate Recipient under the QMCSO. A National Medical Child Support Notice that the Plan receives from a state agency that involves coverage for a child will also be treated as a QMCSO. The Plan will review the QMCSO and determine whether it is qualified in accordance with the Plan's written procedures for handling medical child support orders. The Plan's procedures for handling medical child support orders will be provided to an Eligible Employee or Beneficiary upon request and free of charge.

(b) Your Child Must Meet at Least One of the Following Criteria:

(1) He is under the age of 26; or

(2) He is permanently and totally disabled and the disability began before the child would have lost coverage from the Plan if not for the disability. For the purposes of this Section 1.12(b)(2) only, an individual is "permanently and totally disabled" if (s)he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. An individual shall not be considered to be "permanently and totally disabled" unless (s)he furnishes proof of the existence thereof in such form and manner, and at such times, as the Plan may require.

Section 1.13 - Initial Date of Coverage for an Eligible Dependent Spouse of an Eligible Employee

As explained in Sections 1.13(a)-(c), if you are an Eligible Employee, your eligible Dependent spouse will only become covered by the Plan if your spouse is enrolled in the Plan in accordance with the following rules:

- If you are married to an eligible Dependent spouse on the date that you become an Eligible Employee (i.e., on the date that you become an Eligible Employee your spouse meets the criteria of Section 1.11), your spouse will become covered by the Plan on the date that you become an Eligible Employee so long as your spouse is enrolled in the Plan within 90 days after such date in accordance with Section 1.13(a);

- If you get married to an eligible Dependent spouse after the date that you became an Eligible Employee (i.e., after the date that you became an Eligible Employee you get married to a spouse that meets the criteria of Section 1.11), your spouse will become covered by the Plan on the date of your marriage so long as your spouse is enrolled in the Plan within 90 days after the date of your marriage in accordance with Section 1.13(b); or

- If you get married after the date that you became an Eligible Employee to a spouse that is not an eligible Dependent spouse (i.e., you get married after the date that you became an Eligible Employee and on the date of your marriage your spouse does not meet the criteria of Section 1.11) and subsequently your spouse meets the criteria of Section 1.11 (i.e., subsequently your spouse either satisfies the Working Spouse Rule or becomes exempt from the Working Spouse Rule), your spouse will become covered by the Plan on the first day of the calendar month following the date that your spouse became an eligible Dependent spouse and enrolled in the Plan in accordance with Section 1.13(c).

NOTE: If your eligible Dependent spouse is not enrolled in the Plan within the timeframes described above, your spouse will become eligible for coverage from the Plan on the first day of the calendar month following the date that her enrollment form is postmarked or otherwise positively received by the Fund

Office. Refer to Sections 1.13(a)-(c) for the detailed rules regarding the date that your eligible Dependent spouse will become covered by the Plan. Note that this Section 1.13 does not address reinstatement of eligibility and coverage for a spouse whose coverage is terminated in accordance with Section 1.16. Refer to Section 1.18 for the rules regarding the reinstatement of eligibility and coverage for a spouse.

(a) Initial Date of Coverage for a Spouse that Is an Eligible Dependent Spouse on the Date that the Employee Becomes Covered by the Plan

If you are married to an eligible Dependent spouse (i.e., your spouse meets the criteria of Section 1.11) on the date that you become an Eligible Employee (either in accordance with Section 1.02 or Section 1.09), your spouse will become covered by the Plan at the same time that you become covered by the Plan so long as a completed enrollment form for your spouse is postmarked or otherwise positively received by the Fund Office within 90 days after the date that you became covered by the Plan.

If your spouse's completed enrollment form is not postmarked or otherwise positively received by the Fund Office within 90 days after the date that you became covered by the Plan, your spouse will become covered by the Plan at 12:00 a.m. on the first day of the calendar month following the date that your spouse's completed enrollment form is postmarked or otherwise positively received by the Fund Office.

(b) Initial Date of Coverage for a Spouse that Gets Married to an Eligible Employee after the Date that the Eligible Employee Becomes Covered by the Plan when the Spouse Is an Eligible Dependent Spouse on the Date of the Marriage

If you get married to an eligible Dependent spouse (i.e., you get married and on the date of your marriage your spouse meets the criteria of Section 1.11) after the date that you became an Eligible Employee (either in accordance with Section 1.02 or Section 1.09), your spouse will become covered by the Plan at 12:00 a.m. on the date of the marriage so long as a completed enrollment form for your spouse is postmarked or otherwise positively received by the Fund Office within 90 days after the date of the marriage.

If your spouse's completed enrollment form is not postmarked or otherwise positively received by the Fund Office within 90 days after the date of the marriage, your spouse will become covered by the Plan at 12:00 a.m. on the first day of the calendar month following the date that your spouse's completed enrollment form is postmarked or otherwise positively received by the Fund Office.

(c) Initial Date of Coverage for a Spouse that Gets Married to an Eligible Employee after the Date that the Eligible Employee Becomes Covered by the Plan when the Spouse Is Not an Eligible Dependent Spouse on the Date of the Marriage

If you get married after the date that you became an Eligible Employee (either in accordance with Section 1.02 or Section 1.09) to a spouse that is not an eligible Dependent spouse (i.e., you get married and on the date of your marriage your spouse does not meet the criteria of Section 1.11) and subsequently your spouse meets the criteria of Section 1.11 (i.e., subsequently your spouse either satisfies the Working Spouse Rule or becomes exempt from the Working Spouse Rule), your spouse will become covered by the Plan at 12:00 a.m. on the first day of the calendar month following the date that she became an eligible Dependent spouse (i.e., the first day of the calendar month following the date that she either satisfied the Working Spouse Rule or became exempt from the Working Spouse Rule) so long as a completed enrollment form for your spouse is postmarked or otherwise positively received by the Fund Office prior to the first day of the calendar month following the date that she became an eligible Dependent spouse.

If your spouse's completed enrollment form is not postmarked or otherwise positively received by the Fund Office prior to the first day of the calendar month following the date that she became an eligible Dependent spouse, your spouse will become covered by the Plan at 12:00 a.m. on the first day of the calendar month following the date that your spouse's completed enrollment form is postmarked or otherwise positively received by the Fund Office.

Section 1.14 - Initial Date of Coverage for an Eligible Dependent Child of an Eligible Employee

As explained in Sections 1.14(a)-(b), if you are an Eligible Employee, your eligible Dependent child will only become covered by the Plan if your child is enrolled in the Plan in accordance with the following rules:

- If you have an eligible Dependent child on the date that you become an Eligible Employee (i.e., on the date that you become an Eligible Employee your child meets the criteria of Section 1.12), your child will become covered by the Plan on the date that you become an Eligible Employee so long as your child is enrolled in the Plan within 90 days after such date in accordance with Section 1.14(a); or

- If you acquire an eligible Dependent child after the date that you became an Eligible Employee (i.e., after the date that you became an Eligible Employee you acquire a child that meets the criteria of Section 1.12), your child will become covered by the Plan on the date that you acquire the child so long as your child is enrolled in the Plan within 90 days after the date you acquire the child in accordance with Section 1.14(b).

NOTE: If your eligible Dependent child is not enrolled in the Plan within the timeframes described above, your child will become eligible for coverage from the Plan on the first day of the calendar month following the date that his/her enrollment form is postmarked or otherwise positively received by the Fund Office. Refer to Sections 1.14(a)-(b) for the detailed rules regarding the date that your eligible Dependent child will become covered by the Plan. Further, this Section 1.14 does not address reinstatement of eligibility and coverage for a child whose coverage is terminated in accordance with Section 1.17. Refer to Section 1.19 for the rules regarding the reinstatement of eligibility and coverage for a child.

(a) Initial Date of Coverage for a Child that Is an Eligible Dependent Child on the Date that the Employee Becomes Covered by the Plan

If you have an eligible Dependent child (i.e., your child meets the criteria of Section 1.12) on the date that you become an Eligible Employee (either in accordance with Section 1.02 or Section 1.09), your child will become covered by the Plan at the same time that you become covered by the Plan so long as a completed enrollment form for your child is postmarked or otherwise positively received by the Fund Office within 90 days after the date that you became covered by the Plan.

If your child's completed enrollment form is not postmarked or otherwise positively received by the Fund Office within 90 days after the date that you became covered by the Plan, your child will become covered by the Plan at 12:00 a.m. on the first day of the calendar month following the date that your child's completed enrollment form is postmarked or otherwise positively received by the Fund Office.

(b) Initial Date of Coverage for an Eligible Dependent Child that Is Acquired by an Eligible Employee after the Date that the Eligible Employee Becomes Covered by the Plan

If you acquire an eligible Dependent child (i.e., you have a new child as a result of marriage, birth, adoption, placement for adoption, or a court order and the child meets the criteria of Section 1.12) after the date that you became an Eligible Employee (either in accordance with Section 1.02 or Section 1.09), your child will become covered by the Plan at 12:00 a.m. on the date that you acquire the child (i.e., the date of the marriage, birth, adoption, placement for adoption, or court order) so long as a completed enrollment form for your child is postmarked or otherwise positively received by the Fund Office within 90 days after the date that you acquired the child.

If your child's completed enrollment form is not postmarked or otherwise positively received by the Fund Office within 90 days after the date that you acquired the child, your child will become covered by the Plan at 12:00 a.m. on the first day of the calendar month following the date that your child's completed enrollment form is postmarked or otherwise positively received by the Fund Office.

Section 1.15 - Waiver of Coverage for an Eligible Dependent of an Eligible Employee

If you are an Eligible Employee, you can waive coverage for your spouse and/or child in accordance with Section 1.15(a) or Section 1.15(b), as applicable. If you waive coverage for your spouse and/or child, your spouse and/or child's coverage will be terminated in accordance with Section 1.16 or Section 1.17, as applicable.

(a) Waiver of Coverage for an Eligible Dependent Spouse of an Eligible Employee

If you are an Eligible Employee, you can waive coverage for your eligible Dependent spouse by providing the Fund Office with a Waiver of Health Care Coverage that is signed by you and a Waiver of Health Care Coverage that is signed by your spouse. The waiver will become effective on the first day of the calendar month following the date that the Fund Office receives both the Waiver of Health Care Coverage that is signed by you and the Waiver of Health Care Coverage that is signed by your spouse.

(b) Waiver of Coverage for an Eligible Dependent Child of an Eligible Employee

If you are an Eligible Employee and your eligible Dependent child is at least 18 years of age, you can waive coverage for your child by providing the Fund Office with a Waiver of Health Care Coverage that is signed by you and a Waiver of Health Care Coverage that is signed by your child. The waiver will become effective on the first day of the calendar month following the date that the Fund Office receives both the Waiver of Health Care Coverage that is signed by you and the Waiver of Health Care Coverage that is signed by your child.

If you are an Eligible Employee and your eligible Dependent child is under the age of 18, you can waive coverage for your child by providing the Fund Office with a Waiver of Health Care Coverage that is signed by you and a Waiver of Health Care Coverage that is signed by your child's other natural or adoptive parent. The waiver will become effective on the first day of the calendar month following the date that the Fund Office receives both the Waiver of Health Care Coverage that is signed by you and the Waiver of Health Care Coverage that is signed by your child's other natural or adoptive parent.

Section 1.16 - Termination of Coverage for a Spouse of an Eligible Employee

As explained in Section 1.16(a) and Section 1.16(b), if you are an Eligible Employee and your spouse is covered by the Plan, the date that your spouse's coverage from the Plan will terminate (i.e., the date your spouse will no longer be covered by the Plan) depends on whether your spouse was considered an eligible Dependent spouse because she satisfied the Working Spouse Rule (see Section 1.16(a)) or your spouse was considered an eligible Dependent spouse because she was exempt from the Working Spouse Rule (see Section 1.16(b)).

(a) Termination of Coverage for a Spouse that Satisfied the Working Spouse Rule

If you are an Eligible Employee and your lawful spouse is covered by the Plan because she satisfies the Working Spouse Rule (i.e., your spouse is covered by the Plan because she meets the criteria of Section 1.11(a) and Section 1.11(b)(1)), your spouse's coverage will terminate at 12:00 a.m. on the earliest of the following days:

(1) The date that your coverage from the Plan terminates for any reason, subject to your spouse's right to continue coverage from the Plan in accordance with Section 1.24;

(2) The date on which your spouse no longer satisfies the Working Spouse Rule because she is no longer enrolled in her employer's Qualifying Health Coverage (i.e., your spouse no longer meets the criteria of Section 1.11(b)(1)) and she is not exempt from the Working Spouse Rule (i.e., your spouse does not meet the criteria of Section 1.11(b)(2));

(3) The date that a waiver of your spouse's coverage from the Plan becomes effective in accordance with Section 1.15(a); or

(4) The first day of the calendar month following the date that a decree of divorce, dissolution of marriage, legal separation, or separate maintenance (regardless of the terms used to describe the divorce or legal separation) is entered.

(b) Termination of Coverage for a Spouse that Was Exempt from the Working Spouse Rule

If you are an Eligible Employee and your lawful spouse is covered by the Plan because she is exempt from the Working Spouse Rule (i.e., your spouse is covered by the Plan because she meets the criteria of Section 1.11(a) and Section 1.11(b)(2)), your spouse's coverage will terminate in accordance with Section 1.16(b)(1) or Section 1.16(b)(2).

(1) If your spouse is no longer exempt from the Working Spouse Rule (i.e., your spouse no longer meets the criteria of Section 1.11(b)(2)) and she does not satisfy the Working Spouse Rule because she is not enrolled in her employer's Qualifying Health Coverage (i.e., your spouse does not meet the criteria of Section 1.11(b)(1)), your spouse's coverage from the Plan will terminate at 11:59 p.m. on March 31 of the first calendar year in which she is no longer exempt from the Working Spouse Rule.

(2) If your spouse remains exempt from the Working Spouse Rule, your spouse's coverage from the Plan will terminate at 12:00 a.m. on the earliest of the following days:

(i) The date that your coverage from the Plan terminates for any reason, subject to your spouse's right to continue coverage from the Plan in accordance with Section 1.24;

(ii) The date that a waiver of your spouse's coverage from the Plan becomes effective in accordance with Section 1.15(a); or

(iii) The first day of the calendar month following the date that a decree of divorce, dissolution of marriage, legal separation, or separate maintenance (regardless of the terms used to describe the divorce or legal separation) is entered.

Each Eligible Employee and each former spouse of an Eligible Employee is responsible for promptly notifying the Fund Office if (s)he has a change in marital status. This means an Eligible Employee and a former spouse must notify the Fund Office immediately in the event of divorce, dissolution of marriage, legal separation, or separate maintenance. Failure to notify the Fund Office of divorce, dissolution of marriage, legal separation, or separate maintenance will be considered an omission that constitutes fraud and an intentional misrepresentation of a material fact that is prohibited by the terms of the Plan. If an Eligible Employee or former spouse does not notify the Fund Office of the divorce, dissolution of marriage, legal separation, or separate maintenance, the Plan may recover any payments made for claims incurred by the former spouse after the divorce, dissolution of marriage, legal separation, or separate maintenance in accordance with Section 13.18.

NOTE: If a spouse's (or former spouse's) coverage is terminated in accordance with this Section 1.16, the spouse (or former spouse) may be eligible for COBRA continuation coverage. Refer to Section 1.30 for information about COBRA continuation coverage.

Section 1.17 - Termination of Coverage for a Child of an Eligible Employee

If you are an Eligible Employee, your child's coverage from the Plan will terminate (i.e., your child will no longer be covered by the Plan) at 12:00 a.m. on the earliest of the following days:

(a) The date that your coverage from the Plan terminates for any reason, subject to your child's right to continue coverage from the Plan in accordance with Section 1.25;

(b) The date that a waiver of your child's coverage from the Plan becomes effective in accordance with Section 1.15(b); or

(c) The first day of the calendar month following the date that your child no longer meets the criteria of Section 1.12(a) or Section 1.12(b).

Each Eligible Employee is responsible for promptly notifying the Fund Office if his/her child no longer meets the criteria of Section 1.12(a) or Section 1.12(b)(2). This means that an Eligible Employee must notify the Fund Office immediately if a child that is covered by the Plan as his/her Dependent is either no longer his/her relative (as that term is defined in Section 1.12(a)) or no longer permanently and totally disabled (as that term is defined in Section 1.12(b)(2)). Failure to notify the Fund Office that a child is no longer a relative or no longer permanently and totally disabled will be considered an omission that constitutes fraud and an intentional misrepresentation of a material fact that is prohibited by the terms of the Plan. If an Eligible Employee does not notify the Fund Office that a child is no longer his/her relative or no longer permanently and totally disabled, the Plan may recover any payments made for claims incurred by the child after the child is no longer the Eligible Employee's relative or no longer permanently and totally disabled in accordance with Section 13.18.

NOTE: If a child's coverage is terminated in accordance with this Section 1.17, the child may be eligible for COBRA continuation coverage. Refer to Section 1.30 for information about COBRA continuation coverage.

Section 1.18 - Reinstatement of Coverage for an Eligible Dependent Spouse of an Eligible Employee

As explained in Sections 1.18(a)-(d), if you are an Eligible Employee and your spouse's coverage from the Plan is terminated in accordance with Section 1.16, the rules regarding reinstatement of your spouse's coverage depend on the reason that your spouse's coverage is terminated.

(a) Reinstatement of Coverage as an Eligible Dependent Spouse Following Termination of Coverage in Accordance with Section 1.16(a)(1) or Section 1.16(b)(2)(i) (i.e., reinstatement of coverage for a spouse whose coverage is terminated because the Eligible Employee's coverage is terminated)

If your spouse's coverage from the Plan is terminated in accordance with Section 1.16(a)(1) or Section 1.16(b)(2)(i) (i.e., your spouse's coverage from the Plan is terminated because your coverage from the Plan is terminated), your coverage is reinstated in accordance with Section 1.09(a), and your spouse is an eligible Dependent spouse on the date that your coverage is reinstated (i.e., your spouse meets the criteria of Section 1.11 on the date that your coverage is reinstated), your spouse's coverage from the Plan will be reinstated at the same time that your coverage from the Plan is reinstated so long as a new enrollment form for your spouse is postmarked or otherwise positively received by the Fund Office within 90 days after the date that your coverage is reinstated. If your spouse's new enrollment form is not postmarked or otherwise positively received by the Fund Office within 90

days after the date that your coverage from the Plan is reinstated, your spouse's coverage from the Plan will be reinstated at 12:00 a.m. on the first day of the calendar month following the date that your spouse's new enrollment form is postmarked or otherwise positively received by the Fund Office.

(b) Reinstatement of Coverage as an Eligible Dependent Spouse Following Termination of Coverage in Accordance with Section 1.16(a)(2) (i.e., reinstatement of coverage for a spouse whose coverage is terminated because she is no longer enrolled in Qualifying Health Coverage available from her employer and therefore no longer satisfies the Working Spouse Rule)

(1) Reinstatement of coverage as an eligible Dependent spouse for a spouse who re-enrolls in her employer's Qualifying Health Coverage

If your spouse's coverage from the Plan is terminated in accordance with Section 1.16(a)(2) (i.e., your spouse's coverage from the Plan is terminated because she is no longer enrolled in Qualifying Health Coverage available from her employer and she is not exempt from the Working Spouse Rule) and your spouse subsequently re-enrolls in her employer's Qualifying Health Coverage, your spouse's coverage from the Plan will be reinstated at 12:00 a.m. on the date that your spouse is re-enrolled in her employer's Qualifying Health Coverage so long as a new enrollment form for your spouse is postmarked or otherwise positively received by the Fund Office within 90 days after the date that your spouse became re-enrolled in her employer's Qualifying Health Coverage. If your spouse's new enrollment form is not postmarked or otherwise positively received by the Fund Office within 90 days after the date that your spouse became re-enrolled in her employer's Qualifying Health Coverage, your spouse's coverage from the Plan will be reinstated at 12:00 a.m. on the first day of the calendar month following the date that your spouse's new enrollment form is postmarked or otherwise positively received by the Fund Office.

If your coverage as an Eligible Employee is terminated prior to the date that your spouse's coverage from the Plan is reinstated in accordance with the preceding paragraph of this Section 1.18(b)(1), your coverage from the Plan is subsequently reinstated in accordance with Section 1.09(a), and your spouse is an eligible Dependent spouse on the date that your coverage is reinstated (i.e., your spouse meets the criteria of Section 1.11 on the date that your coverage is reinstated), your spouse's coverage from the Plan will be reinstated at the same time that your coverage from the Plan is reinstated so long as a new enrollment form for your spouse is postmarked or otherwise positively received by the Fund Office within 90 days after the date that your coverage is reinstated. If your spouse's new enrollment form is not postmarked or otherwise positively received by the Fund Office within 90 days after the date that your coverage from the Plan is reinstated, your spouse's coverage from the Plan will be reinstated at 12:00 a.m. on the first day of the calendar month following the date that your spouse's new enrollment form is postmarked or otherwise positively received by the Fund Office.

(2) Reinstatement of Coverage as an eligible Dependent spouse for a spouse who loses eligibility for Qualifying Health Coverage

If your spouse's coverage from the Plan is terminated in accordance with Section 1.16(a)(2) (i.e., your spouse's coverage from the Plan is terminated because she is no longer enrolled in Qualifying Health Coverage available from her employer and she is not exempt from the Working Spouse Rule) and your spouse subsequently loses eligibility for Qualifying Health Coverage (i.e., subsequently your spouse is no longer employed and/or no longer eligible for her employer's Qualifying Health Coverage), your spouse's coverage from the Plan will be reinstated at 12:00 a.m. on the date that your spouse is no longer eligible for Qualifying

Health Coverage from her employer so long as a new enrollment form for your spouse is postmarked or otherwise positively received by the Fund Office within 90 days after the date that your spouse was no longer eligible for Qualifying Health Coverage. If your spouse's new enrollment form is not postmarked or otherwise positively received by the Fund Office within 90 days after the date that your spouse was no longer eligible for Qualifying Health Coverage from her employer, your spouse's coverage from the Plan will be reinstated at 12:00 a.m. on the first day of the calendar month following the date that your spouse's new enrollment form is postmarked or otherwise positively received by the Fund Office.

If your coverage as an Eligible Employee is terminated prior to the date that your spouse's coverage from the Plan is reinstated in accordance with the preceding paragraph of this Section 1.18(b)(2), your coverage from the Plan is subsequently reinstated in accordance with Section 1.09(a), and your spouse is an eligible Dependent spouse on the date that your coverage is reinstated (i.e., your spouse meets the criteria of Section 1.11 on the date that your coverage is reinstated), your spouse's coverage from the Plan will be reinstated at the same time that your coverage from the Plan is reinstated so long as a new enrollment form for your spouse is postmarked or otherwise positively received by the Fund Office within 90 days after the date that your coverage is reinstated. If your spouse's new enrollment form is not postmarked or otherwise positively received by the Fund Office within 90 days after the date that your coverage from the Plan is reinstated, your spouse's coverage from the Plan will be reinstated at 12:00 a.m. on the first day of the calendar month following the date that your spouse's new enrollment form is postmarked or otherwise positively received by the Fund Office.

(c) Reinstatement of Coverage as an Eligible Dependent Spouse Following Termination of Coverage in Accordance with Section 1.16(b)(1) (i.e., reinstatement of coverage for a spouse whose coverage is terminated because she is no longer exempt from the Working Spouse Rule and she is not enrolled in Qualifying Health Coverage available from her employer)

(1) Reinstatement of coverage as an eligible Dependent spouse for a spouse who enrolls in her employer's Qualifying Health Coverage on April 1

If your spouse's coverage from the Plan is terminated in accordance with Section 1.16(b)(1) (i.e., your spouse's coverage from the Plan is terminated because she is no longer exempt from the Working Spouse Rule and she is not enrolled in Qualifying Health Coverage available from her employer) and your spouse enrolls in her employer's Qualifying Health Coverage on April 1 of the same calendar year in which her coverage from the Plan is terminated, your spouse's coverage from the Plan will be reinstated at 12:00 a.m. on April 1 of that year (i.e., her coverage will be reinstated on the date that she becomes covered by her employer's Qualifying Health Coverage) so long as a new enrollment form for your spouse is postmarked or otherwise positively received by the Fund Office by March 31 of that year and the new enrollment form indicates that your spouse is enrolled in her employer's Qualifying Health Coverage on April 1 of that year. If your spouse's new enrollment form is not postmarked or otherwise positively received by the Fund Office by March 31 of the calendar year in which your spouse's coverage is terminated, your spouse's coverage from the Plan will still be reinstated on April 1 of that calendar year so long as a new enrollment form for your spouse is postmarked or otherwise positively received by the Fund Office by June 30 of that year. If your spouse's new enrollment form is not postmarked or otherwise positively received by the Fund Office by June 30 of that year, your spouse's coverage from the Plan will be reinstated at 12:00 a.m. on the first day of the calendar month following the date that your spouse's new enrollment form is postmarked or otherwise positively received by the Fund Office.

If your coverage as an Eligible Employee is terminated prior to the date that your spouse's coverage from the Plan is reinstated in accordance with the preceding paragraph of this Section 1.18(c)(1), your coverage from the Plan is subsequently reinstated in accordance with Section 1.09(a), and your spouse is an eligible Dependent spouse on the date that your coverage is reinstated (i.e., your spouse meets the criteria of Section 1.11 on the date that your coverage is reinstated), your spouse's coverage from the Plan will be reinstated at the same time that your coverage from the Plan is reinstated so long as a new enrollment form for your spouse is postmarked or otherwise positively received by the Fund Office within 90 days after the date that your coverage is reinstated. If your spouse's new enrollment form is not postmarked or otherwise positively received by the Fund Office within 90 days after the date that your coverage from the Plan is reinstated, your spouse's coverage from the Plan will be reinstated at 12:00 a.m. on the first day of the calendar month following the date that your spouse's new enrollment form is postmarked or otherwise positively received by the Fund Office.

(2) Reinstatement of coverage as an eligible Dependent spouse for a spouse who enrolls in her employer's Qualifying Health Coverage after April 1

If your spouse's coverage from the Plan is terminated in accordance with Section 1.16(b)(1) (i.e., your spouse's coverage from the Plan is terminated because she is no longer exempt from the Working Spouse Rule and she is not enrolled in Qualifying Health Coverage available from her employer) and your spouse enrolls in her employer's Qualifying Health Coverage after April 1 of the same calendar year in which her coverage from the Plan is terminated, your spouse's coverage from the Plan will be reinstated at 12:00 a.m. on the date that your spouse is enrolled in her employer's Qualifying Health Coverage so long as a new enrollment form for your spouse is postmarked or otherwise positively received by the Fund Office within 90 days after the date that your spouse became enrolled in her employer's Qualifying Health Coverage. If your spouse's new enrollment form is not postmarked or otherwise positively received by the Fund Office within 90 days after the date that your spouse became enrolled in her employer's Qualifying Health Coverage, your spouse's coverage from the Plan will be reinstated at 12:00 a.m. on the first day of the calendar month following the date that your spouse's new enrollment form is postmarked or otherwise positively received by the Fund Office.

If your coverage as an Eligible Employee is terminated prior to the date that your spouse's coverage from the Plan is reinstated in accordance with the preceding paragraph of this Section 1.18(c)(2), your coverage from the Plan is subsequently reinstated in accordance with Section 1.09(a), and your spouse is an eligible Dependent spouse on the date that your coverage is reinstated (i.e., your spouse meets the criteria of Section 1.11 on the date that your coverage is reinstated), your spouse's coverage from the Plan will be reinstated at the same time that your coverage from the Plan is reinstated so long as a new enrollment form for your spouse is postmarked or otherwise positively received by the Fund Office within 90 days after the date that your coverage is reinstated. If your spouse's new enrollment form is not postmarked or otherwise positively received by the Fund Office within 90 days after the date that your coverage from the Plan is reinstated, your spouse's coverage from the Plan will be reinstated at 12:00 a.m. on the first day of the calendar month following the date that your spouse's new enrollment form is postmarked or otherwise positively received by the Fund Office.

(3) Reinstatement of coverage as an eligible Dependent spouse for a spouse who loses eligibility for Qualifying Health Coverage

If your spouse's coverage from the Plan is terminated in accordance with Section 1.16(b)(1) (i.e., your spouse's coverage from the Plan is terminated because she is no longer exempt from the Working Spouse Rule and she is not enrolled in Qualifying Health Coverage available from her employer) and your spouse subsequently loses eligibility for Qualifying Health Coverage (i.e., subsequently your spouse is no longer employed and/or no longer eligible for her employer's Qualifying Health Coverage), your spouse's coverage from the Plan will be reinstated at 12:00 a.m. on the date that your spouse is no longer eligible for Qualifying Health Coverage from her employer so long as a new enrollment form for your spouse is postmarked or otherwise positively received by the Fund Office within 90 days after the date that your spouse was no longer eligible for Qualifying Health Coverage. If your spouse's new enrollment form is not postmarked or otherwise positively received by the Fund Office within 90 days after the date that your spouse was no longer eligible for Qualifying Health Coverage from her employer, your spouse's coverage from the Plan will be reinstated at 12:00 a.m. on the first day of the calendar month following the date that your spouse's new enrollment form is postmarked or otherwise positively received by the Fund Office.

If your coverage as an Eligible Employee is terminated prior to the date that your spouse's coverage from the Plan is reinstated in accordance with the preceding paragraph of this Section 1.18(c)(3), your coverage from the Plan is subsequently reinstated in accordance with Section 1.09(a), and your spouse is an eligible Dependent spouse on the date that your coverage is reinstated (i.e., your spouse meets the criteria of Section 1.11 on the date that your coverage is reinstated), your spouse's coverage from the Plan will be reinstated at the same time that your coverage from the Plan is reinstated so long as a new enrollment form for your spouse is postmarked or otherwise positively received by the Fund Office within 90 days after the date that your coverage is reinstated. If your spouse's new enrollment form is not postmarked or otherwise positively received by the Fund Office within 90 days after the date that your coverage from the Plan is reinstated, your spouse's coverage from the Plan will be reinstated at 12:00 a.m. on the first day of the calendar month following the date that your spouse's new enrollment form is postmarked or otherwise positively received by the Fund Office.

(d) Reinstatement of Coverage as an Eligible Dependent Spouse Following Termination of Coverage in Accordance with Section 1.16(a)(3) or Section 1.16(b)(2)(ii) (i.e., reinstatement of coverage for a spouse whose coverage is terminated because her coverage was waived in accordance with Section 1.15(a))

If your spouse's coverage from the Plan is terminated in accordance with Section 1.16(a)(3) or Section 1.16(b)(2)(ii) (i.e., your spouse's coverage from the Plan is terminated because her coverage was waived in accordance with Section 1.15(a)) and your spouse is an eligible Dependent spouse (i.e., your spouse meets the criteria of Section 1.11), your spouse's coverage from the Plan will be reinstated at 12:00 a.m. on the first day of the calendar month following the date that a new enrollment form for your spouse is postmarked or otherwise positively received by the Fund Office.

If your coverage as an Eligible Employee is terminated prior to the date that your spouse's coverage from the Plan is reinstated in accordance with the preceding paragraph of this Section 1.18(d), your coverage from the Plan is subsequently reinstated in accordance with Section 1.09(a), and your spouse is an eligible Dependent spouse on the date that your coverage is reinstated (i.e., your spouse meets the criteria of Section 1.11 on the date that your coverage is reinstated), your spouse's coverage from the Plan will be reinstated at the same time that your coverage from the Plan is reinstated so

long as a new enrollment form for your spouse is postmarked or otherwise positively received by the Fund Office within 90 days after the date that your coverage is reinstated. If your spouse's new enrollment form is not postmarked or otherwise positively received by the Fund Office within 90 days after the date that your coverage from the Plan is reinstated, your spouse's coverage from the Plan will be reinstated at 12:00 a.m. on the first day of the calendar month following the date that your spouse's new enrollment form is postmarked or otherwise positively received by the Fund Office.

Section 1.19 - Reinstatement of Coverage for an Eligible Dependent Child of an Eligible Employee

(a) Reinstatement of Coverage as an Eligible Dependent Child Following Termination of Coverage in Accordance with Section 1.17(a) (i.e., reinstatement of coverage for a child whose coverage is terminated because the Eligible Employee's coverage is terminated)

If your child's coverage from the Plan is terminated in accordance with Section 1.17(a) (i.e., your child's coverage from the Plan is terminated because your coverage from the Plan is terminated), your coverage is reinstated in accordance with Section 1.09(a), and your child is an eligible Dependent child on the date that your coverage is reinstated (i.e., your child meets the criteria of Section 1.12 on the date that your coverage is reinstated), your child's coverage from the Plan will be reinstated at the same time that your coverage from the Plan is reinstated so long as a new enrollment form for your child is postmarked or otherwise positively received by the Fund Office within 90 days after the date that your coverage is reinstated. If your child's new enrollment form is not postmarked or otherwise positively received by the Fund Office within 90 days after the date that your coverage from the Plan is reinstated, your child's coverage from the Plan will be reinstated at 12:00 a.m. on the first day of the calendar month following the date that your child's new enrollment form is postmarked or otherwise positively received by the Fund Office.

(b) Reinstatement of Coverage as an Eligible Dependent Child Following Termination of Coverage in Accordance with Section 1.17(b) (i.e., reinstatement of coverage for a child whose coverage is terminated because his/her coverage was waived in accordance with Section 1.15(b))

If your child's coverage from the Plan is terminated in accordance with Section 1.17(b) (i.e., your child's coverage from the Plan is terminated because his/her coverage was waived in accordance with Section 1.16(b)) and your child is an eligible Dependent child (i.e., your child meets the criteria of Section 1.12), your child's coverage from the Plan will be reinstated at 12:00 a.m. on the first day of the calendar month following the date that a new enrollment form for your child is postmarked or otherwise positively received by the Fund Office.

If your coverage as an Eligible Employee is terminated prior to the date that your child's coverage from the Plan is reinstated in accordance with the preceding paragraph of this Section 1.19(b), your coverage from the Plan is subsequently reinstated in accordance with Section 1.09(a), and your child is an eligible Dependent child on the date that your coverage is reinstated (i.e., your child meets the criteria of Section 1.12 on the date that your coverage is reinstated), your child's coverage from the Plan will be reinstated at the same time that your coverage from the Plan is reinstated so long as a new enrollment form for your child is postmarked or otherwise positively received by the Fund Office within 90 days after the date that your coverage is reinstated. If your child's new enrollment form is not postmarked or otherwise positively received by the Fund Office within 90 days after the date that your coverage from the Plan is reinstated, your child's coverage from the Plan will be reinstated at 12:00 a.m. on the first day of the calendar month following the date that your child's new enrollment form is postmarked or otherwise positively received by the Fund Office.

Section 1.20 - Qualification as an Eligible Dependent Spouse of a Retiree

If you are a Retiree, your spouse is only eligible for coverage from the Plan if your spouse is considered an eligible Dependent. Your spouse is considered an eligible Dependent if you and your spouse are legally married under the laws of the United States or a foreign jurisdiction that has the legal authority to sanction marriages, regardless of where you and your spouse live and regardless of whether you and your spouse are of the same or opposite gender.

Section 1.21 - Qualification as an Eligible Dependent Child of a Retiree

If you are a Retiree, your child is only eligible for coverage from the Plan if your child is considered an eligible Dependent. Your child is considered an eligible Dependent if your child meets the criteria of Section 1.21(a) and Section 1.21(b).

(a) Your Child Must Be Related to You in at Least One of the Following Ways:

(1) He is your son, daughter, stepson, or stepdaughter;

(2) He is your eligible foster child;

(3) He is legally adopted or lawfully placed with you for adoption prior to his/her 18th birthday; or

(4) He is a child for whom you have a legal responsibility by virtue of a court order for custody and support or maintenance (including a legal guardianship), or who is the subject of a QMCSO.

NOTE: A child is considered an eligible foster child if the child is placed with the Retiree by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

A child is considered an eligible Dependent if the Plan receives a QMCSO from the court ordering the Plan to provide coverage to the child as the Alternate Recipient under the QMCSO. A National Medical Child Support Notice that the Plan receives from a state agency that involves coverage for a child will also be treated as a QMCSO. The Plan will review the QMCSO and determine whether it is qualified in accordance with the Plan's written procedures for handling medical child support orders. The Plan's procedures for handling medical child support orders will be provided to a Retiree or Beneficiary upon request and free of charge.

(b) Your Child Must Meet at Least One of the Following Criteria:

(1) He is under the age of 26; or

(2) He is permanently and totally disabled and the disability began before the child would have lost coverage from the Plan if not for the disability. For the purposes of this Section 1.21(b)(2) only, an individual is "permanently and totally disabled" if (s)he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. An individual shall not be considered to be "permanently and totally disabled" unless (s)he furnishes proof of the existence thereof in such form and manner, and at such times, as the Plan may require.

Section 1.22 - Coverage for an Eligible Dependent of a Retiree

(a) Coverage for an Eligible Dependent Spouse of a Retiree

As explained in Sections 1.22(a)(1)-(3), if you are a Retiree, your spouse will only become covered by the Plan if you elect coverage for your spouse in accordance with the following rules:

- If you elect coverage for your eligible Dependent spouse at the same time that you elect Retiree coverage for yourself in accordance with Section 1.06(e) (i.e., when you make a Retiree health coverage election for yourself, you also elect coverage for your spouse), your spouse will become covered by the Plan on the date that you become a Retiree in accordance with Section 1.22(a)(1);
- If you get married to an eligible Dependent spouse after the date that you became a Retiree (i.e., you get married to a spouse that meets the criteria of Section 1.20 after the date that you became a Retiree) and you elect coverage for your spouse within 30 days after the date of your marriage, your spouse will become covered by the Plan on the date of your marriage in accordance with Section 1.22(a)(2); or
- If you do not elect coverage for your eligible Dependent spouse at the same time that you elect Retiree coverage for yourself or within 30 days after the date of your marriage, as applicable, the reason that you do not elect coverage for your spouse is that she has coverage from another group health plan, and you elect coverage for your spouse within 30 days after the date that she is no longer covered by another group health plan, your spouse will become covered by the Plan on the date that your spouse no longer has coverage from another group health plan in accordance with Section 1.22(a)(3).

NOTE: If you do not elect coverage for your eligible Dependent spouse within the timeframes described above, your spouse will not be eligible for coverage from the Plan. Refer to Sections 1.22(a)(1)-(3) for the detailed rules regarding the manner in which you must elect coverage for your Dependent spouse.

(1) Coverage for an eligible Dependent spouse on the date that an Employee (or former Employee) becomes a Retiree

If you are married to a lawful spouse (i.e., a spouse that meets the criteria of Section 1.20) on the date that you become a Retiree and you elect coverage for your eligible Dependent spouse at the same time that you elect Retiree coverage for yourself in accordance with Section 1.06(e) (i.e., when you make a Retiree health coverage election for yourself, you also elect coverage for your spouse), your spouse will become covered by the Plan at the same time that you become a Retiree. **If you do not elect coverage for your spouse at the time that you elect Retiree coverage for yourself, your spouse may not subsequently obtain coverage from the Plan unless she has other group health coverage and becomes covered by the Plan in accordance with Section 1.22(a)(3).**

(2) Coverage for an eligible Dependent spouse on the date that the spouse gets married to a Retiree

If you get married to an eligible Dependent spouse (i.e., you get married and on the date of your marriage your spouse meets the criteria of Section 1.20) after the date that you became a Retiree and you elect coverage for your spouse within 30 days after the date of your marriage, your spouse will become covered by the Plan at 12:00 a.m. on the date of your marriage. To elect coverage for your spouse, you must submit a completed enrollment form for your spouse to the Fund Office within 30 days after the date of your marriage. **If a completed enrollment form for your**

spouse is not postmarked or otherwise positively received by the Fund Office within 30 days after the date of your marriage, your spouse may not subsequently obtain coverage from the Plan unless she has other group health coverage and becomes covered by the Plan in accordance with Section 1.22(a)(3).

(3) Coverage for an eligible Dependent spouse of a Retiree after the spouse loses other group health coverage

If you do not elect coverage for your eligible Dependent spouse in accordance with Section 1.22(a)(1) or Section 1.22(a)(2) (i.e., you do not elect coverage for your spouse at the time that you elect Retiree coverage for yourself or within 30 days after the date of your marriage, as applicable) and the reason that you do not elect coverage for your spouse is that your spouse has coverage from another group health plan, your spouse will become covered by the Plan at 12:00 a.m. on the date that your spouse no longer has coverage from another group health plan so long as the criteria of Section 1.22(a)(3)(i) and Section 1.22(a)(3)(ii) are met.

(i) **The Fund Office must receive a written notification which indicates that your spouse is not electing coverage from the Plan because she has other health coverage, and proof of your spouse's other health coverage, by the date that you would be required to elect coverage for your Dependent spouse in accordance with Section 1.22(a)(1) or Section 1.22(a)(2), as applicable.** This means that if you were required to elect coverage for your eligible Dependent spouse at the same time that you elected Retiree coverage for yourself in accordance with Section 1.22(a)(1), the written notification and proof of your spouse's other health coverage must be postmarked or otherwise positively received by the Fund Office at the same time that you elect Retiree coverage for yourself in accordance with Section 1.06(e). If you were required to elect coverage for your eligible Dependent spouse within 30 days after the date of your marriage in accordance with Section 1.22(a)(2), the written notification and proof of your spouse's other health coverage must be postmarked or otherwise positively received by the Fund Office within 30 days after the date of your marriage. If the written notification and/or proof of your spouse's other health coverage are not postmarked or otherwise positively received by the Fund Office by the date that you were required to elect coverage for your eligible Dependent spouse in accordance with Section 1.22(a)(1) or Section 1.22(a)(2), as applicable, your spouse may not subsequently obtain coverage from the Plan.

(ii) **The Fund Office must receive an enrollment form for your spouse within 30 days after the date that your spouse no longer has coverage from another health plan.** If your eligible Dependent spouse's completed enrollment form is not postmarked or otherwise positively received by the Fund Office within 30 days after the date that your spouse no longer has coverage from another group health plan, your spouse may not subsequently obtain coverage from the Plan.

(b) Coverage for an Eligible Dependent Child of a Retiree

As explained in Section 1.22(b)(1) and Section 1.22(b)(2), if you are a Retiree, your child will only become covered by the Plan if you elect coverage for your child in accordance with the following rules:

- If you elect coverage for your eligible Dependent child at the same time that you elect Retiree coverage for yourself in accordance with Section 1.06(e) (i.e., when you make a Retiree health coverage election for yourself, you also elect coverage for your child), your child will become covered by the Plan on the date that you become a Retiree in accordance with Section 1.22(b)(1); or

- If you acquire an eligible Dependent child after the date that you became a Retiree (i.e., you acquire a child that meets the criteria of Section 1.21 after the date you become a Retiree) and you elect coverage for your child within 30 days after the date that you acquire the child, your child will become covered by the Plan on the date that you acquire the child in accordance with Section 1.22(b)(2).

NOTE: If you do not elect coverage for your eligible Dependent child within the timeframes described above, your child will not be eligible for coverage from the Plan. Refer to Section 1.22(b)(1) and Section 1.22(b)(2) for the detailed rules regarding the manner in which you must elect coverage for your Dependent child.

(1) Coverage for an eligible Dependent child on the date that an Employee (or former Employee) becomes a Retiree

If you have an eligible Dependent child (i.e., a child that meets the criteria of Section 1.21) on the date that you become a Retiree and you elect coverage for your eligible Dependent child at the same time that you elect Retiree coverage for yourself in accordance with Section 1.06(e) (i.e., when you make a Retiree health coverage election for yourself, you also elect coverage for your child), your child will become covered by the Plan at the same time that you become a Retiree. **If you do not elect coverage for your child at the time that you elect Retiree coverage for yourself, your child may not subsequently obtain coverage from the Plan.**

(2) Coverage for an eligible Dependent child on the date that the child is acquired by a Retiree

If you acquire an eligible Dependent child (i.e., you have a new child as a result of marriage, birth, adoption, placement for adoption, or a court order and the child meets the criteria of Section 1.21) after the date that you became a Retiree and you elect coverage for your child within 30 days after the date that you acquire the child, your child will become covered by the Plan at 12:00 a.m. on the date that you acquired the child. To elect coverage for your child, you must submit a completed enrollment form for your child to the Fund Office within 30 days after the date you acquire the child. This means that if you acquire an eligible Dependent child after the date that you become a Retiree, your child will become covered by the Plan on the date that you acquired the child (i.e., the date of the marriage, birth, adoption, placement for adoption, or court order) so long as a completed enrollment form for your child is postmarked or otherwise positively received by the Fund Office within 30 days after the date that you acquired the child. **If a completed enrollment form for your child is not postmarked or otherwise positively received by the Fund Office within 30 days after the date that you acquired the child, your child may not subsequently obtain coverage from the Plan.**

Section 1.23 - Termination of Coverage for a Spouse and/or Child of a Retiree

If you are a Retiree and your spouse is covered by the Plan, your spouse's coverage from the Plan will terminate in accordance with Section 1.23(a). If you are a Retiree and your child is covered by the Plan, your child's coverage from the Plan will terminate in accordance with Section 1.23(b).

(a) Termination of Coverage for a Spouse of a Retiree

If you are a Retiree, your spouse's coverage from the Plan will terminate (i.e., your spouse will no longer be covered by the Plan) at 12:00 a.m. on the earliest of the following days:

(1) The date that your coverage from the Plan terminates for any reason, subject to your spouse's right to continue coverage from the Plan in accordance with Section 1.27;

(2) The first day of the calendar month for which you did not pay the appropriate Retiree premium in accordance with Section 1.07; or

(3) The first day of the calendar month following the date that a decree of divorce, dissolution of marriage, legal separation, or separate maintenance (regardless of the terms used to describe the divorce or legal separation) is entered.

Each Retiree and each former spouse of a Retiree is responsible for promptly notifying the Fund Office if (s)he has a change in marital status. This means a Retiree and a former spouse must notify the Fund Office immediately in the event of divorce, dissolution of marriage, legal separation, or separate maintenance. Failure to notify the Fund Office of divorce, dissolution of marriage, legal separation, or separate maintenance will be considered an omission that constitutes fraud and an intentional misrepresentation of a material fact that is prohibited by the terms of the Plan. If a Retiree or former spouse does not notify the Fund Office of the divorce, dissolution of marriage, legal separation, or separate maintenance, the Plan may recover any payments made for claims incurred by the former spouse after the divorce, dissolution of marriage, legal separation, or separate maintenance in accordance with Section 13.18.

NOTE: If a spouse's (or former spouse's) coverage is terminated in accordance with this Section 1.23(a), the spouse (or former spouse) may be eligible for COBRA continuation coverage. Refer to Section 1.30 for information about COBRA continuation coverage.

(b) Termination of Coverage for a Child of a Retiree

If you are a Retiree, your child's coverage from the Plan will terminate (i.e., your child will no longer be covered by the Plan) at 12:00 a.m. on the earliest of the following days:

(1) The date that your coverage from the Plan terminates for any reason, subject to your child's right to continue coverage from the Plan in accordance with Section 1.28;

(2) The first day of the calendar month for which you did not pay the appropriate Retiree premium in accordance with Section 1.07; or

(3) The first day of the calendar month following the date that your child no longer meets the criteria of Section 1.21(a) or Section 1.21(b).

Each Retiree is responsible for promptly notifying the Fund Office if a child no longer meets the criteria of Section 1.21(a) or Section 1.21(b)(2). This means that a Retiree must notify the Fund Office immediately if a child that is covered by the Plan as his/her Dependent is either no longer his/her relative (as that term is defined in Section 1.21(a)) or no longer permanently and totally disabled (as that term is defined in Section 1.21(b)(2)). Failure to

notify the Fund Office that a child is no longer a relative or no longer permanently and totally disabled will be considered an omission that constitutes fraud and an intentional misrepresentation of a material fact that is prohibited by the terms of the Plan. If a Retiree does not notify the Fund Office that a child is no longer his/her relative or no longer permanently and totally disabled, the Plan may recover any payments made for claims incurred by the child after the child is no longer the Retiree's relative or no longer permanently and totally disabled in accordance with Section 13.18.

NOTE: If a child's coverage is terminated in accordance with this Section 1.23(b), the child may be eligible for COBRA continuation coverage. Refer to Section 1.30 for information about COBRA continuation coverage.

Section 1.24 - Coverage for a Surviving Spouse of an Eligible Employee

If you died while you were an Eligible Employee, your lawful spouse may remain covered by the Plan as your surviving spouse in accordance with the following rules:

- If you were covered by the Plan as an Eligible Employee based on the hours that you worked in Covered Employment during the Qualifying Period(s) immediately prior to the date of your death (i.e., on the date of your death you were covered by the Plan because you worked sufficient hours in Covered Employment in accordance with Section 1.02 or Section 1.03(a)), your lawful spouse will remain covered by the Plan in accordance with Section 1.24(a)(1)(i) for as long as you would have remained covered by the Plan. When your lawful spouse is no longer eligible for coverage from the Plan based on the hours that you worked in Covered Employment prior to the date of your death, your spouse may remain covered by the Plan as your surviving spouse if she pays a surviving spouse premium in accordance with Section 1.24(a)(1)(ii).
- If you were covered by the Plan as an Eligible Employee based on a self-payment (i.e., on the date of your death you were are covered by the Plan because you paid the self-payment premium in accordance with Section 1.03(b)), your lawful spouse may remain covered by the Plan as your surviving spouse if she pays a surviving spouse premium in accordance with Section 1.24(a)(2).

Once your spouse becomes covered by the Plan as your surviving spouse in accordance with Section 1.24(a)(1) or Section 1.24(a)(2), your spouse's coverage from the Plan will continue for each calendar month that her coverage is not terminated in accordance with Section 1.24(b).

(a) Continuation of Coverage for a Surviving Spouse of an Eligible Employee

(1) Continuation of coverage for a surviving spouse of an Eligible Employee who was covered by the Plan in accordance with Section 1.02 or Section 1.03(a) on the date of his/her death (i.e., continuation of coverage for a surviving spouse of an Eligible Employee who was covered by the Plan based on the hours that (s)he worked in Covered Employment)

(i) Continuation of coverage for a surviving spouse of an Eligible Employee based on the hours that the Eligible Employee worked in Covered Employment prior to the date of his/her death

If you were covered by the Plan as an Eligible Employee based on the hours that you worked in Covered Employment during the Qualifying Period(s) immediately prior to the date of your death (i.e., on the date of your death you were covered by the Plan because you worked sufficient hours in Covered Employment in accordance with Section 1.02 or Section 1.03(a)) and you were married to a lawful spouse on the date of your death (i.e., on the date of your death, your spouse met the criteria of Section 1.11(a)), your spouse will automatically remain covered by the Plan as your

surviving spouse. Once your spouse becomes covered by the Plan as your surviving spouse in accordance with this Section 1.24(a)(1)(i), your spouse will remain covered by the Plan as your surviving spouse for as long as you would have remained covered by the Plan based on the hours that you worked in Covered Employment prior to the date of your death so long as your spouse's coverage is not terminated in accordance with Section 1.24(b).

When your lawful spouse is no longer eligible for coverage from the Plan based on the hours that you worked in Covered Employment prior to the date of your death, your spouse may remain covered by the Plan as your surviving spouse if she pays a surviving spouse premium in accordance with Section 1.24(a)(1)(ii).

(ii) Continuation of coverage for a surviving spouse of an Eligible Employee based on surviving spouse premium payments

If your lawful surviving spouse is no longer eligible for coverage from the Plan in accordance with Section 1.24(a)(1)(i) (i.e., your spouse is no longer eligible for coverage from the Plan based on the hours that you worked in Covered Employment prior to the date of your death), your spouse may pay a surviving spouse premium to remain covered by the Plan as your surviving spouse if all of the following criteria are met:

(A) You worked at least 1,500 hours in Covered Employment prior to the date of your death;

(B) Your spouse elects surviving spouse coverage within 90 days after the date of your death; and

(C) Your spouse pays the appropriate surviving spouse premium in accordance with Section 1.26.

Once your spouse becomes covered by the Plan as your surviving spouse in accordance with this Section 1.24(a)(1)(ii), your spouse's coverage from the Plan will continue for each calendar month that her coverage is not terminated in accordance with Section 1.24(b).

(2) Continuation of coverage for a surviving spouse of an Eligible Employee who was covered by the Plan in accordance with Section 1.03(b) on the date of his/her death (i.e., continuation of coverage for a surviving spouse of an Eligible Employee who was covered by the Plan based on a self-payment)

If you were covered by the Plan as an Eligible Employee based on a self-payment that you made during the month that contains the date of your death (i.e., on the date of your death you were covered by the Plan because you paid the self-payment premium in accordance with Section 1.03(b)) and you were married to a lawful spouse on the date of your death (i.e., on the date of your death, your spouse met the criteria of Section 1.11(a)), your spouse may pay a surviving spouse premium to remain covered by the Plan as your surviving spouse if all of the following criteria are met:

(i) You worked at least 1,500 hours in Covered Employment prior to the date of your death;

(ii) Your spouse elects surviving spouse coverage within 90 days after the date of your death; and

(iii) Your spouse pays the appropriate surviving spouse premium in accordance with Section 1.26.

Once your spouse becomes covered by the Plan as your surviving spouse in accordance with this Section 1.24(a)(2), your spouse's coverage from the Plan will continue for each calendar month that her coverage is not terminated in accordance with Section 1.24(b).

(b) Termination of Coverage for a Surviving Spouse of an Eligible Employee

If you died while you were an Eligible Employee and your spouse subsequently became covered by the Plan as your surviving spouse, your spouse's coverage from the Plan will terminate (i.e., your spouse will no longer be covered by the Plan) at 12:00 a.m. on the earliest of the following days:

(1) The first day of the calendar month for which your spouse is not eligible for coverage from the Plan in accordance with Section 1.24(a)(1)(i) (i.e., your spouse is not eligible for coverage from the Plan based on the hours that you worked in Covered Employment prior to the date of your death) and your spouse did not pay the surviving spouse premium in accordance with Section 1.24(a)(1)(ii) or Section 1.24(a)(2), as applicable;

(2) The first day of the calendar month following your spouse's death; or

(3) The first day of the calendar month following the date on which your spouse gets remarried.

Each surviving spouse is responsible for promptly notifying the Fund Office if she has a change in marital status. This means a surviving spouse must notify the Fund Office immediately in the event she remarries. Failure to notify the Fund Office of remarriage will be considered an omission that constitutes fraud and an intentional misrepresentation of a material fact that is prohibited by the terms of the Plan. If a surviving spouse does not notify the Fund Office of her remarriage, the Plan may recover any payments made for claims incurred by the surviving spouse after the date of her remarriage in accordance with Section 13.18.

NOTE: For purposes of COBRA continuation coverage, your surviving spouse's qualifying event (i.e., losing coverage due to your death) occurs when your surviving spouse's coverage from the Plan is terminated in accordance with this Section 1.24(b). This means that if your surviving spouse's coverage from the Plan is terminated in accordance with this Section 1.24(b), your surviving spouse may elect COBRA continuation coverage in accordance with Section 1.30.

Section 1.25 - Coverage for a Surviving Dependent Child of an Eligible Employee

If you died while you were an Eligible Employee, your eligible Dependent child may remain covered by the Plan as your surviving Dependent child in accordance with the following rules:

- If you were covered by the Plan as an Eligible Employee based on the hours that you worked in Covered Employment during the Qualifying Period(s) immediately prior to the date of your death (i.e., on the date of your death you were covered by the Plan because you worked sufficient hours in Covered Employment in accordance with Section 1.02 or Section 1.03(a)), your eligible Dependent child will remain covered by the Plan in accordance with Section 1.25(a)(1)(i) for as long as you would have remained covered by the Plan. When your eligible Dependent child is no longer eligible for coverage from the Plan based on the hours that you worked in Covered Employment prior to the date of your death, your child may remain covered by the Plan as your surviving Dependent child if your surviving spouse remains covered by the Plan in accordance with Section 1.24(a)(1)(ii) and your eligible Dependent child is your surviving spouse's Dependent child in accordance with Section 1.25(a)(1)(ii).

- If you were covered by the Plan as an Eligible Employee based on a self-payment (i.e., on the date of your death you were covered by the Plan because you paid the self-payment premium in accordance with Section 1.03(b)), your eligible Dependent child may remain covered by the Plan as your surviving Dependent child if your surviving spouse remains covered by the Plan in accordance with Section 1.24(a)(2) and your eligible Dependent child is your surviving spouse's Dependent child in accordance with Section 1.25(a)(2).

Once your child becomes covered by the Plan as your surviving Dependent child in accordance with Section 1.25(a)(1) or Section 1.25(a)(2), your child's coverage from the Plan will continue for each calendar month that his/her coverage is not terminated in accordance with Section 1.25(b).

(a) Continuation of Coverage for a Surviving Dependent Child of an Eligible Employee

(1) Continuation of coverage for a surviving Dependent child of an Eligible Employee who was covered by the Plan in accordance with Section 1.02 or Section 1.03(a) on the date of his/her death (i.e., continuation of coverage for a surviving Dependent child of an Eligible Employee who was covered by the Plan based on the hours that (s)he worked in Covered Employment)

(i) Continuation of coverage for a surviving Dependent child of an Eligible Employee based on the hours that the Eligible Employee worked in Covered Employment prior to the date of his/her death

If you were covered by the Plan as an Eligible Employee based on the hours that you worked in Covered Employment during the Qualifying Period(s) immediately prior to the date of your death (i.e., on the date of your death you were covered by the Plan because you worked sufficient hours in Covered Employment in accordance with Section 1.02 or Section 1.03(a)) and your child was an eligible Dependent child on the date of your death, your child will automatically remain covered by the Plan as your surviving Dependent child. Once your child becomes covered by the Plan as your surviving Dependent child in accordance with this Section 1.25(a)(1)(i), your child will remain covered by the Plan as your surviving Dependent child for as long as you would have remained covered by the Plan based on the hours that you worked in Covered Employment prior to the date of your death so long as your child's coverage is not terminated in accordance with Section 1.25(b).

When your eligible Dependent child is no longer eligible for coverage from the Plan based on the hours that you worked in Covered Employment prior to the date of your death, your child may remain covered by the Plan as your surviving Dependent child if your surviving spouse remains covered by the Plan in accordance with Section 1.24(a)(1)(ii) and your eligible Dependent child is your surviving spouse's Dependent child in accordance with Section 1.25(a)(1)(ii).

NOTE: For purposes of this Section 1.25(a)(1)(i), a child is considered your eligible Dependent child on the date of your death if the child meets the criteria of Section 1.12 on the date of your death. A child is also considered your eligible Dependent child on the date of your death if your lawful spouse was pregnant with the child on the date of your death.

(ii) Continuation of coverage for a surviving Dependent child of an Eligible Employee based on coverage of the Eligible Employee's surviving spouse

If your eligible Dependent child is no longer eligible for coverage from the Plan in accordance with Section 1.25(a)(1)(i) (i.e., your child is no longer eligible for coverage

from the Plan based on the hours that you worked in Covered Employment prior to the date of your death), your child may remain covered by the Plan as your surviving Dependent child if your surviving spouse remains covered by the Plan in accordance with Section 1.24(a)(1)(ii) and your eligible Dependent child is your surviving spouse's Dependent child. Your eligible Dependent child is considered your surviving spouse's Dependent child if all of the following criteria are met:

(A) Your surviving spouse elects coverage for your eligible Dependent child at the same time that she elects surviving spouse coverage for herself in accordance with Section 1.24(a)(1)(ii)(B) (i.e., when your spouse makes a surviving spouse coverage election for herself, she also elects coverage for your child); and

(B) Your child is related to your surviving spouse in at least one of the following ways:

- He is your surviving spouse's son, daughter, stepson, or stepdaughter;
- He is your surviving spouse's eligible foster child (i.e., (s)he was placed with your surviving spouse by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction);
- He is legally adopted or lawfully placed with your surviving spouse for adoption prior to his/her 18th birthday; or
- He is a child for whom your surviving spouse has a legal responsibility by virtue of a court order for custody and support or maintenance (including a legal guardianship), or who is the subject of a QMCSO.

NOTE: For purposes of this Section 1.25(a)(1)(ii), a child is considered your eligible Dependent child on the date of your death if the child meets the criteria of Section 1.12 on the date of your death. A child is also considered your eligible Dependent child on the date of your death if your lawful spouse was pregnant with the child on the date of your death.

Once your child becomes covered by the Plan as your surviving Dependent child in accordance with this Section 1.25(a)(1)(ii), your child's coverage from the Plan will continue for each calendar month that his/her coverage is not terminated in accordance with Section 1.25(b).

(2) Continuation of coverage for a surviving Dependent child of an Eligible Employee who was covered by the Plan in accordance with Section 1.03(b) on the date of his/her death (i.e., continuation of coverage for a surviving Dependent child of an Eligible Employee who was covered by the Plan based on a self-payment)

If you were covered by the Plan as an Eligible Employee based on a self-payment that you made during the month that contains the date of your death (i.e., on the date of your death you were covered by the Plan because you paid the self-payment premium in accordance with Section 1.03(b)) and your child was an eligible Dependent child on the date of your death, your child may remain covered by the Plan as your surviving Dependent child if your surviving spouse remains covered by the Plan in accordance with Section 1.24(a)(2) and your eligible Dependent child is your surviving spouse's Dependent child. Your eligible Dependent child is considered your surviving spouse's Dependent child if all of the following criteria are met:

(i) Your surviving spouse elects coverage for your eligible Dependent child at the same time that she elects surviving spouse coverage for herself in accordance with Section 1.24(a)(2)(ii)(B) (i.e., when your spouse makes a surviving spouse coverage election for herself, she also elects coverage for your child); and

(ii) Your child is related to your surviving spouse in at least one of the following ways:

- He is your surviving spouse's son, daughter, stepson, or stepdaughter;
- He is your surviving spouse's eligible foster child (i.e., (s)he was placed with your surviving spouse by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction);
- He is legally adopted or lawfully placed with your surviving spouse for adoption prior to his/her 18th birthday; or
- He is a child for whom your surviving spouse has a legal responsibility by virtue of a court order for custody and support or maintenance (including a legal guardianship), or who is the subject of a QMCSO.

NOTE: For purposes of this Section 1.25(a)(2), a child is considered your eligible Dependent child on the date of your death if the child meets the criteria of Section 1.12 on the date of your death. A child is also considered your eligible Dependent child on the date of your death if your lawful spouse was pregnant with the child on the date of your death.

Once your child becomes covered by the Plan as your surviving Dependent child in accordance with this Section 1.25(a)(2), your child's coverage from the Plan will continue for each calendar month that his/her coverage is not terminated in accordance with Section 1.25(b).

(b) Termination of Coverage for a Surviving Dependent Child of an Eligible Employee

If you died while you were an Eligible Employee and your child subsequently became covered by the Plan as your surviving Dependent child, your child's coverage from the Plan will terminate (i.e., your child will no longer be covered by the Plan) at 12:00 a.m. on the earliest of the following days:

(1) The first day of the calendar month in which your child is not eligible for coverage from the Plan in accordance with Section 1.25(a)(1)(i) (i.e., your child is not eligible for coverage from the Plan based on the hours that you worked in Covered Employment prior to the date of your death) and your surviving spouse is not covered by the Plan in accordance with Section 1.24(a)(1)(ii) or Section 1.24(a)(2), as applicable;

(2) The first day of the calendar month in which your child is not eligible for coverage from the Plan in accordance with Section 1.25(a)(1)(i) (i.e., your child is not eligible for coverage from the Plan based on the hours that you worked in Covered Employment prior to the date of your death) and your child is not considered your surviving spouse's Dependent child in accordance with Section 1.25(a)(1)(ii) or Section 1.25(a)(2), as applicable; or

(3) The first day of the calendar month following the date on which your child no longer meets the criteria of Section 1.12(b).

NOTE: For purposes of COBRA continuation coverage, your surviving Dependent child's qualifying event (i.e., losing coverage due to your death) occurs when your surviving Dependent child's coverage from the Plan is terminated in accordance with this Section 1.25(b). This means that if your surviving Dependent child's coverage from the Plan is terminated in accordance with

this Section 1.25(b), your surviving Dependent child may elect COBRA continuation coverage in accordance with Section 1.30.

Section 1.26 - Surviving Spouse Premium for the Surviving Spouse of an Eligible Employee

The surviving spouse premium amount is the dollar amount that your surviving spouse is required to pay to receive a month of coverage from the Plan as your surviving spouse. As explained in Section 1.26(a) and Section 1.26(b), the manner in which your surviving spouse's premium amount is calculated depends on whether you died prior to June 1, 2008 (see Section 1.26(a)) or on or after June 1, 2008 (see Section 1.26(b)). The Board of Trustees has the authority to establish and change the surviving spouse premium amount from time to time, as it may deem appropriate in its sole and exclusive discretion.

Your surviving spouse's first premium payment is due in full on the first day of the calendar month for which your surviving spouse intends to begin receiving coverage from the Plan by paying the surviving spouse premium (e.g., if your surviving spouse intends to begin receiving coverage by paying the surviving spouse premium on January 1, 2023, your surviving spouse's first surviving spouse premium payment is due on January 1, 2023). Your surviving spouse's first surviving spouse premium payment will satisfy the payment requirement for both your surviving spouse's first and third months of coverage (e.g., your surviving spouse's January 1, 2023 payment will satisfy the surviving spouse premium payment requirement for both January 2023 and March 2023).

Your surviving spouse's second premium payment is due in full on the first day of the second calendar month for which your surviving spouse intends to continue receiving coverage from the Plan by paying the surviving spouse premium (e.g., if your surviving spouse began receiving coverage by paying the surviving spouse premium on January 1, 2023 and your surviving spouse intends to continue receiving coverage on February 1, 2023, your surviving spouse's second surviving spouse premium payment is due on February 1, 2023). Your surviving spouse's second surviving spouse premium payment will satisfy the payment requirement for both your surviving spouse's second and fourth months of coverage (e.g., your surviving spouse's February 1, 2023, payment will satisfy the surviving spouse premium payment requirement for both February 2023 and April 2023).

Starting with your surviving spouse's fifth month of coverage, your surviving spouse's premium payment is due in full on the first day of the calendar month two months prior to the calendar month for which your surviving spouse intends to pay the surviving spouse premium to continue receiving coverage from the Plan (e.g., your surviving spouse's premium payment for the month of May 2023 is due on March 1, 2023).

Unless there are extenuating circumstances, as determined solely by the Plan Administrator, your surviving spouse's coverage from the Plan will terminate if the Fund Office does not receive your surviving spouse's premium in full by the 15th calendar day of the calendar month for which your surviving spouse is required to pay the surviving spouse premium to receive coverage from the Plan (e.g., if your surviving spouse's premium for the month of May 2023 is due on March 1, 2023 but not paid by March 15, 2023, your surviving spouse's coverage from the Plan will terminate on May 1, 2023 unless the Plan Administrator determines that the late payment occurred due to extenuating circumstances).

(a) Surviving Spouse Premium Amount for the Surviving Spouse of an Eligible Employee Who Died Prior to June 1, 2008

If you died prior to June 1, 2008, your surviving spouse's premium amount will be determined by a number of factors, including your age on the date of your death and the number of hours that you worked in Covered Employment prior to the date of your death. For more information about the surviving spouse premium amount for surviving spouses of Eligible Employees who died prior to June 1, 2008, contact the Fund Office.

(b) Surviving Spouse Premium Amount for the Surviving Spouse of an Eligible Employee Who Died On or After June 1, 2008

If you died on or after June 1, 2008, your surviving spouse's initial premium amount (i.e., the premium amount that she is required to pay on the date that she began paying a premium to remain covered by the Plan in accordance with Section 1.24(a)(1)(ii) or Section 1.24(a)(2)) will be calculated in accordance with Section 1.26(b)(1). After your surviving spouse's initial premium amount is calculated, her premium amount will subsequently be recalculated in accordance with the following rules:

- If your surviving spouse has family coverage (i.e., she has at least one Dependent child that is covered by the Plan) and subsequently her child's (or children's, if more than one child is covered by the Plan) coverage from the Plan is terminated in accordance with Section 1.25(b) (i.e., subsequently she no longer has any Dependent children that are covered by the Plan), your surviving spouse's premium amount will be recalculated in accordance with Section 1.26(b)(2)(i) on the date that her child's (or children's, as applicable) coverage from the Plan is terminated;
- If your surviving spouse becomes eligible for Medicare, her premium amount will be recalculated in accordance with Section 1.26(b)(2)(ii) on the date that she becomes eligible for Medicare; and
- If your spouse is covered by the Plan as your surviving spouse on May 31 of the calendar year and on June 1 of that calendar year your surviving spouse's premium amount is not recalculated in accordance with either of the bullet points above (i.e., on June 1 of that calendar year she does not change from family coverage to single coverage and she does not become eligible for Medicare), her premium amount will be recalculated in accordance with Section 1.26(b)(2)(iii) on June 1 of that calendar year (i.e., on June 1 of each calendar year, your surviving spouse's premium amount is recalculated. The manner in which your surviving spouse's premium amount is recalculated depends on whether or not either of the events described in the bullet points above occurred on June 1 of that calendar year. If neither of the events described in the bullet points above occurred on June 1 of that calendar year, then your surviving spouse's premium amount is recalculated in accordance with Section 1.26(b)(2)(iii)).

NOTE: Throughout this Section 1.26(b), examples are used to illustrate how your surviving spouse's premium amount is calculated. These examples are rounded to the nearest cent ($0.01). Additionally, the Contribution Rate used in these examples is a hypothetical number used solely for the purpose of illustrating how your surviving spouse's premium amount is calculated. The Contribution Rate used in these examples does not reflect the actual Contribution Rate. For information about the actual Contribution Rate, contact the Fund Office.

(1) Calculation of initial surviving spouse premium amount

If you died on or after June 1, 2008, your surviving spouse's initial premium amount (i.e., the premium amount that she is required to pay on the date that she began paying a premium to remain covered by the Plan in accordance with Section 1.24(a)(1)(ii) or Section 1.24(a)(2)) will be calculated in accordance with the following rules:

(i) **Step 1**: Your surviving spouse's base rate is calculated by multiplying the Contribution Rate in effect on the date that she began making payments to remain covered by the Plan by 140 (i.e., the Contribution Rate in effect on the date that she began paying a premium in accordance with Section 1.24(a)(1)(ii) or Section 1.24(a)(2) is multiplied by 140). For example, if the Contribution Rate is $10.00 on the date that your surviving spouse began making payments to remain covered by the Plan, her base rate would equal $1,400.00 ($10.00 x 140 = $1,400.00).

(ii) **Step 2**: Your surviving spouse's adjusted base rate is calculated by either increasing or decreasing her base rate based on whether she has single coverage (i.e., she does not have any Dependent children that are covered by the Plan) or family coverage (i.e., she has at least one Dependent child that is covered by the Plan). If your surviving spouse has single coverage, her adjusted base rate is calculated by reducing her base rate by 33% (i.e., the amount that was calculated in accordance with Section 1.26(b)(1)(i) is reduced by 33%). If your surviving spouse has family coverage, her adjusted base rate is calculated by increasing her base rate by 33% (i.e., the amount that was calculated in accordance with Section 1.26(b)(1)(i) is increased by 33%). For example, if your surviving spouse's base rate is $1,400.00 and she has single coverage, her adjusted base rate would equal $938.00 ($1,400.00 - 33% of $1,400.00 = $938.00). If your surviving spouse's base rate is $1,400.00 and she has family coverage, her adjusted base rate would equal $1,862.00 ($1,400.00 + 33% of $1,400.00 = $1,862.00).

(iii) **Step 3**: Your surviving spouse's Plan subsidy is determined based on the Years of Service that you earned as of the date of your death. For purposes of this Section 1.26(b)(1)(iii), your Years of Service are calculated in accordance with the following rules:

- If you worked at least one hour in Covered Employment during a Plan Year that began prior to June 1, 1981, you are credited with one Year of Service for that Plan Year; and
- If you worked at least 800 hours in Covered Employment during a Plan Year that began on or after June 1, 1981, you are credited with one Year of Service for that Plan Year.

The following chart illustrates how your surviving spouse's Plan subsidy is calculated:

If on the date of your death you had . . .	Your surviving spouse's Plan subsidy is . . .
at least 10 Years of Service	2.00% per Year of Service, up to 30 years, plus 0.25% for each Year of Service over 30, up to 35 years.
less than 10 Years of Service	zero.

For example, if you had 15 Years of Service, your surviving spouse's Plan subsidy would be 30.0% (2.00% x 15 = 30.0%).

(iv) **Step 4**: Your surviving spouse's subsidized base rate is calculated by reducing her adjusted base rate by her Plan subsidy (i.e., the amount that was calculated in accordance with Section 1.26(b)(1)(ii) is reduced by the percentage that was calculated in accordance with Section 1.26(b)(1)(iii)). For example, if your surviving spouse's adjusted base rate is $938.00 and her Plan subsidy is 30%, her subsidized base rate would equal $656.60 ($938.00 - 30% of $938.00 = $656.60).

(v) **Step 5**: Your surviving spouse's initial premium amount is determined based on whether or not she is eligible for Medicare in accordance with the following rules:

- If your surviving spouse is not eligible for Medicare, her initial premium amount equals her subsidized base rate (i.e., her initial premium amount equals the

amount that was calculated in accordance with Section 1.26(b)(1)(iv)). For example, if your surviving spouse's subsidized base rate is $656.60 and she is not eligible for Medicare, her initial premium amount would equal $656.60.

- If your surviving spouse is eligible for Medicare, her initial premium amount equals 76% of her subsidized base rate (i.e., her initial premium amount equals 76% of the amount that was calculated in accordance with Section 1.26(b)(1)(iv)). For example, if your surviving spouse's subsidized base rate is $656.60 and she is eligible for Medicare, her initial premium amount would equal $499.02 (76% of $656.60 = $499.02).

(2) Recalculation of surviving spouse premium amount

After your surviving spouse's initial premium amount is calculated in accordance with Section 1.26(b)(1), her premium amount will subsequently be recalculated in accordance with the rules described in this Section 1.26(b)(2).

(i) Recalculation of your surviving spouse's premium amount when your surviving spouse changes from family coverage to single coverage

If you died on or after June 1, 2008, your surviving spouse has family coverage (i.e., she has at least one Dependent child that is covered by the Plan), and subsequently her child's (or children's, if more than one child is covered by the Plan) coverage from the Plan is terminated in accordance with Section 1.25(b) (i.e., subsequently she no longer has any Dependent children that are covered by the Plan), your surviving spouse's premium amount will be recalculated on the date that her child's (or children's, as applicable) coverage from the Plan is terminated in accordance with the following rules:

(A) **Step 1**: Your surviving spouse's base rate is calculated by multiplying the Contribution Rate in effect on the date that her child's (or children's, as applicable) coverage from the Plan was terminated by 140 (i.e., the Contribution Rate in effect on the date that your surviving spouse changed from family coverage to single coverage is multiplied by 140). For example, if the Contribution Rate is $10.00 on the date that your surviving spouse's child's (or children's, as applicable) coverage from the Plan was terminated, her base rate would equal $1,400.00 ($10.00 x 140 = $1,400.00).

(B) **Step 2**: Your surviving spouse's adjusted base rate is calculated by reducing her base rate by 33% (i.e., the amount that was calculated in accordance with Section 1.26(b)(2)(i)(A) is reduced by 33%). For example, if your surviving spouse's base rate is $1,400.00, her adjusted base rate would equal $938.00 ($1,400.00 - 33% of $1,400.00 = $938.00).

(C) **Step 3**: Your surviving spouse's subsidized base rate is calculated by reducing her adjusted base rate by her Plan subsidy (i.e., the amount that was calculated in accordance with Section 1.26(b)(2)(i)(B) is reduced by the percentage that was calculated in accordance with Section 1.26(b)(1)(iii)). For example, if your surviving spouse's adjusted base rate is $938.00 and her Plan subsidy is 30%, her subsidized base rate would equal $656.60 ($938.00 - 30% of $938.00 = $656.60).

(D) **Step 4**: Your surviving spouse's new premium amount is determined based on whether or not she is eligible for Medicare in accordance with the following rules:

- If your surviving spouse is not eligible for Medicare, her new premium amount equals her subsidized base rate (i.e., her new premium amount equals the amount that was calculated in accordance with Section 1.26(b)(2)(i)(C)). For example, if your surviving spouse's subsidized base rate is $656.60 and she is not eligible for Medicare, her new premium amount would equal $656.60.
- If your surviving spouse is eligible for Medicare, her new premium amount equals 76% of her subsidized base rate (i.e., her new premium amount equals 76% of the amount that was calculated in accordance with Section 1.26(b)(2)(i)(C)). For example, if your surviving spouse's subsidized base rate is $656.60 and she is eligible for Medicare, her new premium amount would equal $499.02 (76% of $656.60 = $499.02).

(ii) **Recalculation of your surviving spouse's premium amount when your surviving spouse becomes eligible for Medicare**

If you died on or after June 1, 2008, and your surviving spouse becomes eligible for Medicare, her premium amount will be recalculated on the date that she becomes eligible for Medicare in accordance with the following rules:

(A) **Step 1**: Your surviving spouse's base rate is calculated by multiplying the Contribution Rate in effect on the date that she became eligible for Medicare by 140. For example, if the Contribution Rate is $10.00 on the date that your surviving spouse became eligible for Medicare, her base rate would equal $1,400.00 ($10.00 x 140 = $1,400.00).

(B) **Step 2**: Your surviving spouse's adjusted base rate is calculated by either increasing or decreasing her base rate based on whether she has single coverage (i.e., she does not have any Dependent children that are covered by the Plan) or family coverage (i.e., she has at least one Dependent child that is covered by the Plan). If your surviving spouse has single coverage, her adjusted base rate is calculated by reducing her base rate by 33% (i.e., the amount that was calculated in accordance with Section 1.26(b)(2)(ii)(A) is reduced by 33%). If your surviving spouse has family coverage, her adjusted base rate is calculated by increasing her base rate by 33% (i.e., the amount that was calculated in accordance with Section 1.26(b)(2)(ii)(A) is increased by 33%). For example, if your surviving spouse's base rate is $1,400.00 and she has single coverage, her adjusted base rate would equal $938.00 ($1,400.00 - 33% of $1,400.00 = $938.00). If your surviving spouse's base rate is $1,400.00 and she has family coverage, her adjusted base rate would equal $1,862.00 ($1,400.00 + 33% of $1,400.00 = $1,862.00).

(C) **Step 3**: Your surviving spouse's subsidized base rate is calculated by reducing her adjusted base rate by her Plan subsidy (i.e., the amount that was calculated in accordance with Section 1.26(b)(2)(ii)(B) is reduced by the percentage that was calculated in accordance with Section 1.26(b)(1)(iii)). For example, if your surviving spouse's adjusted base rate is $938.00 and her Plan subsidy is 30%, her subsidized base rate would equal $656.60 ($938.00 - 30% of $938.00 = $656.60).

(D) **Step 4**: Your surviving spouse's new premium amount equals 76% of her subsidized base rate (i.e., her new premium amount equals 76% of the amount that was calculated in accordance with Section 1.26(b)(2)(ii)(C)). For example, if your surviving spouse's subsidized base rate is $656.60, her new premium amount would equal $499.02 (76% of $656.60 = $499.02).

(iii) Recalculation of your surviving spouse's premium amount on June 1

If you died on or after June 1, 2008, your spouse is covered by the Plan as your surviving spouse on May 31 of the calendar year, and on June 1 of that calendar year your surviving spouse's premium amount is not recalculated in accordance with either Section 1.26(b)(2)(i) or Section 1.26(b)(2)(ii) (i.e., on June 1 of that calendar year your surviving spouse does not change from family coverage to single coverage and she does not become eligible for Medicare), her premium amount will be recalculated on June 1 of that calendar year in accordance with the following rules:

(A) **Step 1**: Your surviving spouse's base rate is calculated by multiplying the Contribution Rate in effect on June 1 of the calendar year by 140. For example, if the Contribution Rate is $10.00 on June 1 of the calendar year, your surviving spouse's base rate would equal $1,400.00 ($10.00 x 140 = $1,400.00).

(B) **Step 2**: Your surviving spouse's adjusted base rate is calculated by either increasing or decreasing her base rate based on whether she has single coverage (i.e., she does not have any Dependent children that are covered by the Plan) or family coverage (i.e., she has at least one Dependent child that is covered by the Plan). If your surviving spouse has single coverage, her adjusted base rate is calculated by reducing her base rate by 33% (i.e., the amount that was calculated in accordance with Section 1.26(b)(2)(iii)(A) is reduced by 33%). If your surviving spouse has family coverage, her adjusted base rate is calculated by increasing her base rate by 33% (i.e., the amount that was calculated in accordance with Section 1.26(b)(2)(iii)(A) is increased by 33%). For example, if your surviving spouse's base rate is $1,400.00 and she has single coverage, her adjusted base rate would equal $938.00 ($1,400.00 - 33% of $1,400.00 = $938.00). If your surviving spouse's base rate is $1,400.00 and she has family coverage, her adjusted base rate would equal $1,862.00 ($1,400.00 + 33% of $1,400.00 = $1,862.00).

(C) **Step 3**: Your surviving spouse's subsidized base rate is calculated by reducing her adjusted base rate by her Plan subsidy (i.e., the amount that was calculated in accordance with Section 1.26(b)(2)(iii)(B) is reduced by the percentage that was calculated in accordance with Section 1.26(b)(1)(iii)). For example, if your surviving spouse's adjusted base rate is $938.00 and her Plan subsidy is 30%, her subsidized base rate would equal $656.60 ($938.00 - 30% of $938.00 = $656.60).

(D) **Step 4**: Your surviving spouse's preliminary premium amount is determined based on whether or not she is eligible for Medicare in accordance with the following rules:

- If your surviving spouse is not eligible for Medicare, her preliminary premium amount equals her subsidized base rate (i.e., her preliminary premium amount equals the amount that was calculated in accordance

with Section 1.26(b)(2)(iii)(C)). For example, if your surviving spouse's subsidized base rate is $656.60 and she is not eligible for Medicare, her preliminary premium amount would equal $656.60.

- If your surviving spouse is eligible for Medicare, her preliminary premium amount equals 76% of her subsidized base rate (i.e., her preliminary premium amount equals 76% of the amount that was calculated in accordance with Section 1.26(b)(2)(iii)(C)). For example, if your surviving spouse's subsidized base rate is $656.60 and she is eligible for Medicare, her preliminary premium amount would equal $499.02 (76% of $656.60 = $499.02).

(E) **Step 5**: Your surviving spouse's new premium amount is determined by comparing her preliminary premium amount (i.e., the premium amount calculated in accordance with Section 1.26(b)(2)(iii)(D)) to the premium amount that she paid in May of the same calendar year (i.e., the premium amount that she paid the prior calendar month) in accordance with the following rules:

- If your surviving spouse's preliminary premium amount is not more than 5% greater than the premium amount that she paid in May of the same calendar year (i.e., if the amount calculated in accordance with Section 1.26(b)(2)(iii)(D) is not more than 5% higher than the premium amount that she paid the prior calendar month), then her new premium amount equals her preliminary premium amount (i.e., her new premium amount equals the amount that was calculated in accordance with Section 1.26(b)(2)(iii)(D)). For example, if your surviving spouse's premium amount in May 2023 was $1,000.00 and her preliminary premium amount is $1,045.00, then her new premium amount on June 1, 2023 would equal $1,045.00 ($1,045.00 is only 4.5% greater than $1,000.00).

- If your surviving spouse's preliminary premium amount is more than 5% greater than the premium amount that she paid in May of the same calendar year (i.e., if the amount calculated in accordance with Section 1.26(b)(2)(iii)(D) is more than 5% higher than the premium amount that she paid the prior calendar month), then her new premium amount equals 5% more than the premium amount that she paid in May of that calendar year (i.e., her new premium amount equals 5% more than the premium amount that she paid the prior calendar month). For example, if your surviving spouse's premium amount in May 2023 was $1,000.00 and her preliminary premium amount is $1,100.00, then her new premium amount on June 1, 2023 would equal $1,050.00 ($1,050.00 is 5% greater than $1,000.00).

Section 1.27 - Coverage for a Surviving Spouse of a Retiree

If you died while you were covered by the Plan as a Retiree, your lawful spouse may remain covered by the Plan as your surviving spouse if she pays a surviving spouse premium in accordance with Section 1.27(a). Once your spouse becomes covered by the Plan as your surviving spouse in accordance with Section 1.27(a), your spouse's coverage from the Plan will continue for each calendar month that her coverage is not terminated in accordance with Section 1.27(b).

(a) Continuation of Coverage for a Surviving Spouse of a Retiree

If you were covered by the Plan as a Retiree and you were married to a lawful spouse on the date of your death (i.e., on the date of your death, your spouse met the criteria of Section 1.20), your spouse may pay a surviving spouse premium to remain covered by the Plan as your surviving spouse if all of the following criteria are met:

(1) Your spouse elects surviving spouse coverage within 90 days after the date of your death;

(2) Your spouse pays the appropriate surviving spouse premium in accordance with Section 1.29; and

(3) Your spouse was either:

(A) Covered by the Plan as your eligible Dependent spouse on the date of your death; or

(B) Covered by another group health plan on the date of your death in accordance with Section 1.22(a)(3) (i.e., you did not elect coverage for your spouse because she had coverage from another group health plan and the Fund Office received the documentation described in Section 1.22(a)(3)(i)).

Once your spouse becomes covered by the Plan as your surviving spouse in accordance with this Section 1.27(a), your spouse's coverage from the Plan will continue for each calendar month that her coverage is not terminated in accordance with Section 1.27(b).

(b) Termination of Coverage for a Surviving Spouse of a Retiree

If you died while you were a Retiree and your spouse subsequently became covered by the Plan as your surviving spouse, your spouse's coverage from the Plan will terminate (i.e., your spouse will no longer be covered by the Plan) at 12:00 a.m. on the earliest of the following days:

(1) The first day of the calendar month for which your spouse did not pay a surviving spouse premium in accordance with Section 1.29;

(2) The first day of the calendar month following your spouse's death; or

(3) The first day of the calendar month following the date on which your spouse gets remarried.

Each surviving spouse is responsible for promptly notifying the Fund Office if she has a change in marital status. This means a surviving spouse must notify the Fund Office immediately in the event she remarries. Failure to notify the Fund Office of remarriage will be considered an omission that constitutes fraud and an intentional misrepresentation of a material fact that is prohibited by the terms of the Plan. If a surviving spouse does not notify the Fund Office of her remarriage, the Plan may recover any payments made for claims incurred by the surviving spouse after the date of her remarriage in accordance with Section 13.18.

NOTE: For purposes of COBRA continuation coverage, your surviving spouse's qualifying event (i.e., losing coverage due to your death) occurs when your surviving spouse's coverage from the Plan is terminated in accordance with this Section 1.27(b). This means that if your surviving spouse's coverage from the Plan is terminated in accordance with this Section 1.27(b), your surviving spouse may elect COBRA continuation coverage in accordance with Section 1.30.

Section 1.28 - Coverage for a Surviving Dependent Child of a Retiree

If you died while you were covered by the Plan as a Retiree, your eligible Dependent child may remain covered by the Plan as your surviving Dependent child if your surviving spouse remains covered by the Plan in accordance with Section 1.27(a) and your eligible Dependent child is your surviving spouse's Dependent child in accordance with Section 1.28(a). Once your child becomes covered by the Plan as your surviving Dependent child in accordance with Section 1.28(a), your child's coverage from the Plan will continue for each calendar month that his/her coverage is not terminated in accordance with Section 1.28(b).

(a) Continuation of Coverage for a Surviving Dependent Child of a Retiree

If you were covered by the Plan as a Retiree and your child was an eligible Dependent child on the date of your death, your child may remain covered by the Plan as your surviving Dependent child if your surviving spouse remains covered by the Plan in accordance with Section 1.27(a) and your eligible Dependent child is your surviving spouse's Dependent child. Your eligible Dependent child is considered your surviving spouse's Dependent child if all of the following criteria are met:

(1) Your surviving spouse elects coverage for your eligible Dependent child at the same time that she elects surviving spouse coverage for herself in accordance with Section 1.27(a)(1) (i.e., when your spouse makes a surviving spouse coverage election for herself, she also elects coverage for your child); and

(2) Your child is related to your surviving spouse in at least one of the following ways:

- He is your surviving spouse's son, daughter, stepson, or stepdaughter;
- He is your surviving spouse's eligible foster child (i.e., (s)he was placed with your surviving spouse by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction);
- He is legally adopted or lawfully placed with your surviving spouse for adoption prior to his/her 18th birthday; or
- He is a child for whom your surviving spouse has a legal responsibility by virtue of a court order for custody and support or maintenance (including a legal guardianship), or who is the subject of a QMCSO.

NOTE: For purposes of this Section 1.28(a), a child is considered your eligible Dependent child on the date of your death if the child meets the criteria of Section 1.21 on the date of your death. A child is also considered your eligible Dependent child on the date of your death if your lawful spouse was pregnant with the child on the date of your death.

Once your child becomes covered by the Plan as your surviving Dependent child in accordance with this Section 1.28(a), your child's coverage from the Plan will continue for each calendar month that his/her coverage is not terminated in accordance with Section 1.28(b).

(b) Termination of Coverage for a Surviving Dependent Child of a Retiree

If you died while you were a Retiree and your child subsequently became covered by the Plan as your surviving Dependent child, your child's coverage from the Plan will terminate (i.e., your child will no longer be covered by the Plan) at 12:00 a.m. on the earliest of the following days:

(1) The first day of the calendar month in which your surviving spouse is not covered by the Plan in accordance with Section 1.27(a);

(2) The first day of the calendar month in which your child is not considered your surviving spouse's Dependent child in accordance with Section 1.28(a); or

(3) The first day of the calendar month following the date on which your child no longer meets the criteria of Section 1.21(b).

NOTE: For purposes of COBRA continuation coverage, your surviving Dependent child's qualifying event (i.e., losing coverage due to your death) occurs when your surviving Dependent child's coverage from the Plan is terminated in accordance with this Section 1.28(b). This means that if your surviving Dependent child's coverage from the Plan is terminated in accordance with this Section 1.28(b), your surviving Dependent child may elect COBRA continuation coverage in accordance with Section 1.30.

Section 1.29 - Surviving Spouse Premium for the Surviving Spouse of a Retiree

The surviving spouse premium amount is the dollar amount that your surviving spouse is required to pay to receive a month of coverage from the Plan as your surviving spouse. As explained in Section 1.29(a) and Section 1.29(b), the manner in which your surviving spouse's premium amount is calculated depends on whether you died prior to June 1, 2008 (see Section 1.29(a)) or on or after June 1, 2008 (see Section 1.29(b)). The Board of Trustees has the authority to establish and change the surviving spouse premium amount from time to time, as it may deem appropriate in its sole and exclusive discretion.

Your surviving spouse's first premium payment is due in full on the first day of the calendar month for which your surviving spouse intends to begin receiving coverage from the Plan by paying the surviving spouse premium (e.g., if your surviving spouse intends to begin receiving coverage by paying the surviving spouse premium on January 1, 2023, your surviving spouse's first surviving spouse premium payment is due on January 1, 2023). Your surviving spouse's first surviving spouse premium payment will satisfy the payment requirement for both your surviving spouse's first and third months of coverage (e.g., your surviving spouse's January 1, 2023, payment will satisfy the surviving spouse premium payment requirement for both January 2023 and March 2023).

Your surviving spouse's second premium payment is due in full on the first day of the second calendar month for which your surviving spouse intends to continue receiving coverage from the Plan by paying the surviving spouse premium (e.g., if your surviving spouse began receiving coverage by paying the surviving spouse premium on January 1, 2023, and your surviving spouse intends to continue receiving coverage on February 1, 2023, by paying the surviving spouse premium, your surviving spouse's second surviving spouse premium payment is due on February 1, 2023). Your surviving spouse's second surviving spouse premium payment will satisfy the payment requirement for both your surviving spouse's second and fourth months of coverage (e.g., your surviving spouse's February 1, 2023, payment will satisfy the surviving spouse premium payment requirement for both February 2023 and April 2023).

Starting with your surviving spouse's fifth month of coverage, your surviving spouse's premium payment is due in full on the first day of the calendar month two months prior to the calendar month for which your surviving spouse intends to pay the surviving spouse premium to continue receiving coverage from the Plan (e.g., your surviving spouse's premium payment for the month of May 2023 is due on March 1, 2023).

Unless there are extenuating circumstances as determined solely by the Plan Administrator, your surviving spouse's coverage from the Plan will terminate if the Fund Office does not receive your surviving spouse's premium payment in full by the 15th calendar day of the calendar month for which your surviving spouse is required to pay the surviving spouse premium to receive coverage from the Plan (e.g., if your surviving spouse must pay the surviving spouse premium to continue coverage and your surviving spouse's premium for the month of May 2023 is not paid by March 15, 2023, your surviving spouse's coverage from the Plan will terminate on May 1, 2023, unless the Plan Administrator determines that the late payment occurred due to extenuating circumstances).

(a) Surviving Spouse Premium Amount for the Surviving Spouse of a Retiree Who Began Receiving Benefits from the Pension Plan Prior to June 1, 2008

If you began receiving benefits from the Pension Plan prior to June 1, 2008, your surviving spouse's premium amount will be determined by a number of factors, including the age you attained and the number of hours that you worked in Covered Employment on the date that you started receiving coverage from the Plan as a Retiree. For more information about the surviving spouse premium amount for surviving spouses of Retirees who began receiving benefits from the Pension Plan prior to June 1, 2008, contact the Fund Office.

(b) Surviving Spouse Premium Amount for the Surviving Spouse of a Retiree Who Began Receiving Benefits from the Pension Plan on or After June 1, 2008

If you began receiving benefits from the Pension Plan on or after June 1, 2008, your surviving spouse's initial premium amount (i.e., the premium amount that she is required to pay on the date that she became covered by the Plan as your surviving spouse in accordance with Section 1.27(a)) will be calculated in accordance with Section 1.29(b)(1). After your surviving spouse's initial premium amount is calculated, her premium amount will subsequently be recalculated in accordance with the following rules:

- If your surviving spouse has family coverage (i.e., she has at least one Dependent child that is covered by the Plan) and subsequently her child's (or children's, if more than one child is covered by the Plan) coverage from the Plan is terminated in accordance with Section 1.28(b) (i.e., subsequently she no longer has any Dependent children that are covered by the Plan), your surviving spouse's premium amount will be recalculated in accordance with Section 1.29(b)(2)(i) on the date that her child's (or children's, as applicable) coverage from the Plan is terminated;
- If your surviving spouse becomes eligible for Medicare, her premium amount will be recalculated in accordance with Section 1.29(b)(2)(ii) on the date that she becomes eligible for Medicare; and
- If your spouse is covered by the Plan as your surviving spouse on May 31 of the calendar year and on June 1 of that calendar year your surviving spouse's premium amount is not recalculated in accordance with either of the bullet points above (i.e., on June 1 of that calendar year she does not change from family coverage to single coverage and she does not become eligible for Medicare), her premium amount will be recalculated in accordance with Section 1.29(b)(2)(iii) on June 1 of that calendar year (i.e., on June 1 of each calendar year, your surviving spouse's premium amount is recalculated. The manner in which your surviving spouse's premium amount is recalculated depends on whether or not either of the events described in the bullet points above occurred on June 1 of that calendar year. If neither of the events described in the bullet points above occurred on June 1 of that calendar year, then your surviving spouse's premium amount is recalculated in accordance with Section 1.29(b)(2)(iii)).

NOTE: Throughout this Section 1.29(b), examples are used to illustrate how your surviving spouse's premium amount is calculated. These examples are rounded to the nearest cent ($0.01). Additionally, the Contribution Rate used in these examples is a hypothetical number used solely for the purpose of illustrating how your surviving spouse's premium amount is calculated. The Contribution Rate used in these examples does not reflect the actual Contribution Rate. For information about the actual Contribution Rate, contact the Fund Office.

(1) Calculation of initial surviving spouse premium amount

If you began receiving benefits from the Pension Plan on or after June 1, 2008, your surviving spouse's initial premium amount (i.e., the premium amount that she is required to pay on the

date that she became covered by the Plan as your surviving spouse in accordance with Section 1.27(a)) will be calculated in accordance with the following rules:

(i) **Step 1**: Your surviving spouse's base rate is calculated by multiplying the Contribution Rate in effect on the date that she became covered by the Plan as your surviving spouse by 140 (i.e., the Contribution Rate in effect on the first day of the month following the date of your death is multiplied by 140). For example, if you died on August 15, 2023, and the Contribution Rate is $10.00 on September 1, 2023, your surviving spouse's base rate would equal $1,400.00 ($10.00 x 140 = $1,400.00).

(ii) **Step 2**: Your surviving spouse's adjusted base rate is calculated by either increasing or decreasing her base rate based on whether she has single coverage (i.e., she does not have any Dependent children that are covered by the Plan) or family coverage (i.e., she has at least one Dependent child that is covered by the Plan). If your surviving spouse has single coverage, her adjusted base rate is calculated by reducing her base rate by 33% (i.e., the amount that was calculated in accordance with Section 1.29(b)(1)(i) is reduced by 33%). If your surviving spouse has family coverage, her adjusted base rate is calculated by increasing her base rate by 33% (i.e., the amount that was calculated in accordance with Section 1.29(b)(1)(i) is increased by 33%). For example, if your surviving spouse's base rate is $1,400.00 and she has single coverage, her adjusted base rate would equal $938.00 ($1,400.00 - 33% of $1,400.00 = $938.00). If your surviving spouse's base rate is $1,400.00 and she has family coverage, her adjusted base rate would equal $1,862.00 ($1,400.00 + 33% of $1,400.00 = $1,862.00).

(iii) **Step 3**: Your surviving spouse's Plan subsidy is determined based on the age that you attained and the Years of Service that you earned on the date that you began receiving benefits from the Pension Plan. For purposes of this Section 1.29(b)(1)(iii), your Years of Service are calculated in accordance with the following rules:

- If you worked at least one hour in Covered Employment during a Plan Year that began prior to June 1, 1981, you are credited with one Year of Service for that Plan Year; and
- If you worked at least 800 hours in Covered Employment during a Plan Year that began on or after June 1, 1981, you are credited with one Year of Service for that Plan Year.

The following chart illustrates how your surviving spouse's Plan subsidy is determined:

If you began receiving coverage from the Plan as a Retiree when you were . . .	And on the date that you began receiving coverage from the Plan as a Retiree you had . . .	Your surviving spouse's Plan subsidy is . . .
55 or 56 years old	at least 15 Years of Service	1.33% per Year of Service, up to 30 years, plus 0.25% for each Year of Service over 30, up to 35 years.
	less than 15 Years of Service	zero.
57, 58, or 59 years old	at least 15 Years of Service	1.66% per Year of Service, up to 30 years, plus 0.25%

		for each Year of Service over 30, up to 35 years.
	less than 15 Years of Service	zero.
at least 60 years old or a Disabled Participant	at least 10 Years of Service	2.00% per Year of Service, up to 30 years, plus 0.25% for each Year of Service over 30, up to 35 years.
	less than 10 Years of Service	zero.

For example, if you began receiving coverage from the Plan as a Retiree when you were 56 years old and had 20 Years of Service, your surviving spouse's Plan subsidy would be 26.6% (1.33% x 20 = 26.6%).

(iv) **Step 4**: Your surviving spouse's subsidized base rate is calculated by reducing her adjusted base rate by her Plan subsidy (i.e., the amount that was calculated in accordance with Section 1.29(b)(1)(ii) is reduced by the percentage that was calculated in accordance with Section 1.29(b)(1)(iii)). For example, if your surviving spouse's adjusted base rate is $938.00 and her Plan subsidy is 26.6%, her subsidized base rate would equal $688.49 ($938.00 - 26.6% of $938.00 = $688.49).

(v) **Step 5**: Your surviving spouse's initial premium amount is determined based on whether or not she is eligible for Medicare in accordance with the following rules:

- If your surviving spouse is not eligible for Medicare, her initial premium amount equals her subsidized base rate (i.e., her initial premium amount equals the amount that was calculated in accordance with Section 1.29(b)(1)(iv)). For example, if your surviving spouse's subsidized base rate is $688.49 and she is not eligible for Medicare, her initial premium amount would equal $688.49.
- If your surviving spouse is eligible for Medicare, her initial premium amount equals 76% of her subsidized base rate (i.e., her initial premium amount equals 76% of the amount that was calculated in accordance with Section 1.29(b)(1)(iv)). For example, if your surviving spouse's subsidized base rate is $688.49 and she is eligible for Medicare, her initial premium amount would equal $523.25 (76% of $688.49 = $523.25).

(2) **Recalculation of surviving spouse premium amount**

After your surviving spouse's initial premium amount is calculated in accordance with Section 1.29(b)(1), her premium amount will subsequently be recalculated in accordance with the rules described in this Section 1.29(b)(2).

(i) **Recalculation of your surviving spouse's premium amount when your surviving spouse changes from family coverage to single coverage**

If you began receiving benefits from the Pension Plan on or after June 1, 2008, your surviving spouse has family coverage (i.e., she has at least one Dependent child that is covered by the Plan), and subsequently her child's (or children's, if more than one child is covered by the Plan) coverage from the Plan is terminated in accordance with Section 1.28(b) (i.e., subsequently she no longer has any Dependent children that are covered by the Plan), your surviving spouse's premium amount will be recalculated

on the date that her child's (or children's, as applicable) coverage from the Plan is terminated in accordance with the following rules:

(A) **Step 1**: Your surviving spouse's base rate is calculated by multiplying the Contribution Rate in effect on the date that her child's (or children's, as applicable) coverage from the Plan was terminated by 140 (i.e., the Contribution Rate in effect on the date that your surviving spouse changed from family coverage to single coverage is multiplied by 140). For example, if the Contribution Rate is $10.00 on the date that your surviving spouse's child's (or children's, as applicable) coverage from the Plan was terminated, her base rate would equal $1,400.00 ($10.00 x 140 = $1,400.00).

(B) **Step 2**: Your surviving spouse's adjusted base rate is calculated by reducing her base rate by 33% (i.e., the amount that was calculated in accordance with Section 1.29(b)(2)(i)(A) is reduced by 33%). For example, if your surviving spouse's base rate is $1,400.00, her adjusted base rate would equal $938.00 ($1,400.00 - 33% of $1,400.00 = $938.00).

(C) **Step 3:** Your surviving spouse's subsidized base rate is calculated by reducing her adjusted base rate by her Plan subsidy (i.e., the amount that was calculated in accordance with Section 1.29(b)(2)(i)(B) is reduced by the percentage that was calculated in accordance with Section 1.29(b)(1)(iii)). For example, if your surviving spouse's adjusted base rate is $938.00 and her Plan subsidy is 26.6%, her subsidized base rate would equal $688.49 ($938.00 - 26.6% of $938.00 = $688.49).

(D) **Step 4:** Your surviving spouse's new premium amount is determined based on whether or not she is eligible for Medicare in accordance with the following rules:

- If your surviving spouse is not eligible for Medicare, her new premium amount equals her subsidized base rate (i.e., her new premium amount equals the amount that was calculated in accordance with Section 1.29(b)(2)(i)(C)). For example, if your surviving spouse's subsidized base rate is $688.49 and she is not eligible for Medicare, her new premium amount would equal $688.49.
- If your surviving spouse is eligible for Medicare, her new premium amount equals 76% of her subsidized base rate (i.e., her new premium amount equals 76% of the amount that was calculated in accordance with Section 1.29(b)(2)(i)(C)). For example, if your surviving spouse's subsidized base rate is $688.49 and she is eligible for Medicare, her new premium amount would equal $523.25 (76% of $688.49 = $523.25).

(ii) **Recalculation of your surviving spouse's premium amount when your surviving spouse becomes eligible for Medicare**

If you began receiving benefits from the Pension Plan on or after June 1, 2008, and your surviving spouse becomes eligible for Medicare, her premium amount will be recalculated on the date that she becomes eligible for Medicare in accordance with the following rules:

(A) **Step 1**: Your surviving spouse's base rate is calculated by multiplying the Contribution Rate in effect on the date that she became eligible for Medicare

by 140. For example, if the Contribution Rate is $10.00 on the date that your surviving spouse became eligible for Medicare, her base rate would equal $1,400.00 ($10.00 x 140 = $1,400.00).

(B) **Step 2**: Your surviving spouse's adjusted base rate is calculated by either increasing or decreasing her base rate based on whether she has single coverage (i.e., she does not have any Dependent children that are covered by the Plan) or family coverage (i.e., she has at least one Dependent child that is covered by the Plan). If your surviving spouse has single coverage, her adjusted base rate is calculated by reducing her base rate by 33% (i.e., the amount that was calculated in accordance with Section 1.29(b)(2)(ii)(A) is reduced by 33%). If your surviving spouse has family coverage, her adjusted base rate is calculated by increasing her base rate by 33% (i.e., the amount that was calculated in accordance with Section 1.29(b)(2)(ii)(A) is increased by 33%). For example, if your surviving spouse's base rate is $1,400.00 and she has single coverage, her adjusted base rate would equal $938.00 ($1,400.00 - 33% of $1,400.00 = $938.00). If your surviving spouse's base rate is $1,400.00 and she has family coverage, her adjusted base rate would equal $1,862.00 ($1,400.00 + 33% of $1,400.00 = $1,862.00).

(C) **Step 3**: Your surviving spouse's subsidized base rate is calculated by reducing her adjusted base rate by her Plan subsidy (i.e., the amount that was calculated in accordance with Section 1.29(b)(2)(ii)(B) is reduced by the percentage that was calculated in accordance with Section 1.29(b)(1)(iii)). For example, if your surviving spouse's adjusted base rate is $938.00 and her Plan subsidy is 26.6%, her subsidized base rate would equal $688.49 ($938.00 - 26.6% of $938.00 = $688.49).

(D) **Step 4**: Your surviving spouse's new premium amount equals 76% of her subsidized base rate (i.e., her new premium amount equals 76% of the amount that was calculated in accordance with Section 1.29(b)(2)(ii)(C)). For example, if your surviving spouse's subsidized base rate is $688.49, her new premium amount would equal $523.25 (76% of $688.49 = $523.25).

(iii) Recalculation of your surviving spouse's premium amount on June 1

If you began receiving benefits from the Pension Plan on or after June 1, 2008, your spouse is covered by the Plan as your surviving spouse on May 31 of the calendar year, and on June 1 of that calendar year your surviving spouse's premium amount is not recalculated in accordance with either Section 1.29(b)(2)(i) or Section 1.29(b)(2)(ii) (i.e., on June 1 of that calendar year your surviving spouse does not change from family coverage to single coverage and she does not become eligible for Medicare), her premium amount will be recalculated on June 1 of that calendar year in accordance with the following rules:

(A) **Step 1**: Your surviving spouse's base rate is calculated by multiplying the Contribution Rate in effect on June 1 of the calendar year by 140. For example, if the Contribution Rate is $10.00 on June 1 of the calendar year, your surviving spouse's base rate would equal $1,400.00 ($10.00 x 140 = $1,400.00).

(B) **Step 2**: Your surviving spouse's adjusted base rate is calculated by either increasing or decreasing her base rate based on whether she has single coverage (i.e., she does not have any Dependent children that are covered by

the Plan) or family coverage (i.e., she has at least one Dependent child that is covered by the Plan). If your surviving spouse has single coverage, her adjusted base rate is calculated by reducing her base rate by 33% (i.e., the amount that was calculated in accordance with Section 1.29(b)(2)(iii)(A) is reduced by 33%). If your surviving spouse has family coverage, her adjusted base rate is calculated by increasing her base rate by 33% (i.e., the amount that was calculated in accordance with Section 1.29(b)(2)(iii)(A) is increased by 33%). For example, if your surviving spouse's base rate is $1,400.00 and she has single coverage, her adjusted base rate would equal $938.00 ($1,400.00 - 33% of $1,400.00 = $938.00). If your surviving spouse's base rate is $1,400.00 and she has family coverage, her adjusted base rate would equal $1,862.00 ($1,400.00 + 33% of $1,400.00 = $1,862.00).

(C) **Step 3**: Your surviving spouse's subsidized base rate is calculated by reducing her adjusted base rate by her Plan subsidy (i.e., the amount that was calculated in accordance with Section 1.29(b)(2)(iii)(B) is reduced by the percentage that was calculated in accordance with Section 1.29(b)(1)(iii)). For example, if your surviving spouse's adjusted base rate is $938.00 and her Plan subsidy is 26.6%, her subsidized base rate would equal $688.49 ($938.00 - 26.6% of $938.00 = $688.49).

(D) **Step 4**: Your surviving spouse's preliminary premium amount is determined based on whether or not she is eligible for Medicare in accordance with the following rules:

- If your surviving spouse is not eligible for Medicare, her preliminary premium amount equals her subsidized base rate (i.e., her preliminary premium amount equals the amount that was calculated in accordance with Section 1.29(b)(2)(iii)(C)). For example, if your surviving spouse's subsidized base rate is $688.49 and she is not eligible for Medicare, her preliminary premium amount would equal $688.49.
- If your surviving spouse is eligible for Medicare, her preliminary premium amount equals 76% of her subsidized base rate (i.e., her preliminary premium amount equals 76% of the amount that was calculated in accordance with Section 1.29(b)(2)(iii)(C)). For example, if your surviving spouse's subsidized base rate is $688.49 and she is eligible for Medicare, her preliminary premium amount would equal $523.25 (76% of $688.49 = $523.25).

(E) **Step 5**: Your surviving spouse's new premium amount is determined by comparing her preliminary premium amount (i.e., the premium amount calculated in accordance with Section 1.29(b)(2)(iii)(D)) to the premium amount that she paid in May of the same calendar year (i.e., the premium amount that she paid the prior calendar month) in accordance with the following rules:

- If your surviving spouse's preliminary premium amount is not more than 5% greater than the premium amount that she paid in May of the same calendar year (i.e., if the amount calculated in accordance with Section 1.29(b)(2)(iii)(D) is not more than 5% higher than the premium amount that she paid the prior calendar month), then her new premium amount equals her preliminary premium amount (i.e., her new premium amount

equals the amount that was calculated in accordance with Section 1.29(b)(2)(iii)(D)). For example, if your surviving spouse's premium amount in May 2023 was $1,000.00 and her preliminary premium amount is $1,045.00, then her new premium amount on June 1, 2023, would equal $1,045.00 ($1,045.00 is only 4.5% greater than $1,000.00).

- If your surviving spouse's preliminary premium amount is more than 5% greater than the premium amount that she paid in May of the same calendar year (i.e., if the amount calculated in accordance with Section 1.29(b)(2)(iii)(D) is more than 5% higher than the premium amount that she paid the prior calendar month), then her new premium amount equals 5% more than the premium amount that she paid in May of that calendar year (i.e., her new premium amount equals 5% more than the premium amount that she paid the prior calendar month). For example, if your surviving spouse's premium amount in May 2023 was $1,000.00 and her preliminary premium amount is $1,100.00, then her new premium amount on June 1, 2023, would equal $1,050.00 ($1,050.00 is 5% greater than $1,000.00).

Section 1.30 - General Notice of COBRA Continuation Coverage Rights

****CONTINUATION COVERAGE RIGHTS UNDER COBRA****

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). **This notice generally explains COBRA continuation coverage, when it may be available to you and your family, and what you need to do to protect your right to receive it.**

COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered by the Plan when they would otherwise lose their group health coverage. This Combination Plan Document and Summary Plan Description contains additional information about your rights and obligations under the Plan and under federal law. For more information regarding COBRA continuation coverage, contact the Fund Office.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end due to a life event known as a qualifying event. Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. A qualified beneficiary is someone who will lose coverage from the Plan due to a qualifying event. Depending on the type of qualifying event, you, your spouse, and your Dependent children could become qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

The coverage provided under COBRA continuation coverage is identical to the medical coverage provided by the Plan to similarly situated Beneficiaries with respect to whom a qualifying event has not occurred. COBRA continuation coverage does not provide ancillary welfare benefits, such as the Plan's Death Benefits, Accident and Sickness Loss of Time Benefits, and AD&D Benefits.

If you are an Eligible Employee, you will become a qualified beneficiary if you lose your coverage from the Plan because either one of the following qualifying events occur:

- Your hours of employment are reduced (that is, you do not work sufficient hours in Covered Employment to remain covered by the Plan as an Eligible Employee); or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an Eligible Employee or Retiree, you will become a qualified beneficiary if you lose your coverage from the Plan because any of the following qualifying events occur:

- Your spouse (i.e., the Eligible Employee or Retiree) dies;
- Your spouse's hours of employment are reduced (that is, your spouse does not work sufficient hours in Covered Employment to remain covered by the Plan as an Eligible Employee);
- Your spouse's employment ends for any reason other than his/her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

If you are the Dependent child of an Eligible Employee or Retiree, you will become a qualified beneficiary if you lose your coverage from the Plan because any of the following qualifying events occur:

- Your parent (i.e., the Eligible Employee or Retiree) dies;
- Your parent's hours of employment are reduced (that is, your parent does not work sufficient hours in Covered Employment to remain covered by the Plan as an Eligible Employee);
- Your parent's employment ends for any reason other than his/her gross misconduct;
- Your parent becomes entitled to Medicare benefits (Part A, Part B, or both);
- Your parents become divorced or legally separated; or
- You cease to be eligible for coverage from the Plan as a Dependent child.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Office determines or has been notified that a qualifying event has occurred. The Fund Office is responsible for determining if you are eligible for COBRA continuation coverage when the qualifying event is the end of employment, reduction of hours of employment, death, or entitlement to Medicare benefits (under Part A, Part B, or both).

For any other qualifying event (divorce or legal separation or a child losing eligibility for coverage as a Dependent child), **YOU must notify the Fund Office within 60 days after the qualifying event occurs.** You must provide this notice to:

The Board of Trustees of the
Pipe Fitters Local 533 Health and Welfare Plan
8600 Hillcrest Road, Suite A
Kansas City, MO 64138

Your notice must be made in writing and must be accompanied by a copy of any legal documentation (such as a divorce decree or order granting legal separation) relating to the qualifying event.

Provision and Duration of COBRA Continuation Coverage

Once the Fund Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary within 14 days after receiving such notice. If you submit notice of a qualifying event and the Fund Office determines that you are not eligible for COBRA continuation coverage, the Fund Office will send you written notice of the unavailability of such coverage.

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Eligible Employees may elect COBRA continuation coverage on behalf of their spouses and parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects it, COBRA continuation coverage will begin on the date that coverage from the Plan would have otherwise been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of an Eligible Employee, an Eligible Employee becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce or legal separation, or a child losing eligibility as a Dependent child, COBRA continuation coverage lasts up to a total of 36 months.

When the qualifying event is the end of employment or reduction of an Eligible Employee's hours of employment, and the Eligible Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Eligible Employee lasts until 36 months after the date of Medicare entitlement. For example, if an Eligible Employee becomes entitled to Medicare eight months before the date on which his/her employment terminates, COBRA continuation coverage for his/her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

Otherwise, when the qualifying event is the end of employment or reduction of an Eligible Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

- **Disability extension of 18-month period of continuation coverage**

  If you or anyone in your family covered by the Plan is determined by the Social Security Administration to be disabled and you notify the Fund Office in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must provide the notice to the Fund Office within the first 60 days of COBRA continuation coverage or, if later, within 60 days from the Social Security Administration's determination of disability and before the end of the 18-month period of COBRA continuation coverage. Additionally, such notice must be accompanied by a copy of the Social Security Administration's determination letter. This notice must be sent to the Fund Office.

- **Second qualifying event extension of 18-month period of continuation coverage**

  If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension is available to your spouse and Dependent children if you die, become entitled to Medicare benefits (under Part A, Part B, or both), get divorced or legally separated, or if your child loses eligibility from the Plan as a Dependent child, but only if the event would have caused your spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

In all of these cases, you must make sure the Fund Office is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Fund Office and must be accompanied by any appropriate documentation.

If You Have Questions

If you have questions concerning your COBRA continuation rights, you should contact the Fund Office. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act ("HIPAA"), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

Termination of COBRA Continuation Coverage

Your COBRA continuation coverage will terminate on the earliest of the following days:

- The date the 18, 29, or 36-month maximum period ends, as described on the Provision and Duration of COBRA Continuation Coverage section of Article I, Section 1.30. Because the Plan does not provide for a conversion option from group coverage under the Plan to an individual policy, you will not receive any notice prior to the termination of your COBRA continuation coverage due to exhaustion of the maximum period;
- The date on which the Plan no longer provides any group health coverage to any individual;
- The first day of the calendar month for which you do not pay your applicable premium on time;
- The date on which you become covered by another group health plan (after the date of your election of COBRA continuation coverage) that does not contain any exclusion or limitation with respect to any pre-existing condition which you may have;
- The date on which you become entitled to Medicare after your election of COBRA continuation coverage; or
- If your coverage was extended up to 29 months due to a disability, the first day of the calendar month following the calendar month in which the Social Security Administration determines that you are not disabled.

COBRA Continuation Procedures

General

An Eligible Employee or Dependent with respect to whom a qualifying event has occurred shall be a qualified beneficiary entitled to elect COBRA continuation coverage. Any person who has properly elected continuation coverage shall remain a qualified beneficiary until continuation coverage is terminated.

If the address of a spouse, former spouse, or other Dependent is different from that of the Eligible Employee or Retiree, it is the responsibility of the Eligible Employee, Retiree, spouse, or Dependent to provide the Fund Office with current address information.

Notification Requirements

Employers are not required to provide notice of qualifying events to the Fund Office. The Fund Office will determine whether a qualifying event has occurred due to the Eligible Employee's termination of employment or reduction in hours of employment, the Eligible Employee's death, or the Eligible Employee becoming entitled to Medicare.

To determine whether a qualifying event has occurred as a result of termination of employment or reduction of hours of employment, the Fund Office will review the monthly contributions that the Plan receives from Employers on behalf of the Eligible Employee. The Fund Office will generally have sufficient information to determine whether an Eligible Employee will lose coverage as a result of a termination of employment or reduction of hours of employment within 45 days after the last day of the calendar month in which the Eligible Employee does not have sufficient hours credited to maintain coverage. The Fund Office shall send

notice of the qualifying event and the qualified beneficiaries' rights to elect COBRA continuation coverage within 14 days after determining that a qualifying event has occurred.

If the qualifying event is the Eligible Employee's death, the Fund Office shall send notice of the qualifying event and all qualified beneficiaries' rights to elect COBRA continuation coverage within 14 days after determining that a qualifying event has occurred.

The Fund Office will determine whether an Eligible Employee has become entitled to Medicare and whether such entitlement constitutes a qualifying event within 30 days following the qualifying event. If the Fund Office determines that a qualifying event has occurred, the Fund Office shall send notice of the qualifying event and all qualified beneficiaries' rights to elect COBRA continuation coverage within 14 days after the determination.

An Eligible Employee, Retiree, or Dependent spouse or child must give written notice to the Fund Office within 60 days after the occurrence of a qualifying event that is a divorce or legal separation of the Eligible Employee (or Retiree) and spouse or Dependent child's ceasing to meet the Plan criteria for an eligible Dependent. The notice must be provided in writing and should be mailed, faxed, or delivered to the Fund Office. The Plan will provide forms to Participants and Beneficiaries that may be used to provide this notice. Use of the Plan's form is not required as long as the written notice of the qualifying event contains all of the necessary information and is accompanied by documentation of the qualifying event, if applicable. The Fund Office will then send a notice of the qualified beneficiaries' rights to elect COBRA continuation coverage, or the unavailability of COBRA continuation coverage, within 14 days after receiving such notice.

<u>Second Qualifying Event and Disability</u>

If a qualified beneficiary experiences a second qualifying event while on COBRA continuation coverage that is subject to a maximum period of 18 or 29 months, the qualified beneficiary must provide written notice to the Fund Office within 60 days after the occurrence of the second qualifying event in order to extend the maximum COBRA continuation coverage period to 36 months. The notice must be provided in writing and should be mailed, faxed, or delivered to the Fund Office. The Plan will provide forms to Participants and Beneficiaries that may be used to provide this notice. Use of the Plan's form is not required as long as the written notice of the second qualifying event contains all of the necessary information and is accompanied by documentation of the second qualifying event, if applicable. The Fund Office will then send a notice of the qualified beneficiaries' extension of the maximum COBRA continuation coverage period, or the unavailability of an extension of the maximum COBRA continuation coverage, within 14 days after receiving such notice.

If a qualified beneficiary or any member of the qualified beneficiary's family is disabled, as determined by the Social Security Administration, at any time within the first 60 days of COBRA continuation coverage, the qualified beneficiary must provide written notice of such disability to the Fund Office within the first 60 days of COBRA continuation coverage or, if later, within 60 days from the Social Security Administration's determination that the qualified beneficiary or family member is disabled. The notice must be accompanied by a copy of the Social Security Administration's determination letter. A qualified beneficiary may, but is not required to, use a form provided by the Fund Office to provide this notice. If the Social Security Administration determines that the person's disability has ended while the person is on COBRA continuation coverage, the qualified beneficiary must provide a copy of the Social Security Administration's letter stating that the person is no longer disabled to the Fund Office within 30 days after the Social Security Administration's determination.

The Fund Office will send a notice of the right to elect an extended period of COBRA continuation coverage, or a notice of the unavailability of an extension of COBRA continuation coverage, within 14 days after receiving notice from the qualified beneficiary.

<u>Applicable Premium for COBRA Continuation Coverage</u>

COBRA premiums are payable monthly, and are due <u>on the first day of the calendar month for the month of coverage</u>. You will have 60 days in which to elect COBRA continuation coverage, and 45 days from the date you elect COBRA continuation coverage to submit your initial premium payment. Payments must be submitted to the Fund Office, as explained more fully in the notice you will receive when you become eligible for COBRA continuation coverage.

The applicable premium is an amount determined by the Board of Trustees to be a fair and appropriate amount to cover the cost of the coverage provided to you, but will never exceed 102% of the total cost to the Plan for your coverage, except as provided for in this paragraph regarding disability. The total cost to the Plan for your coverage is calculated on an actuarial basis by making a reasonable estimate of the cost of providing coverage for similarly situated Participants and Beneficiaries. This amount may be recalculated annually. The Plan reserves the right to charge an additional premium for qualified beneficiaries who take advantage of the 11-month extension of COBRA continuation coverage for totally disabled qualified beneficiaries and family members of such qualified beneficiaries described in the Second Qualifying Event and Disability section of this Article I, Section 1.30. If you are eligible for the 11-month extension (up to a maximum of 29 months of continuation coverage), the maximum applicable premium for those additional 11 months is 150% of the total Plan cost of your coverage.

<u>Unavailability of COBRA Continuation Coverage</u>

When the Fund Office receives a notice from an Eligible Employee or Beneficiary relating to a qualifying event, second qualifying event, or determination of disability by the Social Security Administration regarding an Eligible Employee, qualified beneficiary, or other individual, and the Fund Office determines that the individual is not entitled to COBRA continuation coverage or an extension of COBRA continuation coverage, the Fund Office will provide a notice to the person explaining why the individual is not entitled to COBRA continuation coverage. The unavailability notice will be sent within 14 days from receipt of the notice from the Eligible Employee, Beneficiary, or other individual.

<u>Early Termination of COBRA Continuation Coverage</u>

Whenever COBRA continuation coverage is terminated before the latest date shown on the election notice (that is, before the end of the 18, 29, or 36-month maximum period), notice must be sent to all affected qualified beneficiaries explaining the reason for the termination, the date of termination, and any rights the qualified beneficiary may have under the Plan or under applicable law to elect alternative group or individual coverage. The termination notice will be provided as soon as practicable following the Fund Office's determination that continuation coverage will terminate.

<u>Premium Rate Increase</u>

In the event COBRA premiums increase, the Fund Office will send notice of such increase to all qualified beneficiaries at least 30 days before the effective date of the increase.

<u>Deficient Premium Payment</u>

In the event a qualified beneficiary submits a payment for COBRA continuation coverage that is less than the full premium amount due, and the deficiency is not more than $50 (or the deficiency is not more than 10% of the applicable premium amount, if 10% of the premium is less than $50), the Fund Office will provide notice of deficiency to the qualified beneficiary demanding payment of the deficiency in full within 30 days from the date of the deficiency notice. The deficient premium will be considered full payment until the end of the 30-day period. If the Fund Office fails to provide notice of the deficiency to the qualified beneficiary within 30 days after receipt of the payment, the amount paid will be deemed to constitute full payment of the applicable premium.

In the event a qualified beneficiary submits a payment for COBRA continuation coverage that is significantly less than the full amount due (that is, the deficiency exceeds the lesser of $50 or 10% of the applicable premium), no additional time will be granted to make up the deficiency. If the deficiency is not paid within the initial 30-day grace period, coverage will be retroactively terminated as of the first day of the calendar month for which full payment was not made.

Section 1.31 - Certificates of Creditable Coverage

The Plan will automatically issue a Certificate of Creditable Group Health Plan Coverage to an individual (including a former Employee, a former Retiree, and a former Dependent) who loses coverage from the Plan. If the individual elects COBRA continuation coverage, the Plan will automatically provide the individual another Certificate of Creditable Coverage when his/her COBRA continuation coverage ends. In addition, the Plan will provide an individual a Certificate of Creditable Coverage upon request so long as the request is submitted to the Fund Office while the individual is covered by the Plan or within 24 months after the date that the individual lost coverage from the Plan. To request a Certificate of Creditable Coverage or obtain additional information, contact the Fund Office.

Section 1.32 - Suspension of Certain Deadlines Due to COVID-19

The rules in this Section 1.32 are temporary and only apply during what is referred to as the "Outbreak Period." Outbreak Period refers to the period that begins on March 1, 2020 and ends on the date 60 days after the end of the national emergency declared by the President concerning the COVID-19 outbreak. During the Outbreak Period, the following deadlines are suspended:

- **Deadlines affecting Dependent enrollment, including:**
  - The 90-day deadline that a Covered Employee has to submit an enrollment form for a new Dependent; and
  - The 30-day deadline that a Retiree has to submit an enrollment form for a new Dependent;
- **Deadlines affecting COBRA, including:**
  - The 60-day deadline that a qualified beneficiary has to elect COBRA continuation coverage following the receipt of a COBRA election notice;
  - The 45-day deadline that a qualified beneficiary has to submit an initial COBRA premium;
  - The 30-day deadline that a qualified beneficiary has to submit subsequent COBRA premiums (i.e., premiums other than the initial premium payment);
  - The 60-day deadline that an employee or retiree has to notify the Plan that (s)he has experienced a COBRA qualifying event (this only applies when the event is divorce or a dependent child no longer qualifies as a dependent); and
  - The 60-day deadline that a qualified beneficiary has to notify the Plan that (s)he experienced a second qualifying event.

ARTICLE II - COMPREHENSIVE MEDICAL BENEFITS

The following topics are discussed under this Article on Comprehensive Medical Benefits:

2.01 Definitions for this Article II Only
2.02 In-Network Cost Sharing, Out-of-Network Cost Sharing, and Notable Exceptions
2.03 Covered Medical Services and Supplies
- a. Ambulance Services
- b. Certain Dental Services
- c. Chiropractic Services
- d. Diagnostic Services
- e. Durable Medical Equipment and Medical Supplies
- f. Employee Assistance Program ("EAP")
- g. Hearing Aid Benefits
- h. Home Health Care Services
- i. Hospice Care Services
- j. Hospital - Emergency Room Services
- k. Hospital and Facility - Inpatient Services
- l. Hospital and Facility - Outpatient Services
- m. Maternity Services
- n. Mental Health and Substance Abuse Services
- o. Nurse Practitioner Retail Clinic Visits
- p. Organ and Tissue Transplant Services
- q. Phenyl-Free Formula
- r. Physical Therapy
- s. Physician and Physician Assistant Visits
- t. Prosthetics and Orthotics
- u. Second Surgical Option
- v. Speech Therapy
- w. Surgical Services
- x. Telehealth Benefits
- y. Well Child Benefits

2.04 Routine Preventive Care Benefits
2.05 Comprehensive Medical Benefit Exclusions and Limitations
2.06 Medicare Advantage and Prescription Drug Plan ("MAPD")
2.07 Filing a Claim
2.08 COVID-19 Vaccines and COVID-19 Testing

NOTE: If you are covered by the MAPD described in Section 2.06, you will not be eligible for benefits under this Article II. Instead, you will be eligible for benefits through the MAPD. For more information about the MAPD, refer to Section 2.06.

COMPREHENSIVE MEDICAL BENEFITS		
PLAN LIMITS, DEDUCTIBLES, AND MAXIMUMS		
DEDUCTIBLE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
• **Eligible Employee or a Dependent of an Eligible Employee**	$600 Person / $1,200 Family	$600 Person / $1,200 Family
• **Post-2007 Retiree or a Dependent of a Post-2007 Retiree**	$300 Person / $600 Family	$300 Person / $600 Family
• **Pre-2007 Retiree or a Dependent of a Pre-2007 Retiree**	$150 Person / $300 Family	$400 Person / $800 Family
You or your family must pay a Deductible each calendar year before the Plan will start paying for Comprehensive Medical Benefits. If your family Deductible is satisfied for a calendar year, Comprehensive Medical Benefits will be payable as if each member of your family has met their individual Deductibles for the calendar year. Allowable Charges for Comprehensive Medical Benefits provided by in-network providers count towards both your in-network Deductible and your out-of-network Deductible. Allowable Charges for Comprehensive Medical Benefits provided by out-of-network providers also count towards both your in-network Deductible and your out-of-network Deductible.		

ANNUAL OUT-OF-POCKET MAXIMUM	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
• **Eligible Employee or a Dependent of an Eligible Employee**	$4,600 Person / $9,200 Family	No Out-of-Pocket Maximum
• **Post-2007 Retiree or a Dependent of a Post-2007 Retiree**	$3,300 Person / $6,600 Family	No Out-of-Pocket Maximum
• **Pre-2007 Retiree or a Dependent of a Pre-2007 Retiree**	$1,650 Person / $3,300 Family	No Out-of-Pocket Maximum
Amounts you pay to in-network providers for Deductibles and Coinsurance for covered services and supplies count towards your Annual Out-of-Pocket Maximum. Except as provided for in Section 2.02(c), amounts you pay to out-of-network providers do not count towards your Annual Out-of-Pocket Maximum. Once you have met your Annual Out-of-Pocket Maximum, the Plan will pay 100% of Allowable Charges for the remainder of the calendar year for Comprehensive Medical Benefits provided by in-network providers. Unless a Plan provision specifically provides otherwise, the Plan will not pay 100% of Allowable Charges for the remainder of the calendar year for Comprehensive Medical Benefits provided by out-of-network providers.		

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
AMBULANCE SERVICES		
• **Eligible Employee or a Dependent of an Eligible Employee**	80% after Deductible	60% after Deductible*
• **Retiree or a Dependent of a Retiree**	85% after Deductible	60% after Deductible**

* The Plan will pay 80% of Allowable Charges, after Deductible, for: (1) ground ambulance services provided by an out-of-network provider due to an Emergency Medical Condition; and (2) air ambulance services provided by an out-of-network provider.

** The Plan will pay 85% of Allowable Charges, after Deductible, for: (1) ground ambulance services provided by an out-of-network provider due to an Emergency Medical Condition; and (2) air ambulance services provided by an out-of-network provider.

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
CERTAIN DENTAL SERVICES		
• **Eligible Employee or a Dependent of an Eligible Employee**	80% after Deductible	60% after Deductible*
• **Retiree or a Dependent of a Retiree**	85% after Deductible	60% after Deductible*

* Except as provided for in Section 2.02(c).

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
CHIROPRACTIC SERVICES		
• **Eligible Employee or a Dependent of an Eligible Employee**	80% after Deductible*	60% after Deductible*
• **Retiree or a Dependent of a Retiree**	85% after Deductible*	60% after Deductible*

* The Plan will pay up to $50 per visit and up to $600 per Covered Person per calendar year.

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
DIAGNOSTIC SERVICES		
• **Eligible Employee or a Dependent of an Eligible Employee**	80% after Deductible	60% after Deductible*
• **Retiree or a Dependent of a Retiree**	85% after Deductible	60% after Deductible*

* Except as provided for in Section 2.02(c).

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES		
• **Eligible Employee or a Dependent of an Eligible Employee**	80% after Deductible	60% after Deductible
• **Retiree or a Dependent of a Retiree**	85% after Deductible	60% after Deductible

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
EMPLOYEE ASSISTANCE PROGRAM		
• **Eligible Employee or a Dependent of an Eligible Employee**	100%*	N/A
• **Retiree or a Dependent of a Retiree**	100%*	N/A
* The Plan will only pay for employee assistance program services provided through Empathia.		

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
HEARING AID BENEFITS		
• **Eligible Employee or a Dependent of an Eligible Employee**	100%, up to $2,000, then 0% - Deductible waived*	100%, up to $2,000, then 0% - Deductible waived*
• **Retiree or a Dependent of a Retiree**	100%, up to $2,000, then 0% - Deductible waived*	100%, up to $2,000, then 0% - Deductible waived*
* Available once every five years.		

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
HOME HEALTH CARE SERVICES		
• **Eligible Employee or a Dependent of an Eligible Employee**	80% after Deductible	60% after Deductible
• **Retiree or a Dependent of a Retiree**	85% after Deductible	60% after Deductible

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
HOSPICE CARE SERVICES		
• **Eligible Employee or a Dependent of an Eligible Employee***	100% - Deductible Waived	100% - Deductible Waived
• **Retiree or a Dependent of a Retiree***	100% - Deductible Waived	100% - Deductible Waived
* Up to 210 days.		

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
HOSPITAL - EMERGENCY ROOM SERVICES		
• **Eligible Employee or a Dependent of an Eligible Employee**	80% after Deductible	60% after Deductible*
• **Retiree or a Dependent of a Retiree**	85% after Deductible	60% after Deductible**
* The Plan will pay 80% of Allowable Charges, after Deductible, for Emergency Services provided by an out-of-network provider.		
** The Plan will pay 85% of Allowable Charges, after Deductible, for Emergency Services provided by an out-of-network provider.		

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
HOSPITAL AND FACILITY - INPATIENT SERVICES		
HOSPITAL/FACILITY CHARGES (i.e., charges for the actual Hospital/Facility)		
• **Eligible Employee or a Dependent of an Eligible Employee**	80% after Deductible	Not Covered
• **Retiree or a Dependent of a Retiree**	85% after Deductible	Not Covered

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
SERVICE PROVIDER CHARGES AT HOSPITAL/FACILITY (e.g., doctor, nurse charges)		
• **Eligible Employee or a Dependent of an Eligible Employee**	80% after Deductible	Not covered if Hospital/Facility is out-of-network*
• **Retiree or a Dependent of a Retiree**	85% after Deductible	Not covered if Hospital/Facility is out-of-network*
* If the Hospital/Facility is in-network, then the Plan will pay 60% of the Allowable Charges, after Deductible, except as provided for in Section 2.02(c).		

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
HOSPITAL AND FACILITY - OUTPATIENT SERVICES		
• **Eligible Employee or a Dependent of an Eligible Employee**	80% after Deductible	60% after Deductible*
• **Retiree or a Dependent of a Retiree**	85% after Deductible	60% after Deductible*
* Except as provided for in Section 2.02(c).		

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
MATERNITY - CHILDBIRTH/DELIVERY PROFESSIONAL SERVICES AND DELIVERY SERVICES		
HOSPITAL/FACILITY CHARGES (i.e., charges for the actual Hospital/Facility)		
• **Eligible Employee or a Dependent of an Eligible Employee***	80% after Deductible	Not Covered
• **Retiree or a Dependent of a Retiree***	85% after Deductible	Not Covered
SERVICE PROVIDER CHARGES AT HOSPITAL/FACILITY (e.g., doctor, nurse charges)		
• **Eligible Employee or a Dependent of an Eligible Employee***	80% after Deductible	Not covered if Hospital/Facility is out-of-network**
• **Retiree or a Dependent of a Retiree***	85% after Deductible	Not covered if Hospital/Facility is out-of-network**
* The Plan does not cover maternity services in connection with a Dependent child's pregnancy or childbirth by a Dependent child. ** If the Hospital/Facility is in-network, then the Plan will pay 60% of the Allowable Charges, after Deductible, except as provided for in Section 2.02(c).		
MATERNITY - OFFICE VISITS		
• **Eligible Employee or a Dependent of an Eligible Employee***	80% after Deductible	60% after Deductible**
• **Retiree or a Dependent of a Retiree***	85% after Deductible	60% after Deductible**
* The Plan does not cover maternity services in connection with a Dependent child's pregnancy or childbirth by a Dependent child. ** Except as provided for in Section 2.02(c).		

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
MENTAL HEALTH (NOT SUBSTANCE ABUSE) - INPATIENT		
HOSPITAL/FACILITY CHARGES (i.e., charges for the actual Hospital/Facility)		
• **Eligible Employee or a Dependent of an Eligible Employee**	80% after Deductible	Not Covered
• **Retiree or a Dependent of a Retiree**	85% after Deductible	Not Covered
SERVICE PROVIDER CHARGES AT HOSPITAL/FACILITY (e.g., doctor, nurse charges)		
• **Eligible Employee or a Dependent of an Eligible Employee**	80% after Deductible	Not covered if Hospital/Facility is out-of-network*
• **Retiree or a Dependent of a Retiree**	85% after Deductible	Not covered if Hospital/Facility is out-of-network*

* If the Hospital/Facility is in-network, then the Plan will pay 60% of the Allowable Charges, after Deductible, except as provided for in Section 2.02(c).

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
MENTAL HEALTH (NOT SUBSTANCE ABUSE) - OUTPATIENT		
• **Eligible Employee or a Dependent of an Eligible Employee**	80% after Deductible	60% after Deductible*
• **Retiree or a Dependent of a Retiree**	85% after Deductible	60% after Deductible*

* Except as provided for in Section 2.02(c).

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
SUBSTANCE ABUSE - INPATIENT		
HOSPITAL/FACILITY CHARGES (i.e., charges for the actual Hospital/Facility)		
• **Eligible Employee or a Dependent of an Eligible Employee**	100% up to $7,500; then 80% after Deductible	Not Covered
• **Retiree or a Dependent of a Retiree**	100% up to $7,500; then 85% after Deductible	Not Covered
SERVICE PROVIDER CHARGES AT HOSPITAL/FACILITY (e.g., doctor, nurse charges)		
• **Eligible Employee or a Dependent of an Eligible Employee**	100% up to $7,500; then 80% after Deductible	Not covered if Hospital/Facility is out-of-network*
• **Retiree or a Dependent of a Retiree**	100% up to $7,500; then 85% after Deductible	Not covered if Hospital/Facility is out-of-network*

* If the Hospital/Facility is in-network, then the Plan will pay 60% of the Allowable Charges, after Deductible, except as provided for in Section 2.02(c).

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
SUBSTANCE ABUSE - OUTPATIENT		
• **Eligible Employee or a Dependent of an Eligible Employee**	80% after Deductible	60% after Deductible*
• **Retiree or a Dependent of a Retiree**	85% after Deductible	60% after Deductible*

* Except as provided for in Section 2.02(c).

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
NURSE PRACTITIONER RETAIL CLINIC VISITS		
• **Eligible Employee or a Dependent of an Eligible Employee**	100% after $15 Copay - Deductible Waived	60% after Deductible
• **Retiree or a Dependent of a Retiree**	100% after $15 Copay - Deductible Waived	60% after Deductible

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
ORGAN AND TISSUE TRANSPLANT SERVICES		
HOSPITAL/FACILITY CHARGES (i.e., charges for the actual Hospital/Facility)		
• **Eligible Employee or a Dependent of an Eligible Employee**	80% after Deductible	Not Covered
• **Retiree or a Dependent of a Retiree**	85% after Deductible	Not Covered
SERVICE PROVIDER CHARGES AT HOSPITAL/FACILITY (e.g., doctor, nurse charges)		
• **Eligible Employee or a Dependent of an Eligible Employee**	80% after Deductible	Not covered if Hospital/Facility is out-of-network*
• **Retiree or a Dependent of a Retiree**	85% after Deductible	Not covered if Hospital/Facility is out-of-network*
* If the Hospital/Facility is in-network, then the Plan will pay 60% of the Allowable Charges, after Deductible, except as provided for in Section 2.02(c).		

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
PHENYL-FREE FORMULA		
• **Eligible Employee or a Dependent of an Eligible Employee**	80%, up to $5,000, then 0% - Deductible waived*	80%, up to $5,000, then 0% - Deductible waived*
• **Retiree or a Dependent of a Retiree**	80%, up to $5,000, then 0% - Deductible waived*	80%, up to $5,000, then 0% - Deductible waived*
* The Plan will cover up to $5,000 per Covered Person per calendar year.		

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
PHYSICAL THERAPY		
• **Eligible Employee or a Dependent of an Eligible Employee***	80% after Deductible	60% after Deductible
• **Retiree or a Dependent of a Retiree***	85% after Deductible	60% after Deductible
* The Plan will cover up to 60 physical therapy visits per Covered Person per calendar year regardless of Medical Necessity and will cover more than 60 visits per calendar year if such additional visits are Medical Necessary.		

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
PHYSICIAN AND PHYSICIAN ASSISTANT VISITS		
• **Eligible Employee or a Dependent of an Eligible Employee**	80% after Deductible	60% after Deductible*
• **Retiree or a Dependent of a Retiree**	85% after Deductible	60% after Deductible*
* Except as provided for in Section 2.02(c).		

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
PROSTHETICS AND ORTHOTICS		
• **Eligible Employee or a Dependent of an Eligible Employee**	80% after Deductible	60% after Deductible
• **Retiree or a Dependent of a Retiree**	85% after Deductible	60% after Deductible

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
SECOND SURGICAL OPINION		
• **Eligible Employee or a Dependent of an Eligible Employee**	100%	100%
• **Retiree or a Dependent of a Retiree**	100%	100%

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
SPEECH THERAPY		
• **Eligible Employee or a Dependent of an Eligible Employee***	80% after Deductible	60% after Deductible
• **Retiree or a Dependent of a Retiree***	85% after Deductible	60% after Deductible
* The Plan will cover up to 20 speech therapy visits per Covered Person per calendar year regardless of Medical Necessity and will cover more than 20 visits per calendar year if such additional visits are Medically Necessary.		

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
SURGICAL SERVICES - INPATIENT		
HOSPITAL/FACILITY CHARGES (i.e., charges for the actual Hospital/Facility)		
• **Eligible Employee or a Dependent of an Eligible Employee**	80% after Deductible	Not Covered
• **Retiree or a Dependent of a Retiree**	85% after Deductible	Not Covered
SERVICE PROVIDER CHARGES AT HOSPITAL/FACILITY (e.g., doctor, nurse charges)		
• **Eligible Employee or a Dependent of an Eligible Employee**	80% after Deductible	Not covered if Hospital/Facility is out-of-network*
• **Retiree or a Dependent of a Retiree**	85% after Deductible	Not covered if Hospital/Facility is out-of-network*

* If the Hospital/Facility is in-network, then the Plan will pay 60% of the Allowable Charges, after Deductible, except as provided for in Section 2.02(c).

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
SURGICAL SERVICES - OUTPATIENT		
• **Eligible Employee or a Dependent of an Eligible Employee**	80% after Deductible	60% after Deductible*
• **Retiree or a Dependent of a Retiree**	85% after Deductible	60% after Deductible*

* Except as provided for in Section 2.02(c).

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
TELEHEALTH BENEFITS		
• **Eligible Employee or a Dependent of an Eligible Employee**	80% after Deductible*	60% after Deductible
• **Retiree or a Dependent of a Retiree**	85% after Deductible*	60% after Deductible

* The Plan will pay 100% of the cost for telehealth visits provided by Blue KC Virtual Care.

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
WELL CHILD PROGRAM		
• **Eligible Employee or a Dependent of an Eligible Employee**	100% after Deductible	100% after Deductible
• **Retiree or a Dependent of a Retiree**	100% after Deductible	100% after Deductible
Limited to: o All visits from the time a child is born until the child is one year old; o Five visits per year while the child is one and two years old; o One visit per year while the child is three, four, five, and six years old; and o Zero visits per year after the child's seventh birthday. Visits in addition to this allowed schedule may be available as Routine Preventive Care Benefits.		

COVERAGE (PLAN PAYS)		
SERVICE	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
ROUTINE PREVENTIVE CARE SERVICES		
• **Eligible Employee or a Dependent of an Eligible Employee**	100% - Deductible Waived	100% up to $300, then 60% after Deductible*
• **Retiree or a Dependent of a Retiree**	100% - Deductible Waived	100% up to $300, then 60% after Deductible*
* For certain childhood immunizations, the Plan will pay 100% of the cost regardless of whether they are provided by an in-network provider or out-of-network provider.		

Section 2.01 - Definitions for This Article II Only

The following terms will have specific meaning when they are used within this Article:

(a) **"Ancillary Benefits"** means the following: (1) items and services that relate to emergency medicine, anesthesiology, pathology, radiology, and neonatology; (2) diagnostic services, including radiology and laboratory services; (3) items and services provided by assistant surgeons, hospitalists, and intensivists; (4) items and services provided by out-of-network providers when there is no in-network provider that can furnish it at the in-network Hospital or Facility; and (5) items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished.

(b) **"Balance Billed"** means a Covered Person being billed by an out-of-network provider for the difference between the out-of-network provider's charge for items and/or services and the Allowable Charge for the items and/or services. For example, if a Covered Person receives a service from an out-of-network provider, the Allowable Charge for the service was $70, and the out-of-network provider charged $100 for the service, the Covered Person would be responsible for the $30 difference between the Allowable charge and the amount the out-of-network provider charged for the service (i.e., the Covered Person would be "Balance Billed" for $30) in addition to any applicable cost-sharing (e.g., Deductible, Coinsurance).

(c) **"Continuing Care Patient"** means a Covered Person who meets at least one of the following criteria: (1) (s)he is undergoing a course of treatment for a serious and complex condition; (2) (s)he is undergoing a course of institutional or inpatient care; (3) (s)he is scheduled to undergo non-elective surgery, including receipt of postoperative care with respect to such surgery; (4) she is pregnant and undergoing a course of treatment for the pregnancy; or (5) (s)he is determined to be terminally ill and is receiving treatment for such illness.

(d) **"Emergency Medical Condition"** means a medical condition (including a Mental Health Care Condition or substance use disorder) manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the Covered Person's health in serious jeopardy (or, with respect to a pregnant woman, result in placing the health of the woman or her unborn child in serious jeopardy) or causing serious impairment or dysfunction to a bodily function, organ, and/or part.

(e) **"Emergency Services"** means services and supplies provided in a Hospital or ambulance in connection with an Emergency Medical Condition. Emergency Services include medical screening examinations that are within the capability of a Hospital's emergency department and further examinations and treatment that are required to stabilize a Covered Person.

(f) **"Facility"** means a place of service that is designed to provide medical treatment and is not used as an office or clinic for the private practice of a Physician or other professional medical provider. A Facility must be licensed by the proper authority of the state in which it is located, have an organized Physician staff, and have permanent building space equipped and operated primarily for the purpose of performing medical services. Nurse practitioner retail clinics, rest homes, homes for the aged, and nursing homes are not Facilities.

(g) **"Hospice"** means palliative care provided to a person with a terminal illness and his/her family, to provide for the basic life functions and necessities of life during this time, including pain relief and services for the Covered Person's family to assist in the transition to the Covered Person's death and to provide grief counseling.

(h) **"MAPD"** means the Medicare and Prescription Drug Plan ("MAPD") described in Section 2.06.

(i) **"Mental Health Care Condition"** means a physical or mental condition that causes cognitive or emotional effects, including any condition listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Ed. (DSM-IV), published by the American Psychiatric Association, or subsequent revisions thereof.

(j) **"Mental Health Care Provider"** means a person licensed by the State in which (s)he practices to provide mental health counseling or therapy, and who has an appropriate educational degree or certificate in psychology, counseling, mental health care, or related field.

(k) **"Non-Ancillary Benefit"** means a benefit that is not an Ancillary Benefit.

(l) **"No Surprises Act"** means the No Surprises Act that was signed into law as part of the Consolidated Appropriations Act of 2021.

(m) **"Nurse Practitioner Retail Clinic"** means a health care facility located in either a retail store, supermarket, or pharmacy that treats routine family illnesses and may provide limited preventative health care services. Such facilities are staffed primarily by licensed Nurse Practitioners or Physician Assistants.

(n) **“Post-2007 Retiree”** means a Retiree who submitted an application for benefits from the Pension Plan after December 29, 2006 or whose pension effective date was after March 31, 2007.

(o) **“Pre-2007 Retiree”** means a Retiree who submitted an application for benefits from the Pension Plan before December 30, 2006 or whose pension effective date was before April 1, 2007.

(p) **“Registered Nurse”** means a professional nurse who is licensed, registered, or certified in the State in which (s)he is providing health care services, and who has the right to use the title "Registered Nurse" and the abbreviation "R.N."

(q) **“Routine Preventive Care Service”** means a service that is considered preventive care under the Affordable Care Act.

(r) **“Treatment Facility”** means for purposes of the Plan's provisions concerning the treatment of Mental Health Care Conditions and alcohol or other substance abuse or dependency, a Facility offering a treatment program certified by the Missouri Department of Mental Health, the Kansas Department of Social and Rehabilitation Services, or like agency of another State.

Section 2.02 - In-Network Cost Sharing, Out-of-Network Cost Sharing, and Notable Exceptions

Costs are generally divided between you and the Plan based on the Plan’s Allowable Charge for the services and supplies you receive and your Deductible, Coinsurance, and Annual Out-of-Pocket Maximum. Comprehensive Medical Benefits are subject to Deductibles, Coinsurance, and Annual Out-of-Pocket Maximums that are separate and distinct from those that apply to Prescription Drug Benefits, Dental Benefits, and Vision Benefits.

As identified in the chart at beginning of this Article II, there are two categories of cost-sharing. The first, in-network cost sharing, is explained in Section 2.02(a) and generally applies to services and supplies you receive from in-network providers. The second, out-of-network cost sharing, is explained in Section 2.02(b), and generally applies to services and supplies you receive from out-of-network providers. As explained in Section 2.02(c), there are numerous exceptions to these general rules. As explained in Section 2.03, additional exceptions apply to certain benefits (for example, as explained in Section 2.03(e), if Medically Necessary and appropriate durable medical equipment or medical supplies are provided to you by an out-of-network provider because the durable medical equipment or medical supplies are not available through an in-network provider, the Plan will cover 80% of the cost of the durable medical equipment or medical supplies after you have met your Deductible).

(a) In-Network Cost Sharing

In-network cost sharing will generally apply to services and supplies you receive from in-network providers. This means that for most Comprehensive Medical Benefits, you must meet your in-network Deductible before the Plan will cover services and supplies provided by in-network providers. Once you have met your in-network Deductible, the Plan will pay the percentage of the Allowable Charge identified in the chart at the beginning of this Article II (and you are responsible for paying the rest) until you meet your Annual Out-of-Pocket Maximum. Once you have reached your Annual Out-of-Pocket Maximum, the Plan will pay 100% of the Allowable Charges for services and supplies provided by in-network providers for the remainder of the calendar year.

(b) Out-of-Network Cost Sharing

Out-of-network cost sharing will generally apply to services and supplies you receive from out-of-network providers. This means that for most Comprehensive Medical Benefits, you must meet your out-of-network Deductible before the Plan will cover services and supplies provided by out-of-network providers. Once you have met your out-of-network Deductible, the Plan will pay the percentage of the Allowable Charge identified in the chart at the beginning of this Article II, and you

are responsible for paying the rest. Generally, amounts you pay to receive services and supplies from out-of-network providers do not count towards your Annual Out-of-Pocket Maximum. Additionally, once you have reached your Annual Out-of-Pocket Maximum, the Plan will continue to pay the percentage of the Allowable Charge identified in the chart at the beginning of this Article II for services and supplies you receive from out-of-network providers. Unless the Plan specifically provides otherwise, the Plan will not pay 100% of the Allowable Charges for services and supplies rendered by out-of-network providers.

(c) Exceptions Where In-Network Cost-Sharing Will Apply to Services and Supplies provided by Out-of-Network Providers

This Section 2.02(c) describes situations where in-network cost-sharing will apply to services and supplies provided by out-of-network providers.

(1) Emergency Services

If you receive Emergency Services from an out-of-network provider, the in-network cost-sharing rules will apply. This means that if you receive Emergency Services from an out-of-network provider, the Plan will pay the in-network percentage of the Allowable Charge identified in the chart at the beginning of this Article II for the services and supplies you receive. This also means that amounts you pay for the Emergency Services will count towards your Annual Out-of-Pocket Maximum. Once you meet your Annual Out-of-Pocket Maximum, the Plan will begin to pay 100% of the Allowable Charge for Emergency Services provided by out-of-network providers for the remainder of the calendar year.

If you are receiving Emergency Services from an out-of-network Hospital or Facility, on the date that you can be transferred to an in-network provider without significant risk to your life or health, out-of-network Coinsurance will apply to services and supplies provided by out-of-network providers unless the Plan specifically provides otherwise.

(2) Ancillary Benefits Received at In-Network Hospitals and Facilities

If you receive Ancillary Benefits from an out-of-network provider at an in-network Hospital or Facility, the in-network cost-sharing rules will apply. This means that if you receive Ancillary Benefits from an out-of-network provider at an in-network Hospital or Facility, the Plan will pay the in-network percentage of the Allowable Charge identified in the chart at the beginning of this Article II for the services and supplies you receive. This also means that amounts you pay for the Ancillary Benefits will count towards your Annual Out-of-Pocket Maximum. Once you meet your Annual Out-of-Pocket Maximum, the Plan will begin to pay 100% of the Allowable Charge for Ancillary Benefits provided by out-of-network providers at in-network Hospitals and Facilities for the remainder of the calendar year.

(3) Non-Ancillary Benefits Received at In-Network Hospitals and Facilities

If you receive Non-Ancillary Benefits from an out-of-network provider at an in-network Hospital or Facility, the in-network cost-sharing rules will apply unless the out-of-network provider provides you with notice of your rights under the No Surprises Act and you consent in writing to be Balanced Billed.

(i) If You Do Not Consent to Be Balanced Billed

If you do not consent to being Balanced Billed, the Plan will pay the in-network percentage of the Allowable Charge identified in the chart at the beginning of this Article II for the Non-Ancillary Benefits you receive. Additionally, amounts you pay for the Non-Ancillary Benefits will count towards your Annual Out-of-Pocket

Maximum and the Plan will begin to pay 100% of the Allowable Charge for the remainder of the calendar year for Non-Ancillary Benefits you receive from out-of-network providers at in-network Hospitals and Facilities unless you consent to be Balanced Billed.

(ii) If You Consent to Be Balanced Billed

If you consent to being Balanced Billed, the Plan will pay the out-of-network percentage of the Allowable Charge identified in the chart at the beginning of this Article II for the Non-Ancillary Benefits you receive. Additionally, amounts you pay for the Non-Ancillary Benefits will not count towards your Annual Out-of-Pocket Maximum and the Plan will not begin to pay 100% of the Allowable Charge for the remainder of the calendar year for Non-Ancillary Benefits you receive from out-of-network providers at in-network Hospitals and Facilities to the extent you consent to be Balanced Billed.

(4) Air Ambulance Services

If you receive air ambulance services from an out-of-network provider, the in-network cost sharing rules will apply. This means that if you receive air ambulance services from an out-of-network provider, the Plan will pay the in-network percentage of the Allowable Charge identified in the chart at the beginning of this Article II for the air ambulance services. This also means that amounts you pay for the air ambulance services will count towards your Annual Out-of-Pocket Maximum. Once you meet your Annual Out-of-Pocket Maximum, the Plan will begin to pay 100% of the Allowable Charge for air ambulance services provided by out-of-network providers for the remainder of the calendar year.

(5) Continuing Care Services

If you are a Continuing Care Patient and you are receiving items and/or services from a provider that ceases to be an in-network provider, the in-network cost sharing rules will continue to apply to the provider with respect to continuing care services until 90 days after the date you are notified that the provider is no longer an in-network provider. This means that during this period, the Plan will pay the in-network percentage of the Allowable Charge identified in the chart at the beginning of this Article II for the continuing care services. This also means that amounts you pay for continuing care services during this period will count towards your Annual Out-of-Pocket Maximum. Once you meet your Annual Out-of-Pocket Maximum, the Plan will begin to pay 100% of the Allowable Charge for continuing care services provided by the out-of-network provider until the earlier of: (1) 90 days after the date you are notified that the provider is no longer an in-network provider; or (2) the end of the calendar year.

(6) Provider Directory Errors

If you receive services and/or supplies from an out-of-network provider because Blue Cross and Blue Shield of Kansas City's ("Blue KC") provider directory incorrectly indicated that the provider is an in-network provider, the in-network cost sharing rules will apply to the services and/or supplies you receive from the out-of-network provider. The in-network cost sharing rules will also apply to an out-of-network provider if you receive services and/or supplies from the provider because Solxsys incorrectly advised you that the provider is an in-network provider. This means that in these circumstances, the Plan will pay the in-network percentage of the Allowable Charge identified in the chart at the beginning of this Article II for the services and/or supplies you receive from the provider. This also means that amounts you pay for the services and/or supplies will count towards your Annual Out-of-Pocket

Maximum. Once you meet your Annual Out-of-Pocket Maximum, the Plan will begin to pay 100% of the Allowable Charge for the remainder of the calendar year for services and supplies you receive from the out-of-network provider due to directory errors.

Section 2.03 - Covered Medical Services and Supplies

The Plan provides benefits that help cover the cost for a wide range of Medically Necessary supplies and services, including Physician, Hospital and Facility charges, diagnostic testing, and surgery. To the extent the benefits are Medically Necessary, the Comprehensive Medical Benefits covered by the Plan are listed in Section 2.03(a) through Section 2.03(y) below. Services and supplies provided to improve or maintain a Covered Person's general health are generally not covered. However, certain wellness and general preventive health care services and supplies are covered by the Plan as Routine Preventive Care Services. To the extent benefits are for Routine Preventive Care Services, the Comprehensive Medical Benefits covered by the Plan are listed in Section 2.04 below.

(a) Ambulance Services

The Plan covers licensed ambulance services for the following circumstances:

(1) To transport a Covered Person to the nearest appropriate Facility for care for an Emergency Medical Condition;

(2) To transport a Covered Person who has received Emergency Services or who is an inpatient at an acute care Facility to the nearest appropriate Facility where appropriate care can be provided;

(3) To transport a bedridden Covered Person to and from a Facility for Medically Necessary and appropriate treatment;

(4) To transport a ventilator-dependent Covered Person; and

(5) To transport a Covered Person who is confined in a Hospital or other Facility to and from the nearest appropriate Facility for testing and/or procedures that cannot be performed at the present Facility.

If you use an in-network provider's ambulance services, your claim will be treated as an in-network claim and the Plan's in-network cost sharing provisions will apply. Except as provided for in Section 2.02(c), if you use an out-of-network provider's ambulance services, your claim will be treated as an out-of-network claim and all out-of-network cost sharing provisions will apply. However, the Plan's in-network cost sharing provisions will apply to ambulance services provided by an out-of-network provider if no ambulance or other appropriate medical transportation services are available to you from an in-network provider (i.e., no in-network provider is capable of providing the specific ambulance services you require or no in-network provider provides ambulance services in the geographic area to or from which you are transported).

(b) Certain Dental Services

The Plan covers the following dental services as Comprehensive Medical Benefits (rather than Dental Benefits) when provided at a Hospital or Facility by a Physician, certified registered nurse anesthetist, or Dentist:

(1) Treatment of natural teeth resulting immediately and exclusively from an accidental injury;

(2) Cutting procedures for the treatment of diseases of the teeth, jaw, or gums;

(3) Treatment of fractures and dislocation of the jaw;

(4) Surgical removal of impacted teeth;

(5) Tooth implantation, but only if the implant is necessary because of an accident and bone replacement is required in the same area as the implant; and

(6) General anesthesia materials, their administration, and medical care Facility charges if provided to the following Covered Persons:

(i) Children age 7 and under; and

(ii) Persons who have medical or behavioral conditions requiring hospitalization or general anesthesia when dental care is provided. Prior authorization is required for Covered Persons requesting anesthesia under this Section 2.03(b)(6)(ii).

NOTE: Charges for the extraction of teeth, fillings, dentures, and straightening of teeth and other dental services not specifically described in this Section 2.03(b), including any other care or treatment related to the mouth, teeth, gums, or jaws (such as treatment of temporomandibular joint ("TMJ") syndrome) are specifically excluded from coverage as Comprehensive Medical Benefits. Any such services will be covered by the Plan, if at all, as Dental Benefits pursuant to Article IV. Oral surgery services provided in a Dentist's office are also specifically excluded from coverage as Comprehensive Medical Benefits. Oral surgery services provided in a Dentist's office will be covered by the Plan, if at all, as Dental Benefits pursuant to Article IV.

(c) Chiropractic Services

The Plan covers services performed by a licensed chiropractor during a visit to the chiropractor's office as Comprehensive Medical Benefits when such services are Medically Necessary, as determined in accordance with Blue KC's policies for chiropractic services.

The following limitations apply to chiropractic services:

- The Plan will not pay more than $50 per visit for chiropractic services.
- The Plan will not pay more than $600 per Covered Person per calendar year for chiropractic services.

(d) Diagnostic Services

The Plan covers diagnostic radiology and laboratory services that are prescribed by a Physician in connection with a Sickness or Injury.

(e) Durable Medical Equipment and Medical Supplies

The Plan covers rental or purchase (whichever costs less) of durable medical equipment and medical supplies. To be covered by the Plan, the durable medical equipment or medical supplies must be prescribed by a Physician and certified by the prescribing Physician as being Medically Necessary for the treatment of a Sickness or Injury. The Plan will not cover equipment that serves solely for your convenience or comfort. Benefits are also not available from the Plan for medical equipment used, rented, or purchased for use during a Covered Person's confinement in a Hospital, skilled nursing Facility, intermediate care Facility, nursing home, or any other Facility.

Any charge in excess of the lesser of the cost for renting or purchasing the necessary equipment will not be calculated into the determination of the Allowable Charge for durable medical equipment or medical supplies.

If the durable medical equipment or medical supplies are provided to you by an in-network provider, your claim will be treated as an in-network claim and the Plan's in-network cost sharing provisions will apply. If the durable medical equipment or medical supplies are provided to you by an out-of-network provider, your claim will generally be treated as an out-of-network claim and the Plan's out-of-network cost sharing provisions will apply. However, if Medically Necessary and appropriate durable medical equipment or medical supplies are provided to you by an out-of-network provider because the durable medical equipment or medical supplies are not available through an in-network provider, the Plan will cover 80% of the cost of the durable medical equipment or medical supplies after you have met your Deductible.

(f) Employee Assistance Program ("EAP")

The Plan provides a free program to help Covered Persons cope with personal difficulties that can affect their lives both at home and at work.

This free program is provided by Empathia and called the LifeMatters program. The LifeMatters program assists Covered Persons with a variety of life problems including alcohol and drug abuse; stress, anxiety, and depression; marital, family, and relationship problems; child and adolescent behavioral problems; domestic violence; child care; elder care; financial and legal concerns; and educational and career related problems. All contact with Empathia is confidential.

To utilize the LifeMatters program, please contact Empathia at (800) 634-6433. Information is also available at: http://members2.mylifematters.com/portal/welcome/sso.

(g) Hearing Aid Benefits

The Plan covers 100% of the cost of a hearing aid, up to a maximum of $2,000, once within a five-calendar year period. You do not have to satisfy a Deductible before the Plan will reimburse you for your hearing aid purchase.

(h) Home Health Care Services

The Plan covers home health care services (e.g., home health aide, in-home skilled nursing care) if the services are provided in accordance with a home health care plan established by your treating Physician. Home health care services are only covered by the Plan if you would have had to be hospitalized if the services were not available in your home.

NOTE: Home Health Care Services provided to a Covered Person while (s)he is receiving Hospice Care are not covered under this Section 2.03(h). Refer to Section 2.03(i) for a description of coverage for Home health care services provided in connection with Hospice Care.

(i) Hospice Care Services

The Plan covers Hospice Care Services provided by an approved Hospice program for palliative care or management of a terminal illness for up to a maximum of 210 days. The Plan also covers Hospice Care Services provided to a Covered Person's family, as explained in Section 2.03(i)(2).

(1) Qualification for Hospice Care Services

The following criteria must be met before you are eligible to receive Hospice Care Services under this Section 2.03(i):

(i) A Physician must certify that you are terminally ill and have a life expectancy of six months or less if your Sickness runs its normal course;

(ii) The charges must be incurred at a Hospice care program certified as such under the federal Medicare Program or by the Joint Commission on Accreditation of Healthcare Organizations;

(iii) A written Hospice care plan must be drafted by the Hospice program and approved by your treating Physician;

(iv) The program must provide for Hospice Care Services to be provided to you at home rather than in a Hospital, nursing home, or other Facility; and

(v) The program must agree to accept the Hospice Care Services benefits provided under this Plan as payment in full for services and supplies provided to you.

(2) Covered Hospice Care Services

Covered Hospice Care Services are limited to the Allowable Charges for the following services:

(i) Nursing care provided by or under the supervision of a Registered Nurse;

(ii) Physical, occupational, and speech therapy;

(iii) Medical social services, if under the direction of a Physician;

(iv) Personal care services and household services needed to maintain a safe and sanitary environment, but only if not provided by either a person who ordinarily resides in your household or a person who is a member of your family;

(v) Drugs, medical supplies, and the use of medical appliances or durable medical equipment;

(vi) Physician services;

(vii) Short-term inpatient care in an appropriate inpatient Facility ("crisis care"), but only on an intermittent, non-routine, and occasional basis, and for no more than five (5) consecutive days; and

(viii) Counseling for members of your family with respect to your care and the adjustment to your death.

The Plan covers 100% of the Allowable Charges for Hospice care services, regardless of whether the Hospice care services are provided by an in-network provider or an out-of-network provider.

Treatment for any medical condition other than the life threatening Sickness is not covered under this Section 2.03(i).

(j) Hospital - Emergency Room Services

The Plan covers treatment and services that you receive when you are in a Hospital emergency room. The treatment and services covered under this Section 2.03(j) include treatment for Mental Health Care Conditions and substance abuse.

As explained in Section 2.02(c), if you receive Emergency Services from an out-of-network provider, the in-network cost-sharing rules will apply.

(k) Hospital and Facility - Inpatient Services

The Plan covers Hospital and Facility - inpatient services. Treatment and services will be covered under this Section 2.03(k) only if the treatment and services you need cannot be provided in a more cost-effective environment, such as an in-network outpatient surgical center, a Doctor's office or other type of outpatient clinic, or your home. The Plan will pay its share of the charges for your confinement (or partial confinement) in another medical Facility only if such confinement is made in lieu of hospitalization. All Allowable Charges for Medically Necessary services and supplies provided in the Hospital will be covered as follows:

(1) If intensive care or other specialized unit confinement is Medically Necessary, the Plan will cover the Allowable Charge for room and board in such unit;

(2) If confinement in a private room is Medically Necessary, the Plan will cover the Allowable Charge for room and board in such private room; or

(3) In all other cases, the Plan will cover the lesser of the Allowable Charge for a semi-private room and the actual billed charge for Facility services. Charges for confinement or partial confinement in a Facility other than a Hospital will be covered only to the extent they do not exceed the charge that otherwise would have been incurred in a Hospital.

The Plan does not cover inpatient services provided at out-of-network Hospitals and Facilities. Unless one of the exceptions described in Section 2.02(c) applies, the Plan's out-of-network cost-sharing provisions will apply to inpatient services provided by out-of-network providers at in-network Hospitals and Facilities.

NOTE: Hospital inpatient services provided to you while you are receiving Hospice care are not covered under this Section 2.03(k). Refer to Section 2.03(i) for a description of coverage for inpatient Hospital and Facility services provided in connection with Hospice care.

(l) Hospital and Facility - Outpatient Services

The Plan covers Hospital and Facility - outpatient services as Comprehensive Medical Benefits. The treatment and services covered under this Section 2.03(l) include Specialty Drugs (including IV infusion therapy) that are administered at the Hospital or Facility.

(m) Maternity Services

The Plan covers maternity services provided in connection with pregnancy and childbirth for an Eligible Employee, Retiree, or spouse (but not in connection with a Dependent child's pregnancy or childbirth by a Dependent child), including follow-up Hospital care for the mother and newborn for up to 48 hours following a vaginal delivery or up to 96 hours following a cesarean section. No benefits are available under this Plan in connection with the pregnancy of a Dependent child or for complications arising out of such Dependent child's pregnancy or childbirth.

For purposes of coverage as a Comprehensive Medical Benefit, pregnancy shall be deemed to be a "Sickness" and prenatal care, post-natal care, and care and treatment for complications of pregnancy or childbirth shall be covered in the same manner and subject to the same cost sharing requirements as other Sicknesses.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or

96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

The Plan does not cover inpatient maternity services provided at out-of-network Hospitals and Facilities. Unless one of the exceptions described in Section 2.02(c) applies, the Plan's out-of-network cost-sharing provisions will apply to inpatient maternity services provided by out-of-network providers at in-network Hospitals and Facilities.

(n) Mental Health and Substance Abuse Services

(1) Inpatient Mental Health Care Services

The Plan covers inpatient mental health services provided at in-network facilities, provided the services are provided by an accredited and licensed Hospital or Treatment Facility.

If a Covered Person requires inpatient treatment for a dual diagnosis of alcohol or other drug abuse and another Mental Health Care Condition, benefits will not be paid under this Section 2.03(n)(1) but instead will be paid only under Section 2.03(n)(2). No benefits for the inpatient treatment of a Mental Health Care Condition shall be provided under any other section of this Plan, except that an Eligible Employee may receive Accident and Sickness Loss of Time Benefits, as set forth in Article VIII, while receiving covered inpatient treatment.

NOTE: The Plan does not cover inpatient mental health care services provided at out-of-network Hospitals and Facilities. Unless one of the exceptions described in Section 2.02(c) applies, the Plan's out-of-network cost-sharing provisions will apply to inpatient mental health care services provided by out-of-network providers at in-network Hospitals and Facilities.

(2) Outpatient Mental Health Care Services

The Plan will cover outpatient mental health care services provided by a duly-licensed Physician, Nurse Practitioner, or Mental Health Care Provider.

The Plan will pay 100% of the cost of outpatient mental health care services that are provided due to a referral that was made by Empathia.

The cost sharing arrangement for any outpatient mental health care services obtained within two years of undergoing an amputation, including a mastectomy, will be the same as that for outpatient medical and surgical benefits provided under this Plan.

(3) Inpatient Substance Abuse Treatment Services

The Plan covers inpatient substance abuse treatment services provided at in-network facilities, provided the services are provided by an accredited and licensed Hospital or Treatment Facility.

The Plan will pay 100% of Medically Necessary inpatient substance abuse treatment services provided by an in-network provider, up to a maximum benefit of $7,500.00 per Covered Person per calendar year. Thereafter, the Plan will cover Medically Necessary inpatient substance abuse treatment services at an in-network Hospital or Facility as an in-network claim and the Plan's in-network cost sharing provisions will apply.

NOTE: The Plan does not cover inpatient substance abuse treatment services provided at out-of-network Hospitals and Facilities. Unless one of the exceptions described in Section 2.02(c) applies, the Plan's out-of-network cost-sharing provisions will apply to inpatient substance abuse treatment services provided by out-of-network providers at in-network Hospitals and Facilities.

(4) Outpatient Substance Abuse Treatment Services

The Plan covers outpatient substance abuse treatment services (including "after care" following inpatient substance abuse treatment when such care is not included in the charge for inpatient treatment) provided by a duly-licensed Physician, Nurse Practitioner, Mental Health Care Provider, or alcohol or drug dependency counselor. Treatment rendered by a provider who is not a licensed Physician, Nurse Practitioner, or Mental Health Care Provider must be provided through a licensed outpatient alcoholism or drug dependency treatment center for such treatment to be covered by the Plan.

The Plan will pay 100% of the cost of outpatient substance abuse treatment services that are provided due to a referral that was made by Empathia.

(o) Nurse Practitioner Retail Clinic Visits

The Plan covers Nurse Practitioner Retail Clinic visits (e.g., CVS MinuteClinics, Walgreens Take Care Clinics, Mercy Quick Clinics, etc.). The Section 2.02 rules regarding cost sharing for Comprehensive Medical Benefits do not apply to covered services provided at Nurse Practitioner Retail Clinics. The required copayment for each visit to an in-network Nurse Practitioner Retail Clinic is $15.00. The Plan will pay 100% of the expenses for covered services provided at an in-network Nurse Practitioner Retail Clinic in excess of the $15.00 for each visit to a Nurse Practitioner Retail Clinic. Nurse Practitioner Retail Clinic visits to an out-of-network provider will be treated as an out-of-network claim and the Plan's out-of-network cost sharing provisions will apply.

NOTE: Once you have met your Annual Out-of-Pocket Maximum, the Plan will pay 100% of the Allowable Charge for covered services provided at an in-network Nurse Practitioner Retail Clinic (i.e., you will no longer have to pay $15.00 for each visit to a Nurse Practitioner Retail Clinic).

(p) Organ and Tissue Transplant Services

The Plan covers organ and tissue transplant services and supplies. With the exception of corneal tissue transplants, organ and tissue transplant services must receive prior authorization from the Plan for both the procedure and the Facility where the procedure will occur. If your organ and tissue transplant services do not receive prior authorization from the Plan, your claims for these services will be denied solely due to your failure to get prior authorization. If it appears that you may need organ and tissue transplant services, the Plan encourages you to review these services with your Physician.

The Plan's coverage of organ and tissue transplant services and supplies are subject to the following additional rules and limitations:

(1) Covered Organ Transplant Services

Covered organ and tissue transplant services are limited to services and supplies ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician charges, organ procurement, and related transplant services. Coverage is limited to the following transplants only when such transplants are Medically Necessary in accordance with Blue KC's policies for transplantation services:

(i) Blood or marrow stem cell transplant procedures;

(ii) Corneal tissue transplant;

(iii) Heart transplant;

(iv) Simultaneous heart-lung transplant;

(v) Kidney transplant;

(vi) Liver transplant;

(vii) Pancreas transplant;

(viii) Simultaneous pancreas-kidney transplant;

(ix) Simultaneous liver-kidney transplant;

(x) Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis;

(xi) Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas; and

(xii) Single, double, or lobar lung transplant. For Covered Persons with end-stage cystic fibrosis, benefits for lung transplantation are limited to double lung transplants.

(2) Related Transplant Services

Covered organ and tissue transplant services include the following related transplant services:

(i) Extraction or reinfusion of blood or marrow stem cells as part of a covered allogeneic or autologous transplant.

(ii) Harvesting, immediate preservation, and storage of stem cells when an autologous blood or marrow stem cell transplant has been scheduled or is anticipated to be scheduled within an appropriate time frame for Covered Persons diagnosed at the time of harvest. Benefits are available for charges related to fees for storage of harvested autologous blood or marrow stem cells related to a covered autologous stem cell transplant that has been scheduled or is anticipated to be scheduled within an appropriate time frame.

(iii) Collection, processing, storage, and distribution of cord blood only when provided as part of a blood or marrow stem cell transplant scheduled or anticipated to be scheduled within an appropriate time frame.

(iv) High-dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for covered transplant procedures.

(v) Testing, typing, or screening when an individual becomes a transplant or tissue donor to a Covered Person.

(vi) Medical and Hospital expenses incurred by an organ donor in connection with covered transplant services provided to a Covered Person.

(3) Re-transplantation

The Plan covers Medically Necessary re-transplantation of organs. With the exception of corneal tissue re-transplantation, re-transplantation of organs must receive prior authorization from the Plan. If your organ and tissue re-transplant services do not receive prior authorization from the Plan, your claims for these services will be denied solely due to your failure to get prior authorization. Review for a re-transplantation request will include review of your compliance with relevant transplant selection criteria including, but not limited to, adherence to medication regimens and abstinence from the use of alcohol and drugs.

(4) Exclusions

The Plan does not cover the following organ and tissue transplant-related services, supplies, equipment, or care, or any complications related to or received in connection with such services, supplies, equipment, or care:

(i) Travel and/or lodging expenses for the patient, donor, or family;

(ii) Nonhuman or mechanical organ and tissue transplants;

(iii) Testing, typing, or screening when the person does not become a transplant or tissue donor;

(iv) Long-term storage of stem cells;

(v) Services that are not pre-authorized as required by this Section 2.02(p) unless such services are provided in connection with a corneal tissue transplant; and

(vi) Services that are excluded under Section 2.05.

The Plan does not cover organ and tissue transplant services provided at out-of-network Hospitals and Facilities. Unless one of the exceptions described in Section 2.02(c) applies, the Plan's out-of-network cost-sharing provisions will apply to organ and tissue transplant services provided by out-of-network providers at in-network Hospitals and Facilities.

(q) Phenyl-Free Formula

The Plan covers 80% of the Allowable Charges for infant formula recommended by a Physician for treatment of phenylketonuria or any inherited disease of amino and organic acids, up to a maximum of $5,000.00 per Covered Person per calendar year (i.e., the $5,000 limit applies separately for each infant for whom a Physician recommends formula for treatment of phenylketonuria or any inherited disease of amino and organic acids).

(r) Physical Therapy

The Plan covers physical therapy, occupational therapy, radiation therapy, physical rehabilitation, cardiac rehabilitation, and respiratory therapy or rehabilitation so long as the treatment or therapy is administered by a properly licensed or certified health care provider, is prescribed by a Physician, and is generally recognized as an appropriate and reasonable treatment by Physicians specializing in the area of medicine implicated by the treatment. The Plan will cover up to 60 physical therapy visits per Covered Person per calendar year regardless of whether or not the physical therapy visits are Medically Necessary. The Plan will not cover more than 60 physical therapy visits per Covered Person per calendar year unless such visits are Medically Necessary.

NOTE: Physical therapy provided to you while you are an inpatient in a Hospital is covered under Section 2.03(k), not this Section 2.03(r). Refer to Section 2.03(k) for a description of coverage for inpatient Hospital and Facility services.

(s) Physician and Physician Assistant Visits

The Plan covers services and supplies for the treatment of Sickness or Injury (including diagnostic treatment and surgical treatment) when the services and supplies are received during a Physician office visit, whether performed at a Doctor's office or clinic.

(t) Prosthetics and Orthotics

The Plan covers prosthetic and orthotic devices. Coverage is limited to the initial purchase and fitting of prosthetic and orthotic devices that are necessary as a result of congenital defects, Sickness, or Injury. Initial purchase and fitting means the entire process necessary to provide a Covered Person's prosthesis and may include one or more temporary prosthetic and/or orthotic devices when Medically Necessary. No benefits are payable from this Plan for prosthetics that may enhance function after the initial purchase. Repair or replacement of a prosthetic or orthotic device is covered only when Medically Necessary because of the following:

(1) A change in the physiological condition of the Covered Person;

(2) An irreparable change in the condition of the device; or

(3) The condition of the device requiring repairs and the cost of such repairs being more than 60% of the cost of a replacement device.

No benefits are payable under the Plan for repairs and replacements if the need for repair or replacement is due to misuse or abuse of the device, or to the extent the device is covered under warranty. Additionally, no benefits are payable under this Plan for replacements of prosthetic and orthotic devices due to changes in technology. No benefits are payable under the Plan for prosthetics that may enhance function after the initial purchase.

Benefits are limited to the amount available for a basic (standard) item which meets the minimum specifications to allow for necessary activities of daily living. Activities of daily living include bathing, dressing, eating, continence, toileting, transferring, and/or ambulating. Charges for deluxe or electronically operated prosthetic or orthotic devices are not covered beyond the extent allowed for basic (standard) items.

If a Medically Necessary and appropriate prosthetic or orthotic device is available through an in-network provider and is authorized by the Plan Administrator, your claim will be treated as an in-network claim and the Plan's in-network cost sharing provisions will apply. If a Medically Necessary and appropriate prosthetic or orthotic device is not available through an in-network provider and is authorized by the Plan Administrator, the Plan will pay 80% of the Allowable Charge after you have met your Deductible.

NOTE: Foot orthotics, including shoes, are covered under Section 2.03(e), not this Section 2.03(t). Refer to Section 2.03(e) for a description of coverage of durable medical equipment and medical supplies.

(u) Second Surgical Opinion

The Plan covers a second surgical opinion that is provided by a Physician to determine whether a proposed surgery is appropriate for your Sickness or injury. The Plan will pay 100% of Covered Charges for a second surgical opinion regardless of whether the opinion is provided by an in-network provider or an out-of-network provider. An opinion from a Physician that performs your surgery is not considered a second surgical opinion and is not covered under this Section 2.03(u).

(v) Speech Therapy

The Plan covers speech therapy to treat the loss or impairment of speech or hearing disorders, so long as the speech therapy is administered by a properly licensed or certified health care provider, is prescribed by a Physician, and is necessary due to at least one of the following:

(1) Injury;

(2) Permanent, moderate to severe, bilateral sensorineural hearing loss;

(3) Birth defects; or

(4) Sickness.

Benefits include examination, evaluation, counseling, and any testing required to diagnose the loss or impairment of speech or hearing. The Plan will cover up to 20 speech therapy visits per Covered Person per calendar year regardless of whether or not the speech therapy visits are Medically Necessary. The Plan will not cover more than 20 speech therapy visits per Covered Person per calendar year unless the speech therapy is being used to treat a Mental Health Care Condition or a determination is made that the additional visits are Medically Necessary.

NOTE: Speech therapy provided to you while you are an inpatient in a Hospital is covered under Section 2.03(k), not this Section 2.03(v). Refer to Section 2.03(k) for a description of coverage for inpatient Hospital and Facility services.

(w) Surgical Services

The Plan covers inpatient and outpatient surgical procedures provided by a Physician at a Physician's office, Hospital, or Facility. The Plan also covers services performed in connection with and related to covered surgical procedures, including preoperative care, postoperative care, and anesthesia.

The Plan does not cover inpatient surgical services provided at out-of-network Hospitals and Facilities. The Plan will cover inpatient surgical services provided by out-of-network providers at in-network Hospitals and Facilities. Unless one of the exceptions described in Section 2.02(c) applies, the Plan's out-of-network cost-sharing provisions will apply to inpatient surgical services provided by out-of-network providers at in-network Hospitals and Facilities.

The following covered surgical services are subject to special terms and conditions:

(1) Bariatric Surgery

The Plan covers bariatric surgery and related services. You must receive prior authorization from the Plan for bariatric surgery services. If your bariatric surgery services do not receive prior authorization from the Plan, your bariatric surgery and related services will be denied solely due to your failure to get prior authorization. If it appears that you may need bariatric surgery services, the Plan encourages you to review these services with your Physician.

The following rules and limitations apply to Comprehensive Medical Benefits payable for bariatric surgery and related services:

(i) If you receive services related to bariatric surgery prior to receiving approval for your bariatric surgery, these services will initially be denied. However, if your bariatric surgery is subsequently approved, then the Plan will review your claims history and adjust claims for services related to bariatric surgery that you received prior to approval of your bariatric surgery.

(ii) The Plan will only cover one bariatric surgical procedure per Covered Person per lifetime unless a Medically Necessary need arises to correct or reverse a complication from a previous bariatric surgery.

(iii) The maximum benefit payable by the Plan for bariatric surgery and related services is $20,000 per Covered Person per lifetime. This $20,000 limit applies to the bariatric surgery and all related services, including treatment of any complications that result of the surgery.

(iv) Services that are related to bariatric surgery include, but are not limited to, esophagogastroduodenoscopy, preoperative medical consultations, preoperative psychiatric consultations, nutritional counseling, Medically Necessary follow-up surgery to correct complications due to the bariatric surgery, post-surgical counseling, routine follow-up visits, Medically Necessary testing, Medically Necessary excess skin removal and routine follow-up visits and lab work.

(2) Mastectomy Surgery

The Plan covers mastectomies and related services that are treated in accordance with the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). If you are receiving benefits from the Plan in connection with a mastectomy and you elect breast reconstruction in connection with such mastectomy, the Plan will provide coverage for the following treatments in a manner determined in consultation with you and the attending Physician:

(i) All stages of reconstruction of a breast on which a mastectomy has been performed;

(ii) Surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance in a manner determined between the Covered Person and the attending Physician;

(iii) Coverage for prostheses and physical complications of all states of mastectomy (including lymphedema); and

(iv) Treatment of physical complications of the mastectomy, including lymphedema.

(x) Telehealth Benefits

The Plan covers 100% of the Allowable Charge for telehealth visits provided by Blue KC Virtual Care. This means that Deductibles and Coinsurance described in the chart at the beginning of this Article II do not apply to telehealth visits provided by Blue KC Virtual Care (i.e., you will not have to pay a Deductible or Coinsurance for a telehealth visit provided by Blue KC Virtual Care).

If you receive telehealth benefits from an in-network provider other than Blue KC Virtual Care, your claim will be treated as an in-network claim and the Plan's in-network cost sharing provisions will apply. If you receive telehealth benefits from an out-of-network provider, your claim will be treated as an out-of-network claim and the Plan's out-of-network cost sharing provisions will apply.

(y) Well Child Benefits

The Plan covers the following Physician-delivered or Physician-supervised well child examinations, including routine well baby care, pediatric preventative services, developmental assessment, and appropriate immunizations and laboratory tests:

(1) All routine and well-child examinations between birth and the child's first birthday;

(2) Five well-child examinations in each of the following periods:

(i) Between the day after the child's first birthday and the child's second birthday; and

(ii) Between the day after the child's second birthday and the child's third birthday;

(3) One well-child examination in each of the following periods:

(i) Between the day after the child's third birthday and the child's fourth birthday;

(ii) Between the day after the child's fourth birthday and the child's fifth birthday;

(iii) Between the day after the child's fifth birthday and the child's sixth birthday; and

(iv) Between the day after the child's sixth birthday and the child's seventh birthday;

(4) No well-child benefits after the child's seventh birthday.

After you have paid your child's Deductible, the Plan will pay 100% of the Allowable Charge for well child benefits regardless of whether the services are provided by an in-network Provider or out-of-network Provider. Certain services and supplies, such as immunization, may be covered as Routine Preventive Care Benefits. Well child benefits that exceed the frequency limitations listed above may also be covered as Routine Preventive Care Benefits. Refer to Section 2.04 for a description of coverage for Routine Preventive Care Benefits.

Section 2.04 - Routine Preventive Care Services

The Plan covers the Routine Preventive Care Services that are considered preventive care under the Affordable Care Act. The Plan will pay the following percentages for Routine Preventive Care Services:

(a) For Routine Preventive Care Services provided by an in-network provider on an outpatient basis, the Plan will waive the Deductible and pay 100% of the cost.

(b) For Routine Preventive Care Services provided by an in-network provider on an inpatient basis, the Plan will waive the Deductible and pay 100% of the cost if the provider itemizes the services rendered during the inpatient visit. If the provider does not itemize Routine Preventive Care Services (for example, if the provider bills the Plan a certain amount for the entire day rather than a separate amount for each service rendered on that day), the Routine Preventive Care Services will be subject to the Plan's standard in-network cost sharing provisions.

(c) For Routine Preventive Care Services provided by an out-of-network provider on an outpatient basis, the Plan will waive the Deductible and pay 100% of the cost up to $300 per Covered Person per calendar year. After the first $300, the Plan will pay 60% of the Allowable Charge after the Covered Person has met his/her Deductible (i.e., out-of-network services over $300 per calendar year are subject to the Plan's standard out-of-network cost sharing provisions) unless the Plan's in-network cost sharing provisions apply in accordance with Section 2.02(c).

(d) The Plan will not cover Routine Preventive Care Services provided by an out-of-network provider on an inpatient basis unless the Plan's in-network cost sharing provisions apply in accordance with Section 2.02(c).

(e) For the childhood immunizations listed in this Section 2.04, the Plan will pay 100% of the cost regardless of whether the immunizations are provided by an in-network provider or out-of-network provider.

Routine Preventive Care Services are available for all Covered Persons but different limitations apply depending on the specific category of routine preventive care services. The table below provides a list of Routine Preventive Care Services covered by the Plan and their limitations. If you do not meet the requirements and limitations described in the chart in this Section 2.04, you will be responsible for the applicable cost sharing requirements listed in the chart at the beginning of this Article II, provided that the service is otherwise covered under Section 2.03 (i.e., if you do not meet the requirements and limitations, the applicable Deductibles and Coinsurance will apply to the supplies and services you receive).

This list is subject to change. You can obtain a complete list of routine preventive care services covered by the Plan by contacting the Fund Office. Covered Persons who have current symptoms or a diagnosed health problem will receive benefits under Section 2.03 above, not this Section 2.04.

ROUTINE PREVENTIVE CARE SERVICE	COVERAGE DETAILS AND LIMITATIONS
Abdominal aortic aneurysm screening (Men)	One-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.
Additional examinations, testing and services: • Hemoglobin/Complete Blood Count ("CBS"); • Metabolic screening; and • Hearing exams	
Alcohol misuse (screening and counseling)	Clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.
Bacteriuria screening (pregnant women)	Screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.
Blood pressure screening in adults	Screening for high blood pressure in adults age 18 years and older obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
BRCA risk assessment and genetic counseling/testing	Primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.
Breast cancer screening	Screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.
Breastfeeding interventions	Provide interventions during pregnancy and after birth to promote and support breastfeeding.
Cervical cancer screening	Screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus ("HPV") testing every 5 years.
Chest x-ray	
Chlamydia Trachomatis testing	
Chlamydia screening (women)	Screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection.

ROUTINE PREVENTIVE CARE SERVICE	COVERAGE DETAILS AND LIMITATIONS
Colorectal cancer exams and laboratory tests consisting of a digital rectal exam and the following: • Fecal occult blood test; • Fecal DNA test; • Flexible sigmoidoscopy; • Colonoscopy; and • Double contrast barium enema	Screening for colorectal cancer starting at age 45 years and continuing until age 75 years.
Contraceptive methods and counseling	All FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity.
Dental caries prevention (infants and children up to age 5 years)	Application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices. Primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.
Depression screening (adolescents)	Screening for major depressive disorder ("MDD") in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
Depression screening (adults)	Screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
Diabetes screening	Screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 35 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.
Electrocardiogram ("EKG")	
Falls prevention in older adults: exercise or physical therapy	Exercise or physical therapy to prevent falls in community-dwelling audits age 65 years or older who are at an increased risk for falls.
Gestational diabetes mellitus screening	Screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.
Glucose screening	
Gonorrhea prophylactic medication (newborns)	Prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.
Gonorrhea testing	

ROUTINE PREVENTIVE CARE SERVICE	COVERAGE DETAILS AND LIMITATIONS
Healthy diet and physical activity counseling to prevent cardiovascular disease (adults with cardiovascular risk factors)	Offering or referring adults who are overweight or obese and have additional cardiovascular disease ("CVD") risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.
Healthy weight and weight gain in pregnancy behavioral counseling interventions	Offering pregnant women behavioral counseling that is aimed at promoting healthy weight gain and preventing excess gestational weight gain during the pregnancy.
Hemoglobinopathies screening (newborns)	Screening for sickle cell disease in newborns.
Hepatitis B screening (non-pregnant adolescents and adults)	Screening for hepatitis B virus infection in persons at high risk for infection.
Hepatitis B screening (Pregnant women)	Screening for hepatitis B virus infection in pregnant women at their first prenatal visit.
Hepatitis C screening (adults)	Screening for Hepatitis C virus infection in adults ages 18 to 79 years.
HCV infection screening (adults)	Screening for HCV infection in persons at high risk for infection. Also recommends offering a 1-time screening for HCV infection to adults born between 1945 and 1965.
HIV screening (non-pregnant adolescents and adults)	Clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.
HIV screening (pregnant women)	Clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.
HPV testing	
Hypothyroidism screening (newborns)	Screening for congenital hypothyroidism in newborns.
Immunizations	Covered Immunizations are limited to parameters recommended by the Advisory Committee on Immunization Practices and/or adopted by the Center for Disease Control. • Catch-up for Hepatitis B; • Catch-up for varicella; • Catch-up for measles, mumps, and rubella; • Tetanus boosters as necessary, including tetanus, diphtheria and pertussis; diphtheria and tetanus; and tetanus only; • Pneumococcal vaccine; • Influenza virus vaccine; • Meningococcal vaccine; • Catch-up for Hepatitis A; • HPV vaccine; • Shingles vaccine; • Polio vaccine; and • Haemophilus Influenza Type b ("Hib") vaccine

ROUTINE PREVENTIVE CARE SERVICE	COVERAGE DETAILS AND LIMITATIONS
Immunizations (childhood)	• At least 5 doses of vaccine against diphtheria, pertussis, tetanus; • At least 4 doses of vaccine against polio, Haemophilus Influenza Type b ("Hib"); • At least 3 doses of vaccine against Hepatitis B; • 2 doses of vaccine against measles, mumps, and rubella; • 2 doses of vaccine against varicella; • At least 4 doses of vaccine against pediatric pneumococcal ("PCV7"); • 1 dose of vaccine against influenza; • At least one dose of vaccine against Hepatitis A; • 3 doses of vaccine against Rotavirus; and • Such other vaccines and dosages as may be prescribed by the State Department of Health
Intimate partner violence screening (women of childbearing age)	Clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.
Lead testing	
Lipid cholesterol panel	
Lung cancer screening	Annual screening for lung cancer with low-dose computed tomography in adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
Mammograms (if ordered by a Physician)	Includes those performed at the direction of a Physician in a mobile Facility certified by the Centers for Medicare and Medicaid Services ("CMS").
Newborn hearing screening, audiological assessment, and follow-up, and initial amplifications	
Obesity screening and counseling (adults)	Screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m2 or higher to intensive, multicomponent behavioral interventions.
Obesity screening and counseling (children and adolescents)	Clinicians screen for obesity in children and adolescents age 6 years and older and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.

ROUTINE PREVENTIVE CARE SERVICE	COVERAGE DETAILS AND LIMITATIONS
Osteoporosis screening (women)	Screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.
Outpatient Physician Examinations	
Pelvic exams and pap smears	Includes those performed at the direction of a Physician in a mobile Facility certified by the CMS.
Phenylketonuria screening (newborns)	Screening for phenylketonuria in newborns.
Preeclampsia prevention screening	Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.
Prostate exams and prostate specific antigen ("PSA") tests	
Rh incompatibility screening (first pregnancy visit)	Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.
Rh incompatibility screening (24-28 weeks' gestation)	Repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.
Sexually transmitted infections counseling	High-intensity behavioral counseling to prevent sexually transmitted infections ("STIs") in all sexually active adolescents and for adults at increased risk for STIs.
Skin cancer behavioral counseling	Counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
Syphilis screening (non-pregnant persons)	Clinicians screen persons at increased risk for syphilis infection.
Syphilis screening (pregnant women)	Clinicians screen all pregnant women for syphilis infection.
Thyroid Stimulating hormone screening	
Tobacco use counseling and interventions (non-pregnant adults)	Clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration ("FDA")-approved pharmacotherapy for cessation to adults who use tobacco. This includes two tobacco cessation attempts per year (both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by an in-network health care provider without prior authorization.

ROUTINE PREVENTIVE CARE SERVICE	COVERAGE DETAILS AND LIMITATIONS
Tobacco use counseling (pregnant women)	Clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco. This includes two tobacco cessation attempts per year (both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by an in-network health care provider without prior authorization.
Tobacco use interventions (children and adolescents)	Clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents. This includes two tobacco cessation attempts per year (both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by an in-network health care provider without prior authorization.
Tuberculosis screening (adults)	Screening for latent tuberculosis infection in populations at increased risk.
Unhealthy alcohol use screening (adults)	Screening for unhealthy alcohol use in primary care settings in adults age 18 and older and providing brief behavioral counseling interventions to persons engaged in risky or hazardous drinking.
Urinalysis	
Visual screening (children)	Vision screening at least once in all children ages 3 to 5 years to detect amblyopia or its risk factors.

Section 2.05 - Comprehensive Medical Benefit Exclusions and Limitations

Comprehensive Medical Benefits will not be payable for any of the following:

(a) Any charges relating to any Sickness or Injury for which the Claimant has received or is entitled to receive compensation under any workers' compensation, occupational disease, or similar law or program, including all charges payable under workers' compensation, occupational disease, or similar law;

(b) Expenses for hospitalization for medical or surgical treatment provided at no charge to the Claimant or paid for by any government agency;

(c) Any expenses related to a Sickness or Injury caused by war or any act of war;

(d) Any expenses related to a Sickness or Injury while engaged in service with the armed forces of any nation or state;

(e) Expenses which neither the Claimant nor the Eligible Employee or Retiree (if the Claimant is a Dependent) is required to pay;

(f) Expenses for routine physical or screening examinations, except as specifically provided as Routine Preventive Care Benefits in accordance with Section 2.04;

(g) Expenses for hearing aids, except as provided under the Hearing Aid Benefit Program described in Section 2.03(g);

(h) Expenses for medical or surgical treatment rendered for cosmetic purposes as well as expenses for complications arising from such treatments;

(i) Expenses for services and supplies that are not Medically Necessary as well as complications arising from services and supplies that are not Medically Necessary unless a Plan provision specifically provides otherwise;

(j) Expenses that exceed the Plan's Allowable Charge limitations;

(k) Expenses for any contraceptive devices or treatments, except as specifically provided as Routine Preventive Care Benefits in accordance with Section 2.04;

(l) Expenses for any product or service whose use is experimental or investigational;

(m) Expenses for any product or service, such as air-conditioners, water beds, and filters, the principal purpose of which is convenience or general comfort;

(n) Expenses for any medical or surgical treatment or examination required by an employer as a condition of employment;

(o) Expenses for confinement in a nursing home, long-term care Facility, or any Facility primarily providing personal care, assisted living, and/or general custodial services, rather than acute medical care;

(p) Expenses that are not incurred while the Covered Person is covered under this Plan, unless a Plan provision specifically provides otherwise. An expense is incurred at the time the service or supply is actually provided;

(q) Expenses for dental treatment, except as provided in Section 2.03(b). Expenses for dental treatment that are not covered by Section 2.03(b) may be covered, if at all, as Dental Benefits in accordance with Article IV;

(r) Expenses for actual or attempted impregnation or fertilization, involving either the Covered Person or a surrogate as donor or recipient; for the diagnosis or treatment of infertility; or for any treatment of sexual dysfunction that is not caused directly by a Sickness or Injury. Expenses for actual or attempted impregnation or fertilization that are not covered by this Article II may be covered, if at all, as Prescription Drug Benefits in accordance with Article III;

(s) Expenses incurred for the treatment of obesity as well as expenses for complications arising from such treatment, except as provided in Section 2.03(w)(1) and Section 2.04;

(t) Expenses incurred by a Dependent child in connection with her pregnancy, the birth of her child, or complications arising from either, except as provided in Section 2.04;

(u) Expenses incurred at an out-of-network skilled nursing Facility, rehabilitation Hospital, or residential Treatment Facility;

(v) Expenses incurred for services provided on an inpatient basis at an out-of-network Hospital or other medical Facility. This exclusion does not apply to services provided in connection with an Emergency Medical Condition, as that term is defined in Section 2.01(d), continuing care services under Section 2.02(c)(5), or services that a Covered Person receives from an out-of-network provider due to a directory error, as explained under Section 2.02(c)(6);

(w) Expenses incurred for services leading to, in connection with, or resulting from sexual transformation or intersex surgery;

(x) Expenses incurred for molecular genetic testing for the purposes of health screening or if not part of a treatment regimen for a specific Sickness, except as provided in Section 2.04;

(y) Expenses incurred for genetic therapy that was not pre-authorized (i.e., the Plan does not cover genetic therapy unless the Covered Person received prior authorization for the therapy);

(z) Expenses incurred for infusions or injections of any of the Specialty Drugs that are included on the list of Specialty Drugs that are only covered by the Plan if purchased at a designated Blue KC specialty pharmacy or designated home infusion vendor. For purposes of this exclusion, a "designated Blue KC specialty pharmacy or designated home infusion vendor" is a specialty pharmacy, home infusion vendor, or hospital that has entered into a contract with Blue KC to provide specialty drugs at a specified rate. To find out if an entity is considered a designated Blue KC specialty pharmacy or designated home infusion vendor, please call Blue KC for prior authorization using the number on the back of your ID card.

The Benefits Exclusions and Limitations in this Section 2.05 do not apply to Hospital - Emergency Room Services in Section 2.03(j) rendered for a Medical Emergency to the extent required by the No Surprises Act.

Section 2.06 - Medicare Advantage and Prescription Drug Plan ("MAPD")

Effective January 1, 2023, if you are a Retiree or a Dependent of a Retiree who has Medicare as your Primary Plan, you will be automatically enrolled in the MAPD. The MAPD is a separate Medicare Advantage and Prescription Drug Plan fully insured by UnitedHealthcare. If you are enrolled in the MAPD, you will not be eligible for benefits under this Article II.

If you are enrolled in the MAPD, you will be eligible for benefits through the MAPD. The MAPD will cover all of the benefits described in this Article II. Additionally, the MAPD will cover certain benefits that are not described in this Article II, including fitness club benefits and routine hearing exams. For information about the benefits available under the MAPD, contact UnitedHealthcare.

NOTE: If you are enrolled in the MAPD, it is important that you do not enroll in another Medicare Advantage program. Enrollment in any other Medicare Advantage program will result in immediate termination of your enrollment in the MAPD.

Section 2.07 - Filing a Claim

Different rules apply depending on whether your Comprehensive Medical Benefit claim is a Pre-Service Comprehensive Medical Benefit Claim or a Post-Service Comprehensive Medical Benefit Claim. Refer to Section 9.03 for a description of how to file a claim for Comprehensive Medical Benefits.

Section 2.08 - COVID-19 Vaccines and COVID-19 Testing

The rules in this Section 2.08 are temporary and only apply during the public health emergency that was declared by the Department of Health and Human Services with respect to COVID-19 ("Public Health Emergency"). Once the Public Health Emergency is over, the temporary rules described in this Section 2.08 will no longer apply and the Plan's standard rules will apply to COVID-19 vaccines and COVID-19 testing.

(a) COVID-19 Vaccines

The Plan will cover 100% of the cost of federally approved COVID-19 vaccines that are received during the Public Health Emergency. This rule applies regardless of whether a vaccine is administered by an in-network provider or an out-of-network provider.

After the date that the Public Health Emergency ends, COVID-19 vaccines will be covered as Routine Preventive Care Services in accordance with Section 2.04.

(b) COVID-19 Testing and Related Tests

During the Public Health Emergency, the Plan will cover COVID-19 tests and related tests in accordance with the following rules:

- For COVID-19 tests provided by an in-network provider, the Plan will pay 100% of the cost regardless of whether the test is administered, ordered, or prescribed at a Doctor's office, Facility, or Hospital.
- For other tests provided by an in-network provider (i.e., tests for conditions other than COVID-19), the Plan will pay 100% of the Allowable Charges if the test meets both of the following criteria:
    - The test causes a provider to administer, order, or prescribe a COVID-19 test; and
    - The test is administered during the same visit in which the COVID-19 test is administered, ordered, or prescribed.
- For COVID-19 tests provided by an out-of-network provider, the Plan will pay 100% of the cost up to the lesser of the cash price listed by the provider on a public internet website or the rate negotiated with the provider, regardless of whether the test is administered, ordered, or prescribed at a Doctor's office, Facility, or Hospital.
- For other tests provided by an out-of-network provider (i.e., tests for conditions other than COVID-19), the Plan will pay 100% of the cost up to the lesser of the cash price listed by the provider on a public internet website or the rate negotiated with the provider, if the test meets both of the following criteria:
    - The test causes a provider to administer, order, or prescribe a COVID-19 test; and
    - The test is administered during the same visit in which the COVID-19 test is administered, ordered, or prescribed.

Effective on the day immediately following the date the Public Health Emergency ends, the Plan's standard cost-sharing provisions will be applied to these benefits.

ARTICLE III - PRESCRIPTION DRUG BENEFITS

The following topics are discussed under this Article on Prescription Drug Benefits:

3.01 Definitions for this Article III Only
3.02 General Information
3.03 Deductibles, Copays, and Annual Out-of-Pocket Maximum
3.04 Covered Prescription Drugs
3.05 Filling a Prescription
3.06 Prior Authorization
3.07 Mandatory Mail Order for Maintenance Medications
3.08 Step Therapy
3.09 Opioid Drugs
3.10 Specialty Drugs
3.11 Routine Preventive Care Prescription Drug Benefits
3.12 Medicare Advantage and Prescription Drug Plan (“MAPD”)
3.13 Prescription Drug Benefit Exclusions and Limitations
3.14 COVID-19 Vaccines and At-Home COVID-19 Tests

<table>
<tr><th colspan="2">PRESCRIPTION DRUG BENEFITS</th></tr>
<tr><th colspan="2">DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS</th></tr>
<tr><td rowspan="2">Prescription Drug Benefit Deductible</td><td>Eligible Employee or a Dependent of an Eligible Employee: $200 Person / $400 Family</td></tr>
<tr><td>Retiree or a Dependent of a Retiree: No Deductible</td></tr>
<tr><td colspan="2">Generally, you or your family must pay the Prescription Drug Benefit Deductible each calendar year before the Plan will start paying benefits. However, the Plan will waive the Prescription Drug Benefit Deductible for Specialty Drugs that are on the list of drugs that are part of Sav-Rx’s HIA Program (see Section 3.10(c) for details). The Plan will also waive the Prescription Drug Benefit Deductible and pay 100% of the cost of Routine Preventive Care Prescription Drugs purchased at retail pharmacies that participate in the Sav-Rx network (see Section 3.11 for details).</td></tr>
<tr><td>Prescription Drug Benefit Annual Out-of-Pocket Maximum</td><td>$2,550 Person / $5,100 Family (This is the maximum you will pay in Copays during a calendar year)</td></tr>
</table>

COVERAGE (PLAN PAYS)		
PRESCRIPTION DRUG TYPE	**PARTICIPATING RETAIL PHARMACY (Up to a 34-Day Supply)**	**MAIL ORDER PHARMACY and PARTICIPATING RETAIL PHARMACY IN SAV-RX'S WALK IN MAIL ORDER NETWORK (Up to a 90-Day Supply)*** **
Generic (other than Statin)	100% after $15 Copay*	100% after $30 Copay*
Formulary Brand	100% after $30 Copay	100% after $60 Copay
Non-Formulary Brand	100% after $50 Copay	100% after $100 Copay
Generic Statin	100% after $10 Copay	100% after $20 Copay
Routine Preventive Care Prescription Drug	100%	100%
Generic Specialty Drugs (30-Day Supply)	100% after $15 Copay*, **	100% after $15 Copay*, **
Generic Specialty Drugs (90-Day Supply)* **	N/A	100% after $30 Copay*, **
Formulary Brand Specialty Drugs	100% after $30 Copay**	100% after $30 Copay**
Non-Formulary Brand Specialty Drugs	100% after $50 Copay**	100% after $50 Copay**

* If a Generic Drug is available and you purchase a Non-Formulary Brand Drug rather than the equivalent Generic Drug, you are required to pay the Copay listed in the chart below plus the difference between the ingredient cost of the Generic Drug and the ingredient cost of the Non-Formulary Brand Drug.

** This Copay does not apply to Specialty Drugs that are on Sav-Rx's HIA Program list. See Section 3.10(c) For details.

*** Specialty Drugs are generally limited to a 30-day supply. 90-day supplies are available for certain Specialty Drugs. See Section 3.10 for details.

Section 3.01 - Definitions for this Article III Only

The following terms will have specific meaning when they are used within this Article:

(a) **"Extenuating Circumstances"** means unusual and unexpected circumstances that cause a Covered Person to fill a Maintenance Medication at a participating retail pharmacy that is not in Sav-Rx's Walk In Mail Order Network (i.e., a retail pharmacy that is in Sav-Rx's network but not in the Walk In Mail Order Network).

(b) **"Federal Legend Drug"** means a drug that, by law, can only be obtained by prescription.

(c) **“Formulary Brand”** means a prescription drug that is included on SavRx’s prescription drug formulary.

(d) **“Generic Drug”** means a prescription drug that is classified as a generic drug on Medi-Span’s Master Drug Data Base.

(e) **“Grandfathered Drug”** means a drug or Continuous Glucose Monitoring System (“CGMS”) that a Covered Person was prescribed or had refilled during the 180-day period that ended on January 1, 2019 (i.e., the period of July 5, 2018 through December 31, 2018). A CGMS is considered to have been filled during the 180-day period that ended on January 1, 2019 if any component of the CGMS was prescribed, refilled, or replaced during this period. For purposes of this definition, a drug is only considered a Grandfathered Drug if the drug or CGMS has the same ingredients, dosage, and strength as the drug or CGMS that the Covered Person was prescribed during the 180-day period. Once a drug or CGMS is considered a Grandfathered Drug, it will remain a Grandfathered Drug until the later of the following dates:

- The date that a Covered Person has gone an entire year without filling a prescription for the drug or CGMS component (e.g., if a Covered Person fills a prescription for a Grandfathered Drug on February 1, 2019, and the Covered Person never fills another prescription, it will only remain a Grandfathered Drug until January 31, 2020); or
- December 31, 2019.

(f) **“HIA Program”** means Sav-Rx’s High Impact Advocacy Program for Specialty Drugs that have manufacturer assistance. See Section 3.10(c) for details.

(g) **“Initial Prescription”** means a prescription for a one to 34-day supply of Maintenance Medication that a Covered Person has not filled more than two times since January 1, 2019 (e.g., if you are prescribed a drug for high blood pressure on January 2, 2019, the first two 34-day (or less) fills of your prescription drug are considered Initial Prescriptions).

(h) **“Maintenance Medication”** means a prescription drug that is either a contraceptive (i.e., birth control) or is taken on a regular basis to treat a chronic health condition (e.g., high blood pressure, high cholesterol, or diabetes) and classified as a Maintenance Medication on Medi-Span’s Master Drug Data Base. For purposes of this definition, a prescription drug that is considered a controlled substance is not a Maintenance Medication even if it is taken on a regular basis to treat a chronic health condition.

(i) **“MAPD”** means the Medicare Advantage and Prescription Drug Plan (“MAPD”) described in Section 3.12.

(j) **“Non-Formulary Brand”** means a prescription drug that is not a Generic Drug or a Formulary Brand Drug (i.e., a prescription drug that is not included on Sav-Rx’s formulary or classified as a generic drug by Medi-Span’s Master Drug Data Base).

(k) **“Routine Preventive Care Prescription Drug”** means a drug that is considered preventive care under the Affordable Care Act and included on SavRx’s prescription drug formulary. See Section 3.11 for details.

(l) **“Specialty Drug”** means an oral, injectable, infused, or inhaled medication that is either self-administered or administered by a healthcare provider and used or obtained in either an outpatient or home setting. Specialty drugs have the following key characteristics:

- Need frequent dosage adjustments;
- Cause more severe side effects than traditional drugs;

- Need special storage, handling, and/or administration;
- Have a narrow therapeutic range; and
- Require periodic laboratory or diagnostic testing.

(m) **"Step Therapy"** means beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to more costly or risky therapy only if necessary. See Section 3.08 for details.

Section 3.02 - General Information

Sav-Rx Prescription Services ("Sav-Rx") is the pharmacy benefit manager that administers the Plan's Prescription Drug Benefits. Sav-Rx provides the following three options for obtaining prescription drugs:

(a) A network of participating retail pharmacies where you can fill prescriptions for up to a 34-day supply;

(b) A Walk In Mail Order Network of participating retail pharmacies where you can fill prescriptions for up to a 90-day supply; and

(c) A Mail Order Pharmacy where you can fill prescriptions for up to a 90-day supply.

Section 3.03 - Deductibles, Copays, and Annual Out-of-Pocket Maximum

If you are an Eligible Employee or a Dependent of an Eligible Employee, you must meet the Deductible identified in the chart at the beginning of this Article before Prescription Drug Benefits become payable. Allowable Charges for prescription drugs provided by participating pharmacies count towards your Prescription Drug Benefit Deductible. If you are an Eligible Employee or a Dependent of an Eligible Employee, your Prescription Drug Benefit Deductible is $200 per Covered Person and $400 per family. This means that you will pay the first $200 of Allowable Charges for Prescription Drug Benefits per calendar year. However, your family will not pay more than a total of $400 in Deductibles for Prescription Drug Benefits in the same calendar year. That is, if your family has a total of $400 in Prescription Drug Benefit expenses applied to Deductibles during a calendar year, your family's Prescription Drug Benefit Deductible will be satisfied. If your family's Prescription Drug Benefit Deductible is satisfied for a calendar year, Prescription Drug Benefits will be payable as if each member of your family has met their individual Deductibles for the calendar year.

If you are a Retiree or a Dependent of a Retiree, you do not have to meet a Deductible prior to receiving Prescription Drug Benefits.

Once you have paid your Deductible (or your family has paid its family Deductible, if applicable), you will generally only be responsible for the applicable Copay identified in the chart at the beginning of this Article. Once you meet the Prescription Drug Benefit Annual Out-of-Pocket Maximum identified in the chart at the beginning of this Article, the Plan will begin to pay 100% of the Allowable Charge for covered Prescription Drug Benefits for the rest of the calendar year.

If you are enrolled in the MAPD described in Section 3.12, your Copay and Annual Out-of-Pocket Maximum may be lower than the amounts identified in the chart at the beginning of this Article. For an explanation of the MAPD, including applicable Copays and Annual Out-of-Pocket Maximums, refer to Section 3.12.

The Deductibles, Copays, and Annual Out-of-Pocket Maximums for Prescription Drug Benefits are separate and distinct from those that apply to Comprehensive Medical Benefits. This means that amounts that you pay towards Prescription Drug Benefits under this Article III do not count towards your Comprehensive Medical Benefit Deductible or your Comprehensive Medical Benefit Out-of-Pocket Maximum.

Section 3.04 - Covered Prescription Drugs

The Plan covers:

(a) Federal Legend Drugs except as specifically excluded in Section 3.13(c);

(b) Self-administered injectables including, but not limited to, insulin injections, glucagon injections, epinephrine injections, generic sumatriptan injections, or contraceptive injections;

(c) Syringes for self-administered injectables;

(d) Compound drugs that meet one of the following criteria:

    (1) The compound drug is Medically Necessary, or

    (2) The compound drug costs less than $100;

(e) Diabetic drugs and supplies, including insulin, disposable insulin needles/syringes, disposable blood/urine glucose/acetone testing agents, blood glucose monitors (provided that the CGMS meets the criteria set forth in Section 3.13(g)), and lancets;

(f) Routine Preventive Care Prescription Drugs as described in Section 3.11; and

(g) Tobacco cessation products, including over-the-counter products when prescribed by a Physician.

NOTE: Drugs and medicines that are administered or provided during a Physician Office Visit, at a Facility, at a Hospital, or by a home health agency are not covered under this Article. Refer to Article II - Comprehensive Medical Benefits for a description of coverage for drugs administered during a Physician Office Visit, at a Facility, at a Hospital, or by a home health agency.

Section 3.05 - Filling a Prescription

Subject to the limitations set forth in Sections 3.07 and 3.10(a), you may fill prescriptions at a participating retail pharmacy, a pharmacy in Sav-Rx's Walk In Mail Order Network, or the Sav-Rx Mail Order Pharmacy. You may also submit a reimbursement request to Sav-Rx.

(a) Purchases at Participating Retail Pharmacies

If you buy prescription drugs from a participating retail pharmacy, including a pharmacy that participates in Sav-Rx's Walk In Mail Order Network, you should present your Sav-Rx identification card to the pharmacist each time you have a prescription filled or refilled. If you are a Retiree or Dependent of a Retiree who is enrolled in the MAPD, as described in Section 3.12, you should present both your Sav-Rx identification card and your UnitedHealthcare identification card to the pharmacist. If your prescription drug meets all of the requirements for coverage provided in this Article, you will then pay the pharmacist the Copay amount described in the chart at the beginning of this Article or, if you are enrolled in the MAPD, the UnitedHealthcare Copay amount if it is less than the Copay amount described in the chart at the beginning of this Article.

No benefits will be paid for prescriptions filled at non-participating retail pharmacies. To view a complete list of participating retail pharmacies, you may either visit the Sav-Rx website at www.savrx.com or call Sav-Rx directly at (800) 238-3108.

(b) Sav-Rx Mail Order Pharmacy Purchases

If you fill your prescription using the Sav-Rx Mail Order Pharmacy, your initial order will consist of three parts: (1) the written prescription from your Doctor; (2) a mail order form; and (3) a Copay.

Mail order forms are available from Sav-Rx or at its website www.savrx.com. Prescriptions may also be submitted to the Sav-Rx Mail Order Pharmacy by calling Sav-Rx at (800) 228-3108 or faxing Sav-Rx at (888) 810-1394. Additionally, your provider may directly e-scribe your prescriptions with the Sav-Rx Mail Order Pharmacy. You should allow 14 days for your order to be completed and shipped to you. If you have a question concerning a medication or a particular order, you can call Sav-Rx at (800) 228-3108.

(c) Reimbursement Requests

If you pay the full retail price for a drug, you may submit a reimbursement request to Sav-Rx. Reimbursement requests may be submitted to Sav-Rx at the address shown on your identification card or by fax to (888) 810-1394. Your reimbursement request must include both a reimbursement request form and the original receipt for the drug or drugs purchased.

If your reimbursement request is for a drug for which prior authorization is necessary, then your reimbursement request will be evaluated under the same clinical criteria that apply to requests for prior authorization.

Reimbursement requests are subject to the procedures for Post-Service Prescription Drug Benefit Claims provided for in Section 9.04(b). A reimbursement request must be filed by the last day of the calendar year following the calendar year in which you incur the expense. If your request is approved, you will be reimbursed to the extent the Plan covers your prescription. If your reimbursement request is denied, in whole or in part, you may file an appeal in accordance with Section 9.04(b).

Section 3.06 - Prior Authorization

Certain prescription drugs require clinical review before Prescription Drug Benefits will be paid by the Plan. For these drugs, it is recommended that you, your pharmacist, or your provider request prior authorization.

The Plan will not cover certain prescription drugs until there is a determination that such drugs are Medically Necessary, prescribed in accordance with Food and Drug Administration ("FDA") criteria, or meet industry dosage recommendations. In addition, some prescription drugs are only covered if they meet certain conditions set forth in this Article. Prescriptions for these drugs are reviewed by Sav-Rx's clinical staff before the Plan will cover the drug to ensure that approved clinical criteria and other conditions set forth in this Article have been satisfied. Because certain prescription drugs require review by Sav-Rx's clinical staff before the Plan will cover the drug, it is recommended that you, your pharmacist, or your provider request prior authorization. If you request prior authorization, Sav-Rx will determine whether the prescribed drug satisfies clinical criteria and is covered by the Plan. To request prior authorization, you, your pharmacist, or your provider must contact Sav-Rx at (800) 228-3108 or submit a request online at www.savrx.com.

A request for prior authorization is not a claim or a Pre-Service Prescription Drug Benefit Claim (as that term is defined in Section 9.01(d)). Rather, it is a service provided by the Plan that allows you to get an advance determination that the prescription drug you seek is covered by the Plan. For prescription drugs that require clinical review, prior authorization allows you to obtain the drug subject to the applicable Copay and Deductible without the need to pay the full retail price while your request undergoes clinical review. If your request for prior authorization is approved, the Plan will cover the prescription drug subject to the applicable Copay and Deductible, provided that it meets all of the other requirements set forth in this Article. If your request for prior authorization is denied, you may file a Pre-Service Prescription Drug Benefit Claim pursuant to Section 9.04(a) or purchase the prescription drug at full retail price and submit a Post-Service Prescription Drug Benefit Claim pursuant to Section 9.04(b). If your request for prior authorization is granted but you disagree with the amount that you are required to pay for the prescription drug, you may also file a Post-Service Prescription Drug Benefit Claim pursuant to the procedures set forth in Section 9.04(b).

Drugs for which the Plan recommends that you obtain prior authorization include the following:

(a) Specialty Drugs, unless there is an immediate need for the prescription;

(b) CGMSs;

(c) Injectable drugs that are not insulin injections, glucagon injections, epinephrine injections, generic sumatriptan injections, or contraceptive injections;

(d) Tretinoin when prescribed to a person over age 26;

(e) Compound drugs that cost more than $100;

(f) Opioids that exceed 90 Morphine Equivalent Doses ("MED");

(g) Proton pump inhibitors; and

(h) Erectile dysfunction drugs (pills or injections) that exceed six doses per calendar month.

If you are enrolled in the MAPD described in Section 3.12, UnitedHealthcare may require that a prescribed drug undergo clinical review to ensure that certain criteria and other conditions are satisfied before it is covered by the MAPD. The prescription drugs that require clinical review under the MAPD may not be the same as the prescription drugs that require clinical review under the Plan. The following rules explain how prior authorization under the Plan is coordinated with prior authorization under the MAPD:

- If UnitedHealthcare requires clinical review for a prescription drug and determines that the MAPD will cover the drug, Sav-Rx will defer to UnitedHealthcare's determination and will not perform a secondary clinical review. For example, if you are enrolled in the MAPD, your doctor prescribes a proton pump inhibitor to you, and UnitedHealthcare grants prior authorization for the proton pump inhibitor, Sav-Rx will defer to UnitedHealthcare's determination that the prescribed drug satisfies clinical criteria and is covered by the Plan (i.e., the Plan will provide wrap-around coverage).

- If UnitedHealthcare requires clinical review for a prescription drug but determines that the MAPD will not cover the drug, and the drug is subject to clinical review under the Plan, Sav-Rx will not defer to UnitedHealthcare's determination. Instead, Sav-Rx will conduct its own clinical review to determine if the prescribed drug satisfies clinical criteria and is covered by the Plan. If Sav-Rx determines that the drug is covered by the Plan, then the Plan will cover the prescribed drug pursuant to the Copays and Annual Out-of-Pocket Maximum described in the chart at the beginning of this Article. Additionally, you may request prior authorization from the Plan for the drug.

- If UnitedHealthcare requires clinical review for a prescription drug, determines that the MAPD will not cover the drug, and the drug is covered by the Plan without having to undergo clinical review, then the Plan will cover the drug pursuant to the Copays and Annual Out-of-Pocket Maximum described in the chart at the beginning of this Article.

- If UnitedHealthcare does not require clinical review for a prescription drug but the drug is subject to clinical review under the Plan, then Sav-Rx will conduct a clinical review pursuant to the terms set forth in this Section 3.06. If Sav-Rx determines that the drug is covered by the Plan, then the Plan will cover the prescribed drug pursuant to the Copays and Annual Out-of-Pocket Maximum described in the chart at the beginning of this Article. If Sav-Rx determines that the drug is not covered by the Plan, then this Plan will pay nothing, and that prescription drug will be covered by the MAPD subject only to the cost-sharing limits applicable to the MAPD.

Contact UnitedHealthcare for a list of prescription drugs that must undergo clinical review under the MAPD and instructions on how to request prior authorization from UnitedHealthcare.

Section 3.07 - Mandatory Mail Order for Maintenance Medications

When you need a medication for a short time period, such as an antibiotic, you may fill your prescription at any participating retail pharmacy. The Plan will cover up to a 34-day supply of medication per prescription through the retail pharmacy program (or a 90-day supply if the pharmacy participates in Sav-Rx's Walk In Mail Order Network). However, when you need a Maintenance Medication, the mandatory mail order rules described in this Section 3.07 apply.

Maintenance Medications must be filled either through the Sav-Rx Mail Order Pharmacy or a retail pharmacy that participates in Sav-Rx's Walk In Mail Order Network. The Plan will cover up to a 90-day supply of Maintenance Medications per prescription. No Prescription Drug Benefits are payable for Maintenance Medications unless the Maintenance Medication is filled through the Sav-Rx Mail Order Pharmacy, is filled through a retail pharmacy that participates in Sav-Rx's Walk In Mail Order Network, or meets one of the following exceptions:

(a) The Maintenance Medication is an Initial Prescription;

(b) The Maintenance Medication is prescribed to a Covered Person who lives in a long-term care facility (i.e., if you live in a long-term care facility and the Maintenance Medication is otherwise covered by the Plan, the Plan will cover your Maintenance Medication even if it is not filled through the Sav-Rx Mail Order Pharmacy or a pharmacy that is in Sav-Rx's Walk In Mail Order Network);

(a) The Maintenance Medication is purchased at a participating retail pharmacy that is not in Sav-Rx's Walk In Mail Order Network (i.e., a retail pharmacy that is in Sav-Rx's network but not in the Walk In Mail Order Network) due to Extenuating Circumstances; or

(b) The Maintenance Medication is prescribed to a Covered Person who participates in the MAPD described in Section 3.12.

Section 3.08 - Step Therapy

No benefits are payable for drugs prescribed to treat diabetes, high cholesterol, high blood pressure, acid related stomach disease, osteoporosis, inflammatory disease, migraines, overactive bladder, allergies, insomnia, depression, glaucoma, or fibromyalgia unless one of the following requirements is met:

(a) The prescription drug is a Grandfathered Drug;

(b) You are enrolled in the MAPD described in Section 3.12; or

(c) The prescription drug meets the Step Therapy requirements.

A prescription drug meets the Step Therapy requirements if it is the most cost-effective medication available to treat a disease or condition. This means that if your Physician prescribes you a new drug to treat one of the conditions listed in this Section 3.08, the Plan will only cover a Generic Drug. If the Generic Drug does not safely and effectively treat your condition, the Plan will cover a Formulary Brand Drug. If the Formulary Brand Drug does not safely and effectively treat your condition, the Plan will cover a Non-Formulary Brand Drug.

If your Physician prescribes you a new drug to treat one of the conditions listed in this Section 3.08, you must follow these steps to ensure that your prescription drug is covered:

- **Step One**: Have your Physician prescribe a Generic Drug. If you try the medication for at least 60 days and it does not work, or you have a medical condition that prevents you from trying the medication for at least 60 days (e.g., an allergy), you may proceed to step two.

- **Step Two**: Have your Physician prescribe a Formulary Brand Drug. If you try the medication for at least 60 days and it does not work, or you have a medical condition that prevents you from trying the medication for at least 60 days (e.g., an allergy), you may proceed to step three.
- **Step Three**: Have your Physician prescribe a Non-Formulary Brand Drug.

The Plan's other rules and limitations apply to a drug that is prescribed to treat one of the conditions listed in this Section 3.08, regardless of whether the drug meets the applicable Step Therapy requirements. For example, if you are prescribed a non-sedating antihistamine for the treatment of allergies, the Plan will not cover the non-sedating antihistamine because it is excluded from coverage pursuant to Section 3.13(i).

Section 3.09 - Opioid Drugs

The Plan will not cover Prescription Drug Benefits for a drug that is classified as an opioid unless the drug meets one of the following criteria:

(a) The opioid is prescribed in a dosage that is less than 90 MED;

(b) The opioid is prescribed in a dosage that is between 90 MED and 200 MED and is Medically Necessary;

(c) You have a life expectancy of six months or less;

(d) You are receiving treatment for cancer; or

(e) The opioid is a Grandfathered Drug.

Even if an opioid drug meets the criteria listed in this Section 3.09, it must also satisfy all other applicable requirements set forth in this Article. For example, if an opioid is also a Specialty Drug, then the opioid must satisfy the Plan's requirements for Specialty Drugs, including the mandatory mail order requirement set forth in Section 3.10(a) and the requirement that the drug is Medically Necessary.

Section 3.10 - Specialty Drugs

(a) Mandatory Mail Order for Specialty Drugs

No Prescription Drug Benefits are payable for Specialty Drugs unless the Specialty Drug is filled through the Sav-Rx Mail Order Pharmacy or meets one of the following exceptions:

(1) The Specialty Drug is not available at the Sav-Rx Mail Order Pharmacy (i.e., you are not able to purchase the Specialty Drug from the Sav-Rx Mail Order Pharmacy). For example, if you have asthma, your doctor prescribes you Xolair, and Xolair is not available at the Sav-Rx Mail Order Pharmacy, then the Plan will cover Xolair if you purchase it at a participating retail pharmacy (i.e., a retail pharmacy that is in Sav-Rx's network).

(2) The Specialty Drug is an immediate need drug. For example, if you have surgery and your Doctor prescribes you seven doses of Enoxaparin to prevent blood clots immediately after the surgery, the Plan will cover the seven doses of Enoxaparin if you purchase them at a participating retail pharmacy (i.e., a retail pharmacy that is in Sav-Rx's network). If your prescription is for more than seven doses, the Plan will only cover the additional (i.e., non-immediate) doses if the Specialty Drug is purchased at the Sav-Rx Mail Order Pharmacy.

(3) The Specialty Drug is the first prescription for a specific Specialty Drug that you have filled after January 1, 2019 (i.e., you did not fill another prescription for the Specialty Drug on or after January 1, 2019).

(b) Refill Limits on Specialty Drugs

Specialty Drugs are generally limited to a 30-day supply. However, the Plan may cover up to a 90-day refill of certain Specialty Drugs. Refills of the following Specialty Drugs may be covered up to a 90-day supply:

- Specialty Drugs prescribed to treat diabetes;
- Specialty Drugs prescribed to treat migraines;
- Azathioprine;
- Generic HIV agents;
- Brand HIV agents;
- Generic transplant agents; and
- Repatha

This list is subject to change. For a current list of Specialty Drugs for which 90-day supplies are available, contact Sav-Rx at (800) 228-3108.

If your Physician prescribes you a new Specialty Drug that is listed in this Section 3.10(b), the Plan will only cover a 30-day supply of your initial prescription for the Specialty Drug unless a 90-day supply is deemed clinically appropriate by Sav-Rx. The reason for this rule is that Specialty Drugs have unique characteristics, such as the need for frequent dosage adjustments, narrow therapeutic ranges, and the tendency to cause more severe side effects than traditional drugs. As such, Sav-Rx needs to ensure that you will likely continue to take the Specialty Drug for the foreseeable future before the Plan will cover a 90-day supply of the drug.

(c) Special Rules for Specialty Drugs that Have Manufacturer Assistance Available

The Plan participates in Sav-Rx's HIA Program. Sav-Rx's HIA Program leverages discounts and rebates offered by the manufacturers of Specialty Drugs to reduce the costs of such drugs for both you and the Plan. If you are prescribed a Specialty Drug that is on the list of drugs that are part of the HIA Program, the Prescription Drug Benefits Deductible and Copays listed in the chart at the beginning of this Article will not apply. Instead, the Copays listed in the chart in this Section 3.10(c) will apply. However, the Copay listed in the chart in this Section 3.10(c) is not what you will actually pay. When you send the Sav-Rx Mail Order Pharmacy an order to fill a prescription for a Specialty Drug that is on the list of drugs that are part of the HIA Program, Sav-Rx will apply for the manufacturer assistance that is available for that drug and will use that assistance to offset your Copay. The result is that you will pay $0.00 for the Specialty Drug. In other words, you will pay nothing for the Specialty Drug because the amount of the manufacturer assistance will offset the amount of the Copay. Because you will not pay anything for the Specialty Drug, the Copay listed in the chart in this Section 3.10(c) will not count towards your Prescription Drug Benefit Annual Out-of-Pocket Maximum.

For example, if you have cancer and you are prescribed a Specialty Drug that is on Sav-Rx's HIA Program list, you should order the drug from the Sav-Rx Mail Order Pharmacy. Once Sav-Rx receives your order, Sav-Rx will apply for manufacturer assistance. If the cost of the Specialty Drug is $5,000 and Sav-Rx receives manufacturer assistance in the amount of $1,000, then your copayment for the Specialty Drug is $1,000. Sav-Rx will apply the $1,000 from the drug manufacturer towards your copayment, which means you will pay $0.00 for the Specialty Drug. The $1,000 will not count towards your Prescription Drug Benefit Annual Out-of-Pocket Maximum because you will not have actually paid any portion of this amount.

The following chart lists the Copays that apply to Specialty Drugs that are on Sav-Rx's HIA Program list:

If the Specialty Drug is …	Your Copay will equal…
Ozempic or Rybelsus	15% of the cost of the drug *
A brand HIV agent or prescribed to treat multiple sclerosis, an inflammatory condition, or cancer	20% of the cost of the drug *
Prescribed to treat hepatitis C	25% of the cost of the drug *
Aimovig, Ajovy, Emgality, Nurtec, Vyepti, Ubrelvy, Reyvow, or prescribed to treat cystic fibrosis	30% of the cost of the drug *
Repatha	35% of the cost of the drug *
A drug that has manufacturer assistance available but not listed above	40% of the cost of the drug *
* If the amount of the manufacturer assistance available for the Specialty Drug is less than the amount of the Copay, then your Copay will equal the amount of the manufacturer assistance that is available for the Specialty Drug. This means that the manufacturer assistance will cover your Copay and you will pay nothing for the Specialty Drug.	

This list is subject to change. For a current list of Specialty Drugs included in the HIA Program, contact Sav-Rx at (800) 238-3108.

If a Specialty Drug is not on Sav-Rx's HIA Program list, this Section will not apply and the Specialty Drug will be subject to the standard Deductibles and Copays set forth in the chart at the beginning of this Article.

This Section 3.10(c) does not apply to Covered Persons who are enrolled in the MAPD described in Section 3.12.

Section 3.11 - Routine Preventive Care Prescription Drug Benefits

The Plan will waive the Prescription Drug Benefit Deductible and pay 100% of the cost of Routine Preventive Care Prescription Drugs purchased at retail pharmacies that participate in the Sav-Rx network. This means that Routine Preventive Care Prescription Drugs purchased at retail pharmacies that participate in the Sav-Rx network are not subject to the Deductibles and Copays set forth in the chart at the beginning of this Article.

Routine Preventive Care Prescription Drugs are available for all Covered Persons but different limitations apply depending on the specific Routine Preventive Care Prescription Drug. Additionally, only certain versions of Routine Preventive Care Prescription Drugs are covered by the Plan at 100%. Routine Preventive Care Prescription Drugs generally include only Generic Drugs or Non-Formulary Brand Drugs with no Generic Drug equivalents. If you choose to fill a prescription for a Non-Formulary Brand Drug that is a Routine Preventive Care Prescription Drug even though an equivalent Generic Drug is available, you will be responsible for the Plan's applicable cost sharing requirements unless your Physician determines that the drug is Medically Necessary. For example, if you fill a prescription for a non-generic version of lovastatin, you will be responsible for the Plan's applicable cost sharing requirements (i.e., the Non-Formulary Brand Drug Copay plus the difference in ingredient cost between the Generic Drug and the Non-Formulary Brand Drug) unless your Physician determines that the non-generic version of lovastatin is Medically Necessary. If your Physician determines that a version of a Routine Preventive Care Prescription Drug that is a Non-Formulary Brand Drug is Medically Necessary, your Physician can request a waiver of the Plan's applicable cost-sharing requirements by contacting Sav-Rx.

The following table provides a list of Routine Preventive Care Prescription Drugs covered by the Plan and their limitations. If you do not meet the requirements and limitations described in the chart in this Section 3.11, you will be responsible for the applicable cost sharing requirements listed in the chart at the beginning

of this Article, provided that the prescription drug is otherwise covered under Section 3.04 (i.e., if you do not meet the requirements and limitations, the applicable Prescription Drug Benefit Deductibles and Copays will apply to the prescription drugs you receive). This list is subject to change. You can obtain a complete list of Routine Preventive Care Prescription Drugs covered by the Plan by contacting the Fund Office.

INCLUDED SERVICES	COVERAGE DETAILS AND LIMITATIONS
Aspirin (Rx and OTC)	Men (ages 45-79) and women (ages 55-79); pregnant women at risk for preeclampsia
Colonoscopy Bowel Preparation	Men and women (ages 50 to 75)
Contraceptives	N/A
Erythromycin Ophthalmic Ointment	Infants under one year of age
Folic Acid (Rx and OTC)	Women capable of pregnancy
Immunizations	Preventive vaccines per guidelines for ages birth to 18 and adults
Iron (Rx and OTC)	Children ages 6 to 12 months
Oral fluorides (Rx only)	Children ages 6 months to 6 years
Raloxifene and Tamoxifen	Breast cancer prevention in high-risk women
Lovastatin, simvastatin, and pravastatin	Men and women ages 40-75 for primary cardiovascular disease prevention
Atorvastatin	Men and women ages 40-75 for primary cardiovascular disease prevention, applicable only for refills of atorvastatin that meet the definition of Grandfathered Drug
Vitamin D	Men and women older than age 64
Tobacco cessation drugs (Rx and OTC)	Subject to quantity limit of up to two quit attempts per calendar year for a 90-day treatment regimen. Tobacco cessation drugs in excess of two quit attempts per year are not Routine Preventive Care Prescription Drugs but remain covered subject to the Prescription Drug Benefit Deductible and Copay.

Section 3.12 - Medicare Advantage and Prescription Drug Plan ("MAPD")

Effective January 1, 2023, if you are a Retiree or a Dependent of a Retiree who has Medicare as your Primary Plan, you will be automatically enrolled in the MAPD. The MAPD is a separate Medicare Advantage and Prescription Drug Plan fully insured by UnitedHealthcare. In addition to benefits provided under the MAPD, this Plan will provide additional Prescription Drug Benefits in order to ensure that the amounts you pay for prescription drugs covered under the MAPD are no more than the Copays and Annual Out-of-Pocket Maximum set forth in the chart at the beginning of this Article.

The MAPD will cover prescription drugs pursuant to the standards and requirements set by Medicare. You will receive information from UnitedHealthcare about the benefits, cost-sharing, and utilization management programs applicable to the MAPD. However, the deductible, copays, and coinsurance applicable to the MAPD are not what you will actually pay. After the MAPD pays its portion of your claim, this Plan will provide additional Prescription Drug Benefits that will "wrap around" the MAPD and cover out-of-pocket prescription drug expenses that are not covered by the MAPD. The MAPD, in combination with the additional Prescription Drug Benefits covered by this Plan, will ensure that you do not pay more than the Copays and Annual Out-of-Pocket Maximum set forth in the chart at the beginning of this Article.

The prescription drug benefit coverage and exclusions under the MAPD are not always the same as the Prescription Drug Benefit coverage and exclusions under this Plan. If a prescription drug is not covered by the MAPD but is covered under the terms of this Article, then this Plan will cover the prescription drug

pursuant to the Copays and Annual Out-of-Pocket Maximum described in the chart at the beginning of this Article. If a prescription drug is covered by the MAPD but is not covered under the terms of this Article, then this Plan will pay nothing and that prescription drug will be covered by the MAPD subject only to the cost-sharing limits applicable to the MAPD. This Plan is not responsible for any part of the cost of a prescription drug greater than what this Plan would have covered without the MAPD, less any amount paid under the MAPD. For a list of covered prescription drugs and exclusions under the MAPD, contact UnitedHealthcare.

If you are covered by the MAPD, any additional Prescription Drug Benefits payable under this Plan are subject to all of the programs and limitations set forth in this Article except for the following:

- You will not be required to pay the difference between the ingredient cost of a Generic Drug and the ingredient cost of a Non-Formulary Brand Drug if a Generic Drug is available and you purchase a Non-Formulary Brand Drug rather than the equivalent Generic Drug as described in the chart at the beginning of this Article;
- You will not be required to purchase Maintenance Medications through the Sav-Rx Mail Order Pharmacy or a retail pharmacy that participates in Sav-Rx's Walk In Mail Order Network as described in Section 3.07;
- You will not be subject to the Step Therapy rules described in Section 3.08; and
- You will not be subject to the HIA Program described in Section 3.10(c).

If you are enrolled in the MAPD and your income and combined savings, investments, and real estate assets are at or below a certain level set by the Centers for Medicare & Medicaid Services ("CMS") (generally, at or below 150% of the federal poverty level), you may qualify for a low income subsidy from CMS (also called the "Medicare Extra Help Program"). You may also qualify for the low-income subsidy if you are enrolled in Medicaid, Supplemental Security Income, or a Medicare Savings Program. If you qualify, the Plan will pass the low-income subsidy back to you.

Section 3.13 - Prescription Drug Benefit Exclusions and Limitations

Prescription Drug Benefits will not be payable for any of the following:

(a) Non-Federal Legend Drugs (i.e., over-the-counter drugs) except as specifically provided for in Section 3.04;

(b) Drugs or other pharmaceutical products for which you incur no charge or have no legal obligation to pay, including drugs provided without charge under any government program or law, or charges for drugs payable under any workers' compensation, occupational disease, or similar law;

(c) Federal Legend Drugs obtained without a valid prescription;

(d) Drugs or medicines covered under Article II - Comprehensive Medical Benefits (e.g., drugs administered while you are confined in a Hospital);

(e) Maintenance Medications that are not filled through the Sav-Rx Mail Order Pharmacy or a participating pharmacy in Sav-Rx's Walk In Mail Order Network unless one of the exceptions in Section 3.07 applies;

(f) Compound drugs that do not meet the requirements of Section 3.04(d);

(g) CGMSs unless the CGMS is Medically Necessary or the CGMS is a Grandfathered Drug and the CGMS (or CGMS component, as applicable) is not under a manufacturer's warranty (i.e., the Plan will not cover a CGMS or a CGMS component that the manufacturer will provide at no cost due to a warranty);

(h) Fertility drugs;

(i) Non-sedating antihistamines;

(j) Growth hormones;

(k) Expenses incurred for more than six daily doses (pills or injections) per calendar month for treatment of erectile dysfunction, unless you meet one of the following criteria:

(1) You are undergoing rehabilitative treatment following prostate surgery in connection with prostate cancer; or

(2) You are being treated for benign prostatic hyperplasia ("BPH");

(l) Proton pump inhibitors except when the proton pump inhibitor is prescribed as follows:

(1) In connection with throat, tongue, stomach, larynx, or esophageal cancer;

(2) In suspended form for children up to age seven;

(3) In connection with a diagnosis of Barrett's esophagus; or

(4) In connection with limited scleroderma ("CREST syndrome"), but only after the Covered Person completes a 30-day trial of an over-the-counter proton pump inhibitor drug;

(m) Administration of any drug or medicine;

(n) Therapeutic devices, appliances, and other nonmedicinal substances except as specifically provided in Section 3.04;

(o) Specialty Drugs that are not Medically Necessary, unless the Specialty Drug is prescribed for an immediate need (for example, a prescription for a Specialty Drug to prevent blood clots immediately after a surgery);

(p) Specialty Drugs that are not purchased through the Sav-Rx Mail Order Pharmacy unless one of the exceptions in Section 3.10(a) applies;

(q) Any expense for a prescription drug to the extent the billed charges exceed the Allowable Charge for such drug;

(r) Any drug prescribed for a cosmetic purpose;

(s) Any drug prescribed for the purpose of weight loss;

(t) Abortifacient drugs;

(u) Any prescription drug that is on Sav-Rx's list of drugs that meet one of the following criteria:

(1) The drug is sold in a package that consists of a medication and a medical supply that you could purchase separately at less cost; or

(2) The drug contains active ingredients that consist solely of a combination of generic and/or over-the-counter medications that are not proven to work better than a two-pill regimen;

(v) Any opioid drug unless the opioid drug meets the requirements provided in Section 3.09;

(w) Any drug prescribed to treat diabetes, high cholesterol, high blood pressure, acid related stomach disease, osteoporosis, inflammatory disease, migraines, overactive bladder, allergies, insomnia, depression, glaucoma, or fibromyalgia, unless the prescribed drug meets the Step Therapy requirements described in Section 3.08;

(x) Prescriptions for a Covered Person who enrolls in a Medicare Part D prescription drug plan that is not the MAPD specifically provided for in Section 3.12; and

(y) Prescription drug orders filled by a retail pharmacy that does not participate in the Sav-Rx network of participating retail pharmacies.

Section 3.14 - COVID-19 Vaccines and At-Home COVID-19 Tests

The rules in this Section 3.14 are temporary and only apply during the public health emergency that was declared by the Department of Health and Human Services with respect to COVID-19 ("Public Health Emergency"). Once the Public Health Emergency is over, the temporary rules described in this Section 3.14 will no longer apply and the Plan's standard rules will apply to COVID-19 vaccines and at-home COVID-19 tests.

(a) COVID-19 Vaccines

The Plan will cover 100% of the cost of federally approved COVID-19 vaccines that are received during the Public Health Emergency. This rule applies regardless of whether or not a vaccine is administered by a participating pharmacy. This means that if you receive a federally approved COVID-19 vaccine during the Public Health Emergency, the exclusion described in Section 3.13(y) will not apply and the Plan will cover 100% of the cost of the vaccine.

After the date that the Public Health Emergency ends, the exclusion described in Section 3.13(y) will apply to COVID-19 vaccines. This means that if you receive a federally approved COVID-19 vaccine from a nonparticipating pharmacy after the Public Health Emergency ends, Prescription Drug Benefits will not be payable with respect to the vaccine. If you receive a federally approved COVID-19 vaccine from a participating pharmacy after the Public Health Emergency ends, the Plan will cover the vaccine as a Routine Preventive Care Prescription Drug.

(b) At-Home COVID-19 Tests

The Plan will cover the cost of up to eight COVID-19 tests per Covered Person per month so long as the tests are purchased during the Public Health Emergency and received FDA approval for at home use ("at-home COVID-19 tests"). You will not have to pay any cost-sharing (i.e., you will not have to pay a Deductible or Copay) if you purchase the test at a participating pharmacy.

Many participating pharmacies are set up to process at-home COVID-19 tests in the same manner as any other prescription drug. In these pharmacies, you can present your Sav-Rx prescription I.D. card to the pharmacy and you will not have to pay anything for the at-home COVID-19 tests. Some participating pharmacies are not set up to process at-home COVID-19 tests in this manner. For these pharmacies, you must pay for the at-home COVID-19 tests up front and apply for reimbursement. Reimbursement request forms are available at www.savrx.com. You may also order at-home COVID-19 tests for free from the Sav-Rx Mail Order Pharmacy. To do so, go to www.savrx.com, click on the "COVID Resources" link, click on the "COVID Test Direct Shipping" link, and follow the instructions.

Reimbursement for at-home COVID-19 tests purchased at nonparticipating pharmacies will be limited to the cost of the test or $12 per test, whichever is less. Amounts that you pay in excess of $12 per test for at-home COVID-19 tests purchased at nonparticipating pharmacies will not count towards your Prescription Drug Benefit Annual Out-of-Pocket Maximum.

ARTICLE IV - DENTAL BENEFITS

The following topics are discussed under this Article on Dental Benefits:

4.01 General Information
4.02 Covered Dental Services and Supplies
4.03 Dental Benefit Exclusions and Limitations
4.04 Filing a Claim for Dental Benefits

DENTAL BENEFITS

BENEFIT	COVERAGE (PLAN PAYS)		
	PARTICIPATING DENTIST		NON-PARTICIPATING DENTIST
	DELTA DENTAL PPO *	DELTA DENTAL PREMIER *	
Diagnostic and Preventive Services	90% up to the Annual Dental Benefit Maximum	80% up to the Annual Dental Benefit Maximum	60% up to the Annual Dental Benefit Maximum
Basic and Major Services	80% up to the Annual Dental Benefit Maximum	80% up to the Annual Dental Benefit Maximum	60% up to the Annual Dental Benefit Maximum
Dental Implants	50% up to the Annual Dental Benefit Maximum	50% up to the Annual Dental Benefit Maximum	50% up to the Annual Dental Benefit Maximum
Orthodontic Services	80% up to the Annual Dental Benefit Maximum	80% up to the Annual Dental Benefit Maximum	60% up to the Annual Dental Benefit Maximum
Oral Surgery Services	80% up to the Oral Surgery Annual Out-of-Pocket Maximum, 100% after reaching the Oral Surgery Annual Out-of-Pocket Maximum**	80% up to the Oral Surgery Annual Out-of-Pocket Maximum, 100% after reaching the Oral Surgery Annual Out-of-Pocket Maximum**	60%

* If a Dentist participates in both Delta Dental PPO and Delta Dental Premier, the Delta Dental PPO Coinsurance will apply.

** The Oral Surgery Annual Out-of-Pocket Maximum is $500. This means that once you have paid out-of-pocket Allowable Charges of $500 for oral surgery services, the Plan will pay 100% of the Allowable Charges for oral surgery services provided by Participating Dentists during the remainder of the calendar year. Services and supplies provided by a non-participating Dentist do not count towards your Oral Surgery Annual Out-of-Pocket Maximum. Refer to Section 4.02(e) for more details.

Annual Dental Benefit Maximum: $1,500 per person

Once you have reached your Annual Dental Benefit Maximum, you are responsible for amounts that exceed your Annual Dental Benefit Maximum. The Annual Dental Benefit Maximum does not apply to oral surgery services. The Annual Dental Benefit Maximum also does not apply to diagnostic & preventive services and basic & major services provided to Covered Persons under age 19. The Annual Dental Benefit Maximum does apply to orthodontic services and dental implants provided to any Covered Persons, regardless of age.

Section 4.01 - General Information

The Plan offers the Delta Dental of Missouri network of dental care providers. Delta Dental of Missouri contracts with these Dentists to offer Dental services to you at reduced rates. There are two networks of providers that contract with Delta Dental of Missouri. The first network is called Delta Dental PPO and the second network is called Delta Dental Premier. The Dentists in each of these networks are called Participating Dentists.

You are not required to use a Participating Dentist. However, using a Participating Dentist has the following advantages:

- The Plan generally pays a percentage of the total Allowable Charge for Dental Benefits under this Article IV and you (not the Plan) are responsible for paying the rest. The percentage that you pay is called "Coinsurance". As illustrated by the chart at the beginning of this Article IV, your Coinsurance will be lower if you use a Participating Dentist.

- The Plan specifically excludes payment for any part of a charge for treatment that exceeds the Allowable Charge. When you receive services from a Participating Dentist, you will not be billed for more than the total Allowable Charge. If you do not use a Participating Dentist, that Dentist could bill for more than the total Allowable Charge. This means that if you do not use a Participating Dentist, you will have to pay the amount that exceeds the Allowable Charge in addition to the Coinsurance.

To find a Participating Dentist in Delta Dental PPO or Delta Dental Premier, visit Delta Dental of Missouri's website at https://www.deltadentalmo.com/ and search for a Dentist participating in Delta Dental PPO or Delta Dental Premier. A Dentist listed in the search results may not participate in Delta Dental PPO and/or Delta Dental Premier for each location listed in the results. Before scheduling an appointment with a Dentist listed in the search results, it is recommended that you contact the Dentist and verify whether or not the Dentist participates in Delta Dental PPO and/or Delta Dental Premier at the desired location. You may also call Delta Dental of Missouri at (314) 656-3001 or (800) 335-8266 to find a Dentist that participates in Delta Dental PPO or Delta Dental Premier.

If your Dentist determines that you need an extensive course of treatment, you or your Dentist may file a dental treatment plan with Delta Dental before treatment begins. A treatment plan is a written report prepared by your Dentist showing the recommended treatment. Delta Dental will provide you and your Dentist with a form for this purpose. Delta Dental will review the treatment plan, determine if the benefits payable for the proposed treatment will be covered by the Plan, and return the form to your Dentist. It is important to remember that filing a dental treatment plan is not a prerequisite for receiving Dental Benefits. It is a service provided by the Plan to enable you to obtain an evaluation of whether or not a particular course of treatment will be covered by the Plan. If you are informed that benefits will not be payable for the proposed treatment, you may still obtain the treatment and submit a claim. Your claim will be evaluated based on the actual information submitted in support of the claim and not the information submitted with the dental treatment plan.

You do not have to meet a deductible prior to receiving Dental Benefits. Further, the Dental Benefits are separate from the Comprehensive Medical Benefits so the amounts you pay for dental services and supplies that are covered under this Article IV do not count towards your Comprehensive Medical Benefit Annual Out-of-Pocket Maximum.

As described in Section 4.01(a), Dental Benefits are subject to Coinsurance. Additionally, as described in Section 4.01(b), the Plan's coverage of most Dental Benefits is limited to an Annual Dental Benefit Maximum. As described in Section 4.02(e), there is also an Oral Surgery Annual Out-of-Pocket Maximum that only applies to oral surgery services covered under Section 4.02(e).

(a) ***Dental Benefit Coinsurance***

The Plan pays a percentage of the Allowable Charge and you are responsible for paying the rest. The percentage that you pay is called "Coinsurance". As illustrated by the chart at the beginning of this Article IV, your Coinsurance is determined by the type of dental services you receive and the provider of the dental services. Your Coinsurance will be lower if you use a Participating Dentist. Additionally, your Coinsurance will be lower if you use a Dentist that participates in Delta Dental PPO. If a Dentist participates in both Delta Dental PPO and Delta Dental Premier, the Delta Dental PPO Coinsurance will apply.

(b) ***Annual Dental Benefit Maximum***

The Annual Dental Benefit Maximum is $1,500 per person. This means that after the Plan has paid $1,500 of your Dental Benefits during a calendar year, you are generally responsible for amounts that exceed $1,500. There are two exceptions to this rule.

The first exception applies to Covered Persons under age 19. For Covered Persons under age 19, Dental Benefits paid for diagnostic and preventive services under Section 4.02(a) and basic and major services under Section 4.02(b) are not limited to or counted towards the $1,500 per person Annual Dental Benefit Maximum. This means that if a Covered Person is under age 19, only amounts paid by the Plan for dental implants under Section 4.02(c) and orthodontic services under Section 4.02(d) count towards the Covered Person's Annual Dental Benefit Maximum. In contrast, if a Covered Person is age 19 and older, amounts paid by the Plan for diagnostic and preventive services, basic and major services, dental implants, and orthodontic services will count towards the Covered Person's Annual Dental Benefit Maximum.

The second exception applies to oral surgery services. Dental Benefits paid for oral surgery services under Section 4.02(e) are not limited to or counted towards the $1,500 per person Annual Dental Benefit Maximum.

Section 4.02 - Covered Dental Services and Supplies

As indicated in the chart at the beginning of this Article, the Plan's coverage for dental services and supplies depends on whether the services and supplies are categorized as diagnostic and preventive services under Section 4.02(a), basic and major services under Section 4.02(b), dental implants under Section 4.02(c), orthodontic services under Section 4.02(d), or oral surgery services under Section 4.02(e).

In addition to covering dental services and supplies under this Article IV, the Plan also covers certain dental services and supplies as Comprehensive Medical Benefits under Article II. Refer to Article II - Comprehensive Medical Benefits for an explanation of dental services and supplies that are covered by the Plan as Comprehensive Medical Benefits.

(a) ***Diagnostic and Preventive Services***

The Plan covers the diagnostic and preventive services described in this Section 4.02(a) as Dental Benefits at the Coinsurance rates set forth in the chart at the beginning of this Article. Amounts paid by the Plan for diagnostic and preventive services are counted towards the $1,500 Annual Dental Benefit Maximum for most Covered Persons. However, for Covered Persons under age 19, Dental Benefits paid for diagnostic and preventive services are not limited to or counted towards the $1,500 per person Annual Dental Benefit Maximum.

Different limitations apply depending on the specific diagnostic and preventive service provided. The following is a list of diagnostic and preventive services covered by the Plan as Dental Benefits and their limitations:

(1) Routine Examinations and Cleanings (also known as oral evaluations): Available twice every calendar year.

(2) Radiography, including the following:

- Full-Mouth X-Rays: Available twice every calendar year;
- Bitewing: Available twice every calendar year;
- Periapical: Available twice every calendar year;
- Occlusal: Available twice every calendar year; and
- Extraoral Radiographic Imaging: Available twice every calendar year.

(3) Prophylaxis (including cleaning, scaling, and polishing): Available twice every calendar year. This does not include treatment for diseases of the gums, which are covered under Section 4.02(b) below.

(4) Topical Application of Fluoride: Available once every calendar year.

(5) Space Maintainers: Applicable only to Covered Persons under age 16.

(6) Palliative Emergency Treatment: Available as needed.

(b) *Basic and Major Services*

The Plan covers the basic and major services described in this Section 4.02(b) as Dental Benefits at the Coinsurance rates set forth in the chart at the beginning of this Article. Amounts paid by the Plan for basic and major services are counted towards the $1,500 Annual Dental Benefit Maximum for most Covered Persons. However, for Covered Persons under age 19, Dental Benefits paid for basic and major services are not limited to or counted towards the $1,500 per person Annual Dental Benefit Maximum.

Different limitations apply depending on the specific basic and major service provided. The following is a list of basic and major services covered by the Plan as Dental Benefits and their limitations:

(1) Restorations using amalgam, ceramic, or composite resin when necessary.

(2) Sealants on caries free teeth.

(3) Simple extractions.

(4) Periodontic services, including the following:

- Periodontic surgical procedures, including gingivectomy, periradicular surgery, gingival flap surgery, and bone graft (but not osseous surgery);
- Scaling and root planning;
- Periodontal splinting; and
- Periodontal prophylaxis.

(5) Endodontic services, including the following:

- Pulp cap;
- Vital pulpotomy;
- Root canal therapy;
- Apexification/recalcification;

- Apicoectomy;
- Retrograde filling;
- Root resection or amputation; and
- Hemisection (including any root removal).

(6) Anesthesia

General anesthesia

Dental Benefits may be payable for Medically Necessary general anesthesia when the treatment is billed by a Dentist for procedures that the Plan covers as Dental Benefits or when treatment is billed by a Dentist for covered comprehensive restorative work performed on a Covered Person under three years of age.

(7) Prosthodontics - Fixed

Fixed bridges - initial placement or replacement

The Plan covers the initial placement of fixed bridges that are required to replace missing teeth. The Plan also covers the replacement of fixed bridges if the original bridge cannot be made serviceable and five years have elapsed since the last placement.

(8) Prosthodontics - Removable

Full or partial dentures - initial placement or replacement

The Plan covers the initial placement of full or partial removable dentures that are required to replace missing teeth. The Plan also covers the replacement of full or partial removable dentures if the existing denture cannot be made serviceable and five years have elapsed since the last replacement. The Plan does not cover charges for overdentures.

(9) Crowns and jackets

Crowns and jackets are covered as Dental Benefits under this Article IV only if the tooth cannot be restored with a filling material. Crowns and jackets that are covered as Dental Benefits under this Article IV include the following:

- Stainless steel crown;
- Gold foil;
- Inlay/onlay restorations, including metallic, porcelain, ceramic, and resin-based, except as provided in Section 4.03(s);
- Labial veneers, except as provided in Section 4.03(a);
- Cast post and core in addition to crown; and
- Prefabricated post and composite or amalgam.

(10) Occlusal guards

The Plan covers the initial placement of occlusal guards to treat bruxism (grinding). The Plan also covers the replacement of occlusal guards if five years have elapsed since the last placement.

(11) Orthotic devices

The Plan covers the initial placement of orthotic devices to treat temporomandibular joint ("TMJ") dysfunction.

(12) Implant supported prosthetics, including supporting structures (connecting bar, abutments), implant- and abutment-supported crowns and dentures, and other implant services not covered under Dental Implants as described in Section 4.02(c) below.

(c) ***Dental Implants***

The Plan covers the dental implants described in this Section 4.02(c) as Dental Benefits at a rate of 50% of the Allowable Charges. Amounts paid by the Plan for dental implants are counted towards the $1,500 Annual Dental Benefit Maximum for any Covered Person, regardless of age. This means that you are responsible for the remaining 50% of the Allowable Charges as well as any charges that exceed the $1,500 Annual Dental Benefit Maximum.

The Plan's coverage of dental implants includes the surgical placement of implants and retaining screws, implant removal, scaling and debridement, and cleaning of exposed implant surfaces. Plan coverage of dental implants does not include implant supported prosthetics covered under Section 4.02(b)(12) above.

(d) ***Orthodontic Services***

The Plan covers the orthodontic services described in this Section 4.02(d) as Dental Benefits at a rate of 50% of the Allowable Charges. Amounts paid by the Plan for orthodontic services are counted towards the $1,500 Annual Dental Benefit Maximum for any Covered Person, regardless of age. This means that you are responsible for the remaining 50% of the Allowable Charge as well as any charges that exceed the $1,500 Annual Dental Benefit Maximum.

The Plan's coverage of orthodontic services includes treatment for the correction of malposed teeth and the establishment of proper occlusion through movement of teeth and their maintenance in position. This includes the following:

- Orthodontist visits;
- Fixed or removable appliance therapy;
- Cephalometric radiography;
- Diagnostic casts; and
- The construction, placement, and removal of orthodontic retention appliances.

(e) ***Oral Surgery Services***

The Plan covers oral surgery services as a Dental Benefit if the services are provided in a dental facility. The Plan covers oral surgery services described in this Section 4.02(e) at a rate of 80% of the Allowable Charges if the services are provided by a Participating Dentist. The Plan covers oral surgery services described in this Section 4.02(e) at a rate of 60% of the Allowable Charges if the services are provided by a non-Participating Dentist. The Annual Dental Benefit Maximum does not apply to oral surgery services covered under Section 4.02(e). This means that oral surgery services are not limited to $1,500 per calendar year. This also means that oral surgery services are not counted towards the $1,500 Annual Dental Benefit Maximum for any Covered Person, regardless of age.

There is a $500 Oral Surgery Annual Out-of-Pocket Maximum that applies to oral surgery services that you receive from Participating Dentists. The Oral Surgery Annual Out-of-Pocket Maximum is the maximum dollar amount of Allowable Charges that you must pay for oral surgery services in a calendar year before the Plan will begin to pay 100% of the Allowable Charges for oral surgery services that you receive from a Participating Dentist. This means that once you have paid out-of-pocket Allowable Charges of $500 for oral surgery services provided by Participating Dentists, the

Plan will pay 100% of the Allowable Charges for oral surgery services that you receive from Participating Dentists during the remainder of the calendar year. The Oral Surgery Annual Out-of-Pocket Maximum is manually applied. Thus, in order for the Plan to pay 100% of the Allowable Charges for oral surgery services, you must submit a reimbursement request to Solxsys. Your reimbursement request must include both an explanation of benefits for the oral surgery services and proof of payment to the provider. If your reimbursement request is approved, you will receive a check from the Plan for the amounts that you paid in excess of $500. For example, if you pay $1,000 in Allowable Charges for oral surgery that you receive from a Participating Dentist, the Plan will subsequently send you a check for $500.

Amounts you pay for oral surgery services provided by non-Participating Dentists do not count towards your Oral Surgery Annual Out-of-Pocket Maximum. Additionally, amounts you pay for diagnostic and preventive services, basic and major services, dental implants, and orthodontic services do not count towards your Oral Surgery Annual Out-of-Pocket Maximum.

NOTE: Oral surgery services that are provided at a medical Facility or Hospital are not covered under this Article and do not count towards your Oral Surgery Annual Out-of-Pocket Maximum. Refer to Article II - Comprehensive Medical Benefits for a description of coverage for oral surgery services provided at a medical Facility or Hospital.

Section 4.03 - Dental Benefit Exclusions and Limitations

Dental Benefits will not be payable for any of the following:

(a) Any treatment that is primarily cosmetic, including teeth whitening;

(b) Crowns or jackets unless the crown or jacket is necessary because a Covered Person's tooth cannot be restored without a filling;

(c) Oral surgery provided in a Hospital or other medical facility. Expenses for oral surgery provided in a Hospital or other medical facility may be covered, if at all, as Comprehensive Medical Benefits in accordance with Article II;

(d) Services or supplies for which the Covered Person, absent this coverage, would normally incur no charge, such as care rendered by a Dentist to a member of his/her immediate family or the immediate family of his/her spouse;

(e) Services or supplies for which coverage is available under workers' compensation or employers' liability laws;

(f) Services or supplies provided as part of a course of treatment which began prior to the Covered Person being covered by the Plan (including prosthetics but not orthodontic care). For example, if you begin receiving a root canal prior to becoming a Covered Person then subsequently become a Covered Person, the Plan will not cover dental services which are associated with the root canal;

(g) Services or supplies related to TMJ dysfunction except as covered under Section 4.02(b)(11);

(h) Replacement of dentures and other dental appliances which are lost or stolen;

(i) Diseases contracted or injuries or conditions sustained as a result of any act of war;

(j) Denture adjustments for the first six months after the dentures are initially received. Separate fees may not be charged by Participating Dentists;

(k) Duplication of radiographs or temporary appliances;

(l) Services or supplies provided or paid for by or under any governmental agency or program or law, except charges which the person is legally obligated to pay (this exclusion extends to any benefits provided under the U.S. Social Security Act, as amended);

(m) Services rendered beyond the scope of a Dentist's or service provider's license;

(n) Experimental or investigational services/supplies;

(o) Services or supplies covered under Article II - Comprehensive Medical Benefits (e.g., services provided while you are confined in a Hospital);

(p) Services or supplies that a Dentist determines for any reason, in his/her professional judgment, should not be provided. If a Dentist determines that a procedure or service has a poor likelihood of success, the Dentist is obligated to inform the Covered Person. If the Covered Person insists on having the service provided, it will be provided at the Covered Person's expense. For example, Dental Benefits will not be payable if a Dentist recommends against placing a crown on a tooth, the Covered Person asks to have a crown placed on the tooth, and the Dentist provides the crown;

(q) Instructions in dental hygiene, dietary planning, or plaque control;

(r) Missed appointments or claim form completion; and

(s) Inlay/onlay restorations to the extent the cost of the inlay/onlay restorations exceed the cost of amalgam restorations.

Section 4.04 - Filing a Claim for Dental Benefits

Your Dental Benefit Claim must be filed with Delta Dental at the address shown on your identification card. Participating Dentists and many other Dentists may file a claim with Delta Dental on your behalf. You should always present your identification card to your provider at the time services are rendered.

If your provider does not file a claim on your behalf, you must file a claim form with Delta Dental using Delta Dental's claim form, which is available from Solxsys. Delta Dental must receive your claim by December 31 of the calendar year following the calendar year in which the expense was incurred. An expense is incurred at the time a product or service is actually provided.

If this Plan is secondary, you or your provider should still file your Dental Benefit Claim with Delta Dental, along with a copy of the primary plan or carrier's explanation of benefits, at the address shown on your identification card.

ARTICLE V - VISION BENEFITS

The following topics are discussed under this Article on Vision Benefits:

5.01 General Information
5.02 Covered Vision Services and Supplies
5.03 Vision Benefit Exclusions
5.04 Filing a Claim

VISION BENEFITS FOR ELIGIBLE EMPLOYEES (i.e., this chart only applies to Eligible Employees)		
BENEFIT	**FREQUENCY ALLOWED**	**PLAN PAYS**
Eye Examination	Once Per Calendar Year	100% up to a maximum of $50
Single Vision Lenses (pair)	Two Pairs and/or Sets (as applicable) Per Calendar Year (i.e., a total of two pairs and/or sets of lenses are covered per calendar year. For example, the Plan would cover one pair of bifocal lenses and one set of elective contact lenses during the 2023 calendar year, subject to the dollar limits in the next column).	100% up to a maximum of $50 per pair, plus $10 per pair for lens tinting
Bifocal Lenses (pair)		100% up to a maximum of $85 per pair, plus $10 per pair for lens tinting
Trifocal Lenses (pair)		100% up to a maximum of $95 per pair, plus $10 per pair for lens tinting
Progressive Lenses (pair)		100% up to a maximum of $95 per pair, plus $10 per pair for lens tinting
Elective Contact Lenses (set)		100% up to a maximum of $100 per set
Visually Necessary Contact Lenses (set)	Two Sets Per Calendar Year	100%, no maximum applies (i.e., there is no dollar limit)
Frames	One Pair Per Calendar Year	100% up to a maximum of $75
Refractive Eye Surgery (e.g., LASIK)	One Surgery Per Eye Per Lifetime	100% up to a maximum of $1,000 per eye

<table>
<tr><th colspan="3">VISION BENEFITS FOR RETIREES
(i.e., this chart only applies to Retirees)</th></tr>
<tr><th>BENEFIT</th><th>FREQUENCY ALLOWED</th><th>PLAN PAYS</th></tr>
<tr><td>Eye Examination</td><td>Once Per Calendar Year</td><td>100% up to a maximum of $50</td></tr>
<tr><td>Single Vision Lenses (pair)</td><td rowspan="5">One Pair or Set (as applicable) Per Calendar Year (i.e., only one pair or set of lenses is covered per calendar year. For example, if the Plan covered a set of elective contact lenses on January 1, 2023, the Plan would not cover any other lenses during the 2023 calendar year, subject to the dollar limits in the next column).</td><td>100% up to a maximum of $50 per pair, plus $10 per pair for lens tinting</td></tr>
<tr><td>Bifocal Lenses (pair)</td><td>100% up to a maximum of $85 per pair, plus $10 per pair for lens tinting</td></tr>
<tr><td>Trifocal Lenses (pair)</td><td>100% up to a maximum of $95 per pair, plus $10 per pair for lens tinting</td></tr>
<tr><td>Progressive Lenses (pair)</td><td>100% up to a maximum of $95 per pair, plus $10 per pair for lens tinting</td></tr>
<tr><td>Elective Contact Lenses (set)</td><td>100% up to a maximum of $100 per set</td></tr>
<tr><td>Visually Necessary Contact Lenses (set)</td><td>One Set Per Calendar Year</td><td>100%, no maximum applies (i.e., there is no dollar limit)</td></tr>
<tr><td>Frames</td><td>One Pair Per Every Two Calendar Years (i.e., one pair is covered every other calendar year)</td><td>100% up to a maximum of $75 per pair</td></tr>
</table>

<table>
<tr><th colspan="3">VISION BENEFITS FOR DEPENDENTS
(i.e., this chart only applies to Dependents)</th></tr>
<tr><th>BENEFIT</th><th>FREQUENCY ALLOWED</th><th>PLAN PAYS</th></tr>
<tr><td>Eye Examination</td><td>Once Per Calendar Year</td><td>100% up to a maximum of $50*</td></tr>
<tr><td>Single Vision Lenses (pair)</td><td rowspan="5">One Pair or Set (as applicable) Per Calendar Year (i.e., only one pair or set of lenses is covered per calendar year. For example, if the Plan covered a set of elective contact lenses on January 1, 2023, the Plan would not cover any other lenses during the 2023 calendar year, subject to the dollar limits in the next column).</td><td>100% up to a maximum of $50** per pair, plus $10 per pair for lens tinting</td></tr>
<tr><td>Bifocal Lenses (pair)</td><td>100% up to a maximum of $85** per pair, plus $10 per pair for lens tinting</td></tr>
<tr><td>Trifocal Lenses (pair)</td><td>100% up to a maximum of $95** per pair, plus $10 per pair for lens tinting</td></tr>
<tr><td>Progressive Lenses (pair)</td><td>100% up to a maximum of $95** per pair, plus $10 per pair for lens tinting</td></tr>
<tr><td>Elective Contact Lenses (set)</td><td>• For Dependents under age 19, 100% up to a maximum of $300 per set
• For Dependents age 19 and older, 100% up to a maximum of $100 per set</td></tr>
<tr><td>Visually Necessary Contact Lenses (set)</td><td>One Set Per Calendar Year</td><td>100%, no maximum applies
(i.e., there is no dollar limit)</td></tr>
<tr><td>Frames</td><td>One Pair Per Every Two Calendar Years (i.e., one pair is covered every other calendar year)</td><td>• For Dependents under age 19, 100% up to a maximum of $130 per pair
• For Dependents age 19 and older, 100% up to a maximum of $75 per pair</td></tr>
<tr><td colspan="3">* The $50 benefit maximum on eye examinations does not apply to Dependents under the age of 19. This means that no dollar limit applies to an eye examination that is provided to a Dependent under the age of 19.

** The $50 benefit maximum on single vision lenses, the $85 benefit maximum on bifocal lenses, the $95 benefit maximum on trifocal lenses, and the $95 benefit maximum on progressive lenses do not apply to Dependents under the age of 19. This means that the only dollar limit applicable to a pair of single vision, bifocal, trifocal, or progressive lenses that is purchased for a Dependent under the age of 19 is the $10 limit on lens tinting.</td></tr>
</table>

Section 5.01 - General Information

The Plan does not offer a network of vision care providers (i.e., there are no vision care providers that are considered in-network). This means that the amount that the Plan pays for a covered vision supply or service does not depend on whether a vision care provider is in a specified network.

You do not have to meet a Deductible prior to receiving Vision Benefits. Further, the Vision Benefits are separate from the Comprehensive Medical Benefits so the amounts you pay for vision services and supplies that are covered under Section 5.02 do not count towards your Comprehensive Medical Benefit Annual Out-of-Pocket Maximum.

Section 5.02 - Covered Vision Services and Supplies

As indicated in the charts at the beginning of this Article and Sections 5.02(a)-(c), the Plan's coverage for vision services or supplies depends on whether the services or supplies are provided to an Eligible Employee (see Section 5.02(a)), a Retiree (see Section 5.02(b)) or a Dependent (see Section 5.02(c)).

(a) Covered Vision Services and Supplies for Eligible Employees

The Plan will pay for the following vision services and supplies that are provided to an Eligible Employee:

(1) Eye Examinations: Available once every calendar year. If the cost of your eye exam exceeds the benefit maximum that is listed in the first chart at the beginning of this Article, you are responsible for the additional amount.

(2) Glasses Lenses: Available twice every calendar year. The lenses that are covered by the Plan in accordance with this Section 5.02(a)(2) are single vision lenses, bifocal lenses, trifocal lenses, and progressive lenses. This means that the Plan covers a total of two pairs of any combination of single vision lenses, bifocal lenses, trifocal lenses, and/or progressive lenses per calendar year, subject to the benefit maximums that are listed in the first chart at the beginning of this Article (for example, the Plan would cover one pair of bifocal lenses and one pair of trifocal lenses during the 2023 calendar year, subject to the applicable benefit maximums). The Plan will also cover tinting that is prescribed by a health care provider for each pair of lenses. The tinting that is covered by the Plan in accordance with this Section 5.02(a)(2) is the addition of any color to a pair of lenses, whether solid, gradient, or equal. If the cost of a pair of your lenses exceeds the applicable benefit maximum, you are responsible for the additional amount.

(3) Elective Contact Lenses: Available twice every calendar as a substitute for the lenses described in Section 5.02(a)(2). The contact lenses that are covered by the Plan in accordance with this Section 5.02(a)(3) are prescription contact lenses that you choose for any purpose other than the visually necessary purpose that is described in Section 5.02(a)(4). This means that if you would like to purchase a set of prescription contact lenses to correct a vision problem(s) that you could also correct with prescription glasses, the Plan will cover a total of two sets or pairs of the contact lenses and/or glasses lenses per calendar year, subject to the benefit maximums that are listed in the first chart at the beginning of this Article (for example, the Plan will cover one set of elective contact lenses and one pair of bifocal lenses during the 2023 calendar year, subject to the applicable benefit maximums). If the cost of a set of your elective contact lenses exceeds the benefit maximum that is listed in the first chart at the beginning of this Article, you are responsible for the additional amount.

(4) Visually Necessary Contact Lenses: Available twice every calendar year. The contact lenses that are covered by the Plan in accordance with this Section 5.02(a)(4) are contact lenses that you need to correct a vision problem that cannot be corrected with prescription glasses.

(5) Frames: Available once every calendar year. If the cost of your frames exceeds the benefit maximum that is listed in the first chart at the beginning of this Article, you are responsible for the additional amount.

(6) Refractive Eye Surgery (e.g., LASIK): Available once for each eye. This means that during your lifetime, the Plan will cover one refractive eye surgery for each of your eyes, subject to the benefit maximum that is listed in the first chart at the beginning of this Article. If the cost of your refractive eye surgery exceeds the benefit maximum, you are responsible for the additional amount.

The frequency limits included in this Section 5.02(a) and the chart at the beginning of this Article apply regardless of whether you lose or break a pair or set of lenses and/or frames during the calendar year. This means that the Plan will not cover a replacement pair or set of lenses or frames except at the regular intervals described in this Section 5.02(a) and the chart at the beginning of this Article. For example, if the Plan covered a set of your elective contact lenses on January 1, 2023, the Plan covered a pair of your bifocal lenses on March 1, 2023, and you lost your contact lenses on June 1, 2023, the Plan would not cover another set of your elective contact lenses until January 1, 2024.

(b) Covered Vision Services and Supplies for Retirees

The Plan will pay for the following vision services and supplies that are provided to a Retiree:

(1) Eye Examinations: Available once every calendar year. If the cost of your eye exam exceeds the benefit maximum that is listed in the second chart at the beginning of this Article, you are responsible for the additional amount.

(2) Glasses Lenses: Available once every calendar year. The lenses that are covered by the Plan in accordance with this Section 5.02(b)(2) are single vision lenses, bifocal lenses, trifocal lenses, and progressive lenses. This means that the Plan only covers one pair of single vision lenses, one pair of bifocal lenses, one pair of trifocal lenses, or one pair of progressive lenses per calendar year, subject to the benefit maximums that are listed in the second chart at the beginning of this Article (for example, if the Plan covered a pair of bifocal lenses on January 1, 2023, the Plan would not cover any other lenses during the 2023 calendar year). The Plan will also cover tinting that is prescribed by a health care provider for each pair of lenses. The tinting that is covered by the Plan in accordance with this Section 5.02(b)(2) is the addition of any color to a pair of lenses, whether solid, gradient, or equal. If the cost of a pair of your lenses exceeds the applicable benefit maximum, you are responsible for the additional amount.

(3) Elective Contact Lenses: Available once every calendar as a substitute for the lenses described in Section 5.02(b)(2). The contact lenses that are covered by the Plan in accordance with this Section 5.02(b)(3) are prescription contact lenses that you choose for any purpose other than the visually necessary purpose that is described in Section 5.02(b)(4). This means that if you would like to purchase a set of prescription contact lenses to correct a vision problem(s) that you could also correct with prescription glasses, the Plan will cover either one set of elective contact lenses or one pair of glasses lenses per calendar year, subject to the benefit maximums that are listed in the second chart at the beginning of this Article (for example, if the Plan covered a set of elective contact lenses that you purchased on January 1, 2023, the Plan would

not cover any other contact lenses or glasses lenses that you purchase during the 2023 calendar year). If the cost of your elective contact lenses exceeds the benefit maximum that is listed in the second chart at the beginning of this Article, you are responsible for the additional amount.

(4) Visually Necessary Contact Lenses: Available once every calendar year. The contact lenses that are covered by the Plan in accordance with this Section 5.02(b)(4) are contact lenses that you need to correct a vision problem that cannot be corrected with prescription glasses.

(5) Frames: Available once every other calendar year. If the cost of your frames exceeds the benefit maximum that is listed in the second chart at the beginning of this Article, you are responsible for the additional amount.

The frequency limits included in this Section 5.02(b) and the chart at the beginning of this Article apply regardless of whether you lose or break a pair or set of lenses and/or frames during the calendar year. This means that the Plan will not cover a replacement pair or set of lenses or frames except at the regular intervals described in this Section 5.02(b) and the chart at the beginning of this Article. For example, if the Plan covered a set of your elective contact lenses on January 1, 2023, and you lose those contact lenses on June 1, 2023, the Plan would not cover another set of your elective contact lenses until January 1, 2024.

(c) Covered Vision Services and Supplies for Dependents

The Plan will pay for the following vision services and supplies that are provided to a Dependent:

(1) Eye Examinations: Available once every calendar year. If the cost of your Dependent's eye exam exceeds the benefit maximum that is listed in the third chart at the beginning of this Article, your Dependent is responsible for the additional amount.

(2) Glasses Lenses: Available once every calendar year. The lenses that are covered by the Plan in accordance with this Section 5.02(c)(2) are single vision lenses, bifocal lenses, trifocal lenses, and progressive lenses. This means that the Plan only covers one pair of single vision lenses, one pair of bifocal lenses, one pair of trifocal lenses, or one pair of progressive lenses per calendar year, subject to the benefit maximums that are listed in the third chart at the beginning of this Article (for example, if the Plan covered a pair of bifocal lenses on January 1, 2023, the Plan would not cover any other lenses during the 2023 calendar year). The Plan will also cover tinting that is prescribed by a health care provider for each pair of lenses. The tinting that is covered by the Plan in accordance with this Section 5.02(c)(2) is the addition of any color to a pair of lenses, whether solid, gradient, or equal. If the cost of a pair of your lenses exceeds the applicable benefit maximum, you are responsible for the additional amount.

(3) Elective Contact Lenses: Available once every calendar as a substitute for the lenses described in Section 5.02(c)(2). The contact lenses that are covered by the Plan in accordance with this Section 5.02(c)(3) are prescription contact lenses that your Dependent chooses for any purpose other than the visually necessary purpose that is described in Section 5.02(c)(4). This means that if your Dependent would like to purchase a set of prescription contact lenses to correct a vision problem(s) that (s)he could also correct with prescription glasses, the Plan will cover either one set of elective contact lenses or one pair of glasses lenses per calendar year, subject to the benefit maximums that are listed in the third chart at the beginning of this Article (for example, if the Plan covered a set of elective contact lenses that your Dependent purchased on January 1, 2023, the Plan would not cover any other contact lenses or glasses lenses that your Dependent purchased during the 2023 calendar year). If the cost of your Dependent's elective contact lenses

exceeds the benefit maximum that is listed in the third chart at the beginning of this Article, your Dependent is responsible for the additional amount.

(4) Visually Necessary Contact Lenses: Available once every calendar year. The contact lenses that are covered by the Plan in accordance with this Section 5.02(c)(4) are contact lenses that your Dependent needs to correct a vision problem that cannot be corrected with prescription glasses.

(5) Frames: Available once every other calendar year. If the cost of your Dependent's frames exceeds the benefit maximum that is listed in the third chart at the beginning of this Article, your Dependent is responsible for the additional amount.

The frequency limits included in this Section 5.02(c) and the chart at the beginning of this Article apply regardless of whether your Dependent loses or breaks a pair or set of lenses and/or frames during the calendar year. This means that the Plan will not cover a replacement pair or set of lenses or frames except at the regular intervals described in this Section 5.02(c) and the chart at the beginning of this Article. For example, if the Plan covered a set of your Dependent's elective contact lenses on January 1, 2023, and your Dependent loses those contact lenses on June 1, 2023, the Plan would not cover another set of your Dependent's elective contact lenses until January 1, 2024.

Section 5.03 - Vision Benefit Exclusions

Vision Benefits will not be payable for any of the following:

(a) Services and supplies that are not listed in the charts at the beginning of this Article;

(b) Charges in excess of the benefit maximums listed in the charts at the beginning of this Article;

(c) Charges for anti-reflective coating, anti-scratch coating, UV coating, or any other special lens addition or coatings except for tinting as described in Sections 5.02(a)(2), 5.02(b)(2), and 5.02(c)(2);

(d) Eye examinations required by an employer as a condition of employment;

(e) Non-prescription supplies, such as sunglasses;

(f) Amounts for services or supplies for which the Covered Person does not pay or is not responsible for paying;

(g) Cosmetic services and supplies; and

(h) Services and supplies covered under Article II of the Plan.

Section 5.04 - Filing a Claim

You will need to pay for all services and supplies at the time you receive them and then submit a claim to Solxsys at the address listed below. Solxsys must receive your claim by December 31 of the calendar year following the calendar year in which the expense was incurred. All claims must include the following information:

(a) An itemized paid receipt listing the services provided or supplies purchased;

(b) A copy of the provider's prescription, if applicable;

(c) A copy of the provider's certification that the patient cannot wear eyeglasses due to a medical condition if you are seeking reimbursement for visually necessary contact lenses;

(d) The Participant's name and Social Security Number; and

(e) The patient's name and Social Security Number.

You must mail your claim to the following address:

Solxsys Administrative Solutions, LLC
8600 Hillcrest Road, Suite A
Kansas City, MO 64138

ARTICLE VI - DEATH BENEFITS

The following topic is discussed under this Article on the Plan's Death Benefits:

6.01 Death Benefits

DEATH BENEFITS
A Participant's Designated Beneficiary may receive a Death Benefit in the amount of $10,000.

Section 6.01 - Death Benefits

The Death Benefits in this Article are only available for the death of a Participant (i.e., the death of an Eligible Employee or a Retiree). The Death Benefits in this Article are not available for the death of a Dependent, qualified beneficiary (i.e., individual covered by COBRA), or surviving spouse.

If a Participant dies after June 1, 2004, the Participant's Designated Beneficiary may receive a Death Benefit in the amount of $10,000 in accordance with the following rules:

(a) If you are a Participant, you may designate a Beneficiary in writing on the Plan's Beneficiary Designation Form and you may change or revoke your Beneficiary designation at any time prior to your death. A Beneficiary Designation Form is only effective if it is filed with the Fund Office prior to your death (i.e., your Beneficiary Designation Form is only effective if it is received by the Fund Office prior to your death).

Notwithstanding the foregoing, if you are a Participant and you designate your spouse as your Beneficiary, your Beneficiary designation will automatically become null and void upon divorce. If you get divorced and you want your ex-spouse to remain your Designated Beneficiary, you must file a new Beneficiary Designation Form with the Fund Office after your divorce. If you designated your spouse and another individual as your Designated Beneficiaries, only the portion of the Beneficiary designation that relates to your spouse will automatically become null and void upon divorce. For example, if your Beneficiary Designation Form lists both your spouse and son as your primary Designated Beneficiaries and you die while you are still married to your spouse, your spouse and son will each receive $5,000 (50% of the Death Benefit). If you divorce your spouse, do not file a new Beneficiary Designation Form with the Fund Office, and then die, your son will receive $10,000 (100% of the Death Benefit).

In any circumstance in which the Plan Administrator reasonably questions the validity of a Beneficiary designation or revocation, including all circumstances in which a Beneficiary Designation Form is submitted to the Fund Office by a person other than the Participant, the Plan Administrator may request additional information to prove the validity of the Beneficiary designation or revocation and may refuse to recognize the Beneficiary designation or revocation until satisfactory proof of its validity has been provided. In the event no satisfactory proof of validity is provided within the time designated by the Plan Administrator (which shall be no less than 45 days), the Plan Administrator may reject such Beneficiary designation or revocation. Further, if the Plan Administrator determines that a Beneficiary designation or revocation is unclear or impractical to apply within 30 days after the date that the Plan Administrator received the Beneficiary designation or revocation, the Plan Administrator may reject such Beneficiary designation or revocation.

(b) If you are a Participant and you die without having validly designated a Beneficiary to receive your Death Benefit, or if all of your Designated Beneficiaries predecease you, the first of the following who survives you shall be your Designated Beneficiary:

(1) Your spouse;

(2) Your descendants, per stirpes;

(3) Your parents, in equal shares;

(4) Your siblings, in equal shares; or

(5) Your estate.

If you designate your spouse as your sole Beneficiary, and the Beneficiary designation becomes null and void in accordance with Section 6.01(a), you will be treated as though you died without having validly designated a Beneficiary unless you file a new Beneficiary Designation Form with the Fund Office prior to your death.

ARTICLE VII - ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

The following topic is discussed under this Article on the Plan's Accidental Death and Dismemberment ("AD&D") Benefits:

7.01 AD&D Benefits

AD&D BENEFITS	
If an Eligible Employee is involved in an accident that causes him/her to lose . . .	**The Eligible Employee may receive an AD&D Benefit in the amount of . . .**
One hand*	$750
One foot**	$750
Entire sight in one eye***	$750
His/Her	$1,500

* Loss of a hand occurs when the entire hand is completely severed from the body through or above the wrist joint.

** Loss of a foot occurs when the entire foot is completely severed from the body through or above the ankle joint.

*** Loss of entire sight occurs when there is no reasonable medical expectation that sight can be recovered, and no residual sight is retained.

The maximum amount that an Eligible Employee may receive for losses that are caused by one accident is $1,500. For example, if one hand and one foot are lost in the same accident, an Eligible Employee will receive $1,500 ($750 for one hand and $750 for one foot). If both hands and one foot are lost in the same accident, an Eligible Employee will receive $1,500 (not $2,250).

Section 7.01 - AD&D Benefits

The AD&D Benefits described in this Article are only available for the accidental death or dismemberment of an Eligible Employee. The AD&D Benefits described in this Article are not available for the accidental death or dismemberment of a Retiree, Dependent, qualified beneficiary (i.e., individual covered by COBRA), or surviving spouse.

If an Eligible Employee dies, loses his/her limb(s), and/or loses his/her sight due to an accident, the Eligible Employee may receive an AD&D Benefit in accordance with the following rules:

(a) If you are an Eligible Employee and you lose your life or your limb(s) (i.e., your hand or foot) and/or your entire sight in one or both eyes as a direct result of an accident, you may receive an AD&D Benefit in the amount listed in the chart at the beginning of this Article. For purposes of this Section 7.01(a), your loss is only considered to have occurred as a direct result of an accident if your loss occurs within 90 days after the date of the accident and your loss is independent of any sickness or other cause. For example, if you are in a car accident and you lose your foot 100 days after the date of the accident due to the injuries that you sustained in the accident, you will not receive an AD&D Benefit for the loss of your foot because your loss occurred more than 90 days after the date of the accident. If, instead, you lose your foot 70 days after the date of the accident, you will receive an AD&D Benefit for the loss of your foot so long as your loss was not caused by any of the events listed in Section 7.01(b).

(b) No AD&D Benefits will be paid by this Plan for:

(1) A loss that is caused by an accident that occurred over 90 days prior to the date of the loss;

(2) A loss that is caused by any sickness or other physical or mental condition;

(3) A loss that is caused by any type of infection, except an infection introduced through a wound sustained in an accidental injury, simultaneously with such accidental injury, and not occurring as a result of later treatment or failure to treat the accidental injury;

(4) A loss that is caused by or contributed to by any medical, surgical, or dental treatment, even if such treatment is provided in response to an accidental injury;

(5) A loss that is caused by suicide, attempted suicide, or intentional self-inflicted injury, regardless of your physical or mental state at the time the act is committed;

(6) A loss that is caused by ingestion of or exposure to poisons, drugs, medicines, chemicals, or other substances, regardless of the state of matter of the substance (including, but not limited to, food poisoning or exposure to carbon monoxide gas);

(7) A loss that is caused by an injury that occurred during the commission or attempted commission of a crime;

(8) A loss that is incurred in connection with war, insurrections, or participation in a riot;

(9) A loss that is incurred while you are serving in any military, naval, or air force of any country at war, declared or undeclared, or in any auxiliary or civilian non-combatant unit serving in a war-related capacity with any such force; or

(10) A loss that is incurred while traveling or flying in or on any type of aircraft, except while riding as a passenger on a regularly scheduled commercial airline operated by a common carrier or by a U.S. Government transport service.

ARTICLE VIII - ACCIDENT AND SICKNESS LOSS OF TIME BENEFITS

The following topics are discussed under this Article on Accident and Sickness Loss of Time Benefits:

8.01 Accident and Sickness Loss of Time Benefits

ACCIDENT AND SICKNESS LOSS OF TIME BENEFITS
An Eligible Employee may receive Accident and Sickness Loss of Time Benefits during any period that the Eligible Employee is not retired and (s)he is unable to work for at least one week due to an Injury or Sickness. The maximum Accident and Sickness Loss of Time Benefit for one Period of Disability is $400 gross amount per week for a maximum of 39 weeks.

Section 8.01 - Accident and Sickness Loss of Time Benefits

The Accident and Sickness Loss of Time Benefits in this Article are only available for Eligible Employees. The Accident and Sickness Loss of Time Benefits are not available for Retirees, Dependents, qualified beneficiaries (i.e., individuals covered by COBRA), or surviving spouses.

If an Eligible Employee is not retired and (s)he is unable to work for at least one week due to an Injury or Sickness, the Eligible Employee may receive Accident and Sickness Loss of Time Benefits in accordance with the following rules:

(a) The maximum Accident and Sickness Loss of Time Benefit you may receive is $400 gross amount per week for a maximum of 39 weeks for any one Period of Disability. The weekly benefit is calculated on a seven calendar day period beginning with the first day of a Period of Disability (in other words, beginning with the first day that you are unable to work due to a covered Injury or Sickness). The first day of any Period of Disability will never be considered to be more than three calendar days prior to the date on which you were first seen by a Physician, Physician Assistant, or Nurse Practitioner for the Injury or Sickness causing the disability. If a Period of Disability lasts less than 39 weeks, but ends with a partial week (for example, if your Period of Disability lasts for 19 days), you will receive a partial week's payment for the number of days you were unable to work in the final week based on the weekly rate divided by seven. For example, if you are unable to work for 19 days, you will get $400 per week for each of the first two weeks and then you will be paid $285.71 ($57.14 per day) for the final partial week (the final five days).

(b) A "Period of Disability" is the total amount of time that you are completely unable to perform any work in your own occupation due to an Injury or Sickness. If you are unable to work after your initial Period of Disability, any subsequent Accident and Sickness Loss of Time Benefits will be paid as follows:

(1) Reoccurring Disability: If the subsequent disability is a "reoccurring disability," you will be treated as if your initial Period of Disability had not ended (except that you will not be entitled to any Accident and Sickness Loss of Time Benefits for the time between the date you stopped

receiving Accident and Sickness Loss of Time Benefits and the date that you are subsequently unable to work due to an Injury or Sickness). This means that if you already received Accident and Sickness Loss of Time Benefits for 39 weeks, you will not be entitled to any additional Accident and Sickness Loss of Time Benefits. If you have not already received Accident and Sickness Loss of Time Benefits for 39 weeks, you may receive Accident and Sickness Loss of Time Benefits for a maximum period of time equal to 39 weeks minus the number of weeks that you have already received Accident and Sickness Loss of Time Benefits.

For purposes of this Section 8.01(b)(1), your disability will be considered a reoccurring disability if both of the following conditions are met:

i. You are completely unable to perform any work in your own occupation due to an Injury or Sickness that is the same as or related to the Injury or Sickness that rendered you unable to work during your initial Period of Disability; and

ii. You have not worked in Covered Employment for at least two weeks after your initial Period of Disability. For purposes of this Section 8.01(b)(1)(ii), "two weeks" means 10 full workdays in a consecutive 14-day period (i.e., you worked at least 10 full days in a period of 14 consecutive days).

(2) Separate Disability: If the subsequent disability is a "separate disability," a second and separate Period of Disability will begin, and you may receive a maximum of 39 additional weeks of Accident and Sickness Loss of Time Benefits (provided all the criteria of this Section 8.01 are met). This means that you may receive Accident and Sickness Loss of Time Benefits for a maximum of 39 weeks, regardless of the duration of your initial Period of Disability. For purposes of this Section 8.01, your disability will be considered a separate disability if one of the following conditions is met:

i. You are completely unable to perform any work in your own occupation due to an Injury or Sickness that is unrelated to the Injury or Sickness that rendered you unable to work during your initial Period of Disability; or

ii. You have returned to and actually worked in Covered Employment for at least two weeks after your initial Period of Disability. For purposes of this Section 8.01(b)(2)(ii), "two weeks" means 10 full workdays in a consecutive 14-day period (i.e., you worked at least 10 full days in a period of 14 consecutive days).

(c) No Accident and Sickness Loss of Time Benefits will be paid under this Plan for:

(1) Any Period of Disability caused by an intentionally self-inflicted Injury, unless the self-inflicted Injury was the result of a physical or mental health condition;

(2) Any Period of Disability caused by a Sickness that is a substance abuse disorder (i.e., the reason you are unable to work is that you have a substance abuse disorder such as alcoholism) except as provided in Section 8.01(d);

(3) Any Period of Disability caused by an Injury or Sickness that occurred because of your use of alcohol or drugs (e.g., a Sickness resulting from a drug overdose or an Injury you incurred while you were under the influence of drugs or alcohol);

(4) Any Period of Disability that lasts less than seven consecutive days;

(5) Any period during which you are engaged in any gainful employment;

(6) Any period during which you are receiving unemployment insurance and/or compensation payments;

(7) Any period during which you are receiving benefits from the Pension Plan; or

(8) Any Period of Disability caused by an Injury or Sickness sustained while performing any act or duty in the course of your employment and for which you have received or are entitled to receive compensation under any program of workers' compensation, occupational disease law, or related program. The exclusion in this Section 8.01(c)(8) shall apply even if you settle your claims under such law(s) or program(s). The exclusion in this Section 8.01(c)(8) shall also apply if you do not receive workers' compensation because you failed to file a timely claim and/or you did not comply with the terms, rules, and/or conditions of such workers' compensation program. Further, the exclusion in this Section 8.01(c)(8) shall apply even if your employer does not carry the workers' compensation insurance that your employer is required to carry in accordance with applicable State and/or Federal law.

(d) If your Period of Disability is caused by a Sickness that is a substance abuse disorder (i.e., if the Sickness that prevents you from working is a substance abuse disorder such as alcoholism) and you are participating in an inpatient treatment program for that disorder at an in-network facility, you may receive Accident and Sickness Loss of Time Benefits during the period that you participate in the inpatient treatment program in accordance with the following rules:

(1) If you successfully complete the inpatient treatment program, you may receive Accident and Sickness Loss of Time Benefits for each day that you participated in the inpatient treatment program for a maximum of 30 days. For example, if you complete an inpatient treatment program that lasts 45 days, you will get $400 a week for each of the first four weeks and $114.28 for the last two days (the first four weeks is 28 days, so benefits are only payable for two additional days even though the program lasted 45 days).

(2) If you successfully complete at least five weeks of the inpatient treatment program but you do not complete the entire inpatient treatment program, then you may receive Accident and Sickness Loss of Time Benefits for each day that you participated in the inpatient treatment program for a maximum of 30 days. For example, if you are in an inpatient treatment program that lasts 45 days and you only completed 35 days of the program, you will get $400 a week for each of the first four weeks (28 days) and $114.28 for the last two days.

(3) If you do not complete at least five weeks of the inpatient treatment program and you do not complete the entire inpatient treatment program, you may receive Accident and Sickness Loss of Time Benefits for each full week of the inpatient treatment program that you completed, but you will not receive Accident and Sickness Loss of Time Benefits for any portion of a week that you did not complete. For example, if you are in an inpatient treatment program that lasts 45 days and you only completed 30 days of the program, you will get $400 a week for each of the first four weeks (28 days) and you will not get anything for the last two days.

(4) You may only receive Accident and Sickness Loss of Time Benefits in accordance with this Section 8.01(d) one time per calendar year. This means that if you received Accident and Sickness Loss of Time Benefits during a period that you participated in an inpatient treatment program, then you will not receive Accident and Sickness Loss of Time Benefits if you participate in another inpatient treatment program during the same calendar year. Further, you may only receive Accident and Sickness Loss of Time Benefits in accordance with this Section 8.01(d) if your inpatient treatment program was provided at an in-network facility.

(e) To become eligible to receive Accident and Sickness Loss of Time Benefits, you must provide the Fund Office proof that you are unable to work due to an Injury or Sickness. You may also be required to periodically submit proof that you are unable to work due to an Injury or Sickness throughout your Period of Disability. If you are receiving Accident and Sickness Loss of Time Benefits in accordance with this Section 8.01, you must notify the Fund Office prior to or immediately upon the occurrence of one of the following events:

(1) You must provide written notice to the Fund Office before engaging in any employment;

(2) You must provide written notice to the Fund Office prior to the date you receive unemployment insurance and/or compensation payments;

(3) You must provide written notice to the Fund Office prior to the date that your inpatient program for treatment of alcoholism or substance abuse ends; and

(4) You must provide written notice to the Fund Office on the date a Physician, Physician Assistant, or Nurse Practitioner determines that you are no longer unable to work because of an Injury or Sickness.

Failure to provide notification in accordance with this Section 8.01(e) could result in an overpayment of benefits that you will be required to repay in accordance with Section 13.18. You may also be responsible for additional costs incurred by the Plan to recover the overpayment.

(f) You will be credited with 16 hours per week for each week that you meet both of the following criteria:

(1) You are absent from work because you are completely unable to perform any work in your own occupation due to an Injury or Sickness; and

(2) You are either receiving Accident and Sickness Loss of Time Benefits in accordance with this Section 8.01 or you are receiving benefits under workers' compensation (or a similar law or program) during the period that you are unable to work in your own occupation.

If you meet both of the criteria above for a period that includes a partial week, you will be credited with a prorated number of hours, calculated by multiplying the 16 hours of weekly credit by a fraction, the numerator of which is the number of days during the partial week that you meet the criteria above, and the denominator of which is seven. You will not be credited with any hours during a period that benefits under workers' compensation (or similar law or program) are paid based on a partial disability.

ARTICLE IX - CLAIMS AND APPEALS PROCEDURES

The following topics are discussed under this Article on Claims and Appeals Procedures:

9.01 Definitions for this Article IX Only

9.02 Use of an Authorized Representative or Other Individual to File a Claim or Appeal on Your Behalf

9.03 Comprehensive Medical Benefit Claims and Appeals

9.04 Prescription Drug Benefit Claims and Appeals

9.05 Dental Benefit Claims and Appeals

9.06 Vision Benefit Claims and Appeals

9.07 Accident and Sickness Loss of Time Benefit Claims and Appeals

9.08 Death Benefit and AD&D Benefit Claim and Appeals

9.09 Rescission of Coverage

9.10 Surprise Billing and Cost-Sharing Protections Under the No Surprises Act

9.11 Judicial Review

9.12 Suspension of Certain Deadlines Due to COVID-19

If your claim is…	Your claim must be filed with…	If your claim is denied, you may file an appeal with…	If your appeal is denied…
A Pre-Service Comprehensive Medical Benefit Claim not involving Organ Transplant Benefits	Blue KC	Solxsys	And your claim involves medical judgment, you may request external review and/or file a lawsuit. If your claim does not involve medical judgment, you may file a lawsuit.
A Pre-Service Comprehensive Medical Benefit Claim involving Organ Transplant Benefits	Blue KC	Blue KC	And your claim involves medical judgment, you may request external review and/or file a lawsuit. If your claim does not involve medical judgment, you may file a lawsuit.
A Post-Service Comprehensive Medical Benefit Claim	Blue KC	Solxsys. Solxsys must receive your appeal within 180 calendar days after the date that you receive notification of the adverse benefit determination.	And your claim involves medical judgment, you may request external review and/or file a lawsuit. If your claim does not involve medical judgment, you may file a lawsuit.
A Pre-Service Prescription Drug Benefit Claim	Solxsys	Solxsys	And your claim involves medical judgment, you may request external review and/or file a lawsuit. If your claim does not involve medical judgment, you may file a lawsuit.
A Post-Service Prescription Drug Benefit Claim	Sav-Rx	Solxsys. Solxsys must receive your appeal within 180 calendar days after the date that you receive notification of the adverse benefit determination.	And your claim involves medical judgment, you may request external review and/or file a lawsuit. If your claim does not involve medical judgment, you may file a lawsuit.
A Dental Benefit Claim	Delta Dental	Solxsys. Solxsys must receive your appeal within 180 calendar days after the date that you receive notification of the adverse benefit determination.	And your claim involves medical judgment, you may request external review and/or file a lawsuit. If your claim does not involve medical judgment, you may file a lawsuit.
A Vision Benefit Claim	Solxsys	Solxsys. Solxsys must receive your appeal within 180 calendar days after the date that you receive notification of the adverse benefit determination.	You may file a lawsuit.
An Accident and Sickness Loss of Time Benefit Claim	Solxsys	Solxsys. Solxsys must receive your appeal within 180 calendar days after the date that you receive notification of the adverse benefit determination.	You may file a lawsuit.
A Death Benefit Claim	Solxsys	Solxsys. Solxsys must receive your appeal within 60 calendar days after the date that you receive notification of the adverse benefit determination.	You may file a lawsuit.
An AD&D Benefit Claim	Solxsys	Solxsys. Solxsys must receive your appeal within 60 calendar days after the date that you receive notification of the adverse benefit determination.	You may file a lawsuit.

This Article describes the procedures for filing claims and the procedures to follow if your claim is denied in whole or in part and you wish to appeal the decision or submit the decision for external review. Throughout

this Article, "you" and "your" may refer to you, your Dependent(s), your personal representative, your authorized representative, and/or your Beneficiary, as applicable.

Except as provided in Section 9.09, the claims and appeals procedures in this Article only apply to requests for benefits from the Plan that are considered claims. Your request for Plan benefits is considered a claim if it is made in accordance with this Article. For example, if your doctor files a claim in accordance with Section 9.03(b)(1), that request is considered a claim. However, a casual inquiry about benefits or the circumstances under which benefits might be paid is not considered a claim.

A request for a determination of whether or not you are eligible for benefits from the Plan is not considered a claim. However, if you file a request for a specific benefit in accordance with this Article, that request will be considered a claim. If that claim is denied because you are not eligible for benefits from the Plan (i.e., your claim is denied because you are not a Covered Person), you may file an appeal by using the procedures in this Article. For example, if your coverage as a Retiree is terminated and you submit a request to Solxsys to have your coverage reinstated, that request will not be considered a claim. However, if your coverage as a Retiree is terminated and then you go to the doctor and your doctor files a claim in accordance with Section 9.03(b)(1), that filing is considered a claim. If Solxsys denies your claim because you are not covered by the Plan, you may file an appeal in accordance with Section 9.03(b)(4).

As described throughout this Article, different rules apply to each benefit. Additionally, for certain types of claims, special rules apply depending on whether or not your claim is a pre-service claim (e.g., a Pre-Service Comprehensive Medical Benefit Claim) or a post-service claim (e.g., a Post-Service Comprehensive Medical Benefit Claim).

Section 9.01 - Definitions for this Article IX Only

The following terms will have a specific meaning when they are used in this Article IX:

(a) **"Pre-Service Comprehensive Medical Benefit Claim"** means a claim for a Comprehensive Medical Benefit that a provider files in accordance with Section 9.03(a)(1) to obtain confirmation that the service will be covered by the Plan prior to the date the service is rendered.

(b) **"Urgent Care Claim"** means a Pre-Service Comprehensive Medical Benefit Claim for an Organ Transplant Benefit that is described in Section 2.03(p), filed in accordance with Section 9.03(a)(1), and with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or, in the opinion of a Physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(c) **"Post-Service Comprehensive Medical Benefit Claim"** means a claim for a Comprehensive Medical Benefit that is not a Pre-Service Comprehensive Medical Benefit Claim and is filed in accordance with Section 9.03(b)(1).

(d) **"Pre-Service Prescription Drug Benefit Claim"** means a claim for a Prescription Drug Benefit that requests reconsideration of a prior authorization that was rendered by Sav-Rx in accordance with Section 3.06 and is filed in accordance with Section 9.04(a)(1) prior to the date on which the prescription drug is purchased.

(e) **"Post-Service Prescription Drug Benefit Claim"** means a claim for a Prescription Drug Benefit that is not a Pre-Service Prescription Drug Benefit Claim and is filed in accordance with Section 9.04(b)(1).

(f) **"Dental Benefit Claim"** means a claim for a Dental Benefit that is filed in accordance with Section 9.05(a).

(g) **"Vision Benefit Claim"** means a claim for a Vision Benefit that is filed in accordance with Section 9.06(a).

(h) **"Accident and Sickness Loss of Time Benefit Claim"** means a claim for an Accident and Sickness Loss of Time Benefit that is filed in accordance with Section 9.07(a).

(i) **"Death Benefit Claim"** means a claim for a Death Benefit that is filed in accordance with Section 9.08(a).

(j) **"AD&D Benefit Claim"** means a claim for an AD&D Benefit that is filed in accordance with Section 9.08(a).

Section 9.02 - Use of an Authorized Representative or Other Individual to File a Claim or Appeal

A claim may be filed by the person who incurred the health care expense, his/her authorized representative, his/her personal representative, or his/her provider (i.e., the person who provided the treatment).

An individual is considered a Covered Person's personal representative if, under applicable law, (s)he has the authority to act on the Covered Person's behalf in making decisions related to health care. For example, a parent may be the personal representative of a minor child.

An individual is considered a Covered Person's authorized representative if (s)he has been designated by the Covered Person to act on the Covered Person's behalf through the Plan's Designation of Authorized Representative Form, available from Solxsys.

An appeal may be filed by the person who incurred the health care expense, his/her authorized representative, or his/her personal representative. An appeal cannot be filed by a provider unless the provider is also the Covered Person's authorized representative or the provider is filing an appeal for a Pre-Service Comprehensive Medical Benefit Claim that involves Organ Transplant Benefits in accordance with Section 9.03(a)(4)(ii).

Section 9.03 - Comprehensive Medical Benefit Claims and Appeals

As explained in Section 9.03(a) and Section 9.03(b), different rules apply depending on whether your Comprehensive Medical Benefit claim is a Pre-Service Comprehensive Medical Benefit Claim or a Post-Service Comprehensive Medical Benefit Claim.

Different rules also apply if you are enrolled in the UnitedHealthcare ("UHC") Medicare Advantage and Prescription Drug Plan ("MAPD") that provides Comprehensive Medical Benefits to Medicare eligible Covered Persons. If you are enrolled in the MAPD, UHC will process your claims and appeals in accordance with procedures set forth by federal regulations and guidance set forth by the Centers for Medicare & Medicaid Services ("CMS").

(a) Pre-Service Comprehensive Medical Benefit Claims

(1) How to file Pre-Service Comprehensive Medical Benefit Claims (including Urgent Care Claims)

Your provider must contact Blue Cross and Blue Shield of Kansas City ("Blue KC") by fax at (816) 926-4253 or through Blue KC's online portal to obtain approval that the service will be covered by the Plan prior to providing the service.

If your Pre-Service Comprehensive Medical Benefit Claim is filed incorrectly but received by Blue KC at the appropriate location and names a specific Claimant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested, Blue KC will inform your provider that your claim was filed incorrectly and will let your provider know the procedures your provider should follow to file your claim. Your provider will receive this information as soon as possible, but no later than five calendar days after Blue KC receives your claim. This notice may be oral, unless written notice is requested by you or your provider.

(2) Timing of benefit determinations for Pre-Service Comprehensive Medical Benefit Claims

Different rules apply depending on whether or not your Pre-Service Comprehensive Medical Benefit Claim involves Organ Transplant Benefits.

(i) Timing of benefit determinations for Pre-Service Comprehensive Medical Benefit Claims that do not involve Organ Transplant Benefits

If your Pre-Service Comprehensive Medical Benefit Claim does not involve Organ Transplant Benefits, Blue KC will render a determination on whether, and/or to what extent, your claim is payable by the Plan. The time period for rendering this determination begins as soon as your claim is received by Blue KC in accordance with Section 9.03(a)(1), regardless of whether or not Blue KC has all the information necessary to render the determination. You will receive notice of Blue KC's determination within a reasonable period of time appropriate to the medical circumstances, but no later than 15 calendar days after the date that Blue KC receives your claim. Blue KC may extend this period once by up to 15 calendar days if both of the following criteria are met:

- Blue KC determines that an extension of time is necessary due to matters beyond its control; and
- Blue KC notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension and the date by which Blue KC expects to render a determination.

If the extension is necessary because Blue KC needs additional information from you to determine whether, and/or to what extent, benefits are payable by the Plan, the notice of the extension will specifically describe the required information and you will be allowed at least 45 calendar days from receipt of the notice to provide the specified information. The time period for rendering a determination on your claim will be suspended (i.e., tolled) from the date on which the notice is sent until the earlier of the following dates:

- The date Blue KC receives your response; or
- 45 calendar days have passed since the date that the notice was sent.

(ii) Timing of benefit determinations for Pre-Service Comprehensive Medical Benefit Claims that involve Organ Transplant Benefits

Different rules apply depending on whether or not your Pre-Service Comprehensive Medical Benefit Claim involving Organ Transplant Benefits is an Urgent Care Claim.

(A) Timing of benefit determinations for Pre-Service Comprehensive Medical Benefit Claims that involve Organ Transplant Benefits but are not Urgent Care Claims

If your Pre-Service Comprehensive Medical Benefit Claim involves Organ Transplant Benefits but is not an Urgent Care Claim, Blue KC will render a determination on whether, and/or to what extent, benefits are payable by the Plan. The time period for rendering this determination begins as soon as your claim is received by Blue KC in accordance with Section 9.03(a)(1), regardless of whether or not Blue KC has all the information necessary to render the determination. You will receive notice of Blue KC's determination within a reasonable period of time appropriate to the medical circumstances, but no later than 15 calendar days after the date that Blue KC receives your claim. Blue KC may extend this period once by up to 15 calendar days if both of the following criteria are met:

- Blue KC determines that an extension of time is necessary due to matters beyond its control; and
- Blue KC notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension and the date by which Blue KC expects to render a determination.

If the extension is necessary because Blue KC needs additional information from you to determine whether, and/or to what extent, benefits are payable by the Plan, the notice of the extension will specifically describe the required information and you will be allowed at least 45 calendar days from receipt of the notice to provide the specified information. The time period for rendering a determination on your claim will be suspended (i.e., tolled) from the date on which the notice is sent until the earlier of the following dates:

- The date Blue KC receives your response; or
- 45 calendar have passed since the date that the notice was sent.

(B) Timing of benefit determinations for Pre-Service Comprehensive Medical Benefit Claims that involve Organ Transplant Benefits and are Urgent Care Claims

If your Pre-Service Comprehensive Medical Benefit Claim involves Organ Transplant Benefits and is an Urgent Care Claim, Blue KC will render a determination on whether, and/or to what extent, benefits are payable by the Plan. The time period for rendering this determination begins as soon as your claim is received by Blue KC in accordance with Section 9.03(a)(1), regardless of whether or not Blue KC has all the information necessary to render the determination. Your provider will receive notice of Blue KC's determination as soon as possible, taking into account the medical exigencies, but no later than 72 hours after Blue KC receives your claim.

If Blue KC needs additional information from your provider to determine whether, and/or to what extent, benefits are payable by the Plan, Blue KC will notify your provider of the specific information necessary to complete your

claim as soon as possible, but no later than 24 hours after your claim is received by Blue KC. Your provider will be allowed at least 48 hours to provide the specified information. Your provider will receive notice of Blue KC's determination as soon as possible, but no later than:

- 48 hours after Blue KC receives the specified information; or
- The end of the period afforded to provide the specified information.

(3) Content of notifications of benefit determination for Pre-Service Comprehensive Medical Benefit Claims

If the determination is that the Plan will pay 100% of the total amount of your Pre-Service Comprehensive Medical Benefit Claim, you will receive a written notice that contains sufficient information to fully apprise you of the approval of your requested benefit.

If the determination is that the Plan will not pay 100% of the total amount of your Pre-Service Comprehensive Medical Benefit Claim, you will receive a written notice of the adverse benefit determination. This notice will include the following information:

(i) Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);

(ii) The specific reason(s) for the adverse benefit determination;

(iii) Reference to the specific Plan provision(s) on which the adverse benefit determination is based;

(iv) A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;

(v) A statement that the diagnosis code, the treatment code, and their corresponding meanings will be provided to you as soon as practicable upon request;

(vi) The denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying your claim;

(vii) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, the notice will either set forth the specific rule, guideline, protocol, or other similar criterion, or it will contain a statement that such a criterion was relied upon in making the adverse benefit determination and that a copy of such criterion will be provided to you free of charge upon request;

(viii) If the adverse benefit determination was based on Medical Necessity, experimental or investigational treatment, or a similar exclusion or limit, the notice will either include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances of your claim, or it will contain a statement that such an explanation will be provided to you free of charge upon request;

(ix) A description of the Plan's internal appeal and external review procedures and any time limits applicable to such procedures;

(x) If the claim is an Urgent Care Claim, a description of the Plan's expedited internal appeal and external review procedures and any time limits applicable to such procedures;

(xi) A statement that you have the right to bring a civil action under Section 502(a) of ERISA if there is an adverse benefit determination on appeal;

(xii) A disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act ("PHSA") to assist individuals with the internal claims and appeals and external review processes; and

(xiii) If the notice is sent to a county where 10% or more of the population is literate only in the same non-English language, the notice will contain a statement in the non-English language which explains the manner in which you can access the Plan's oral language services and informs you that a written notice in the non-English language will be provided to you upon request.

(4) How to file appeals for Pre-Service Comprehensive Medical Benefit Claims

Different rules apply depending on whether or not your Pre-Service Comprehensive Medical Benefit Claim involves Organ Transplant Benefits.

(i) How to file appeals for Pre-Service Comprehensive Medical Benefit Claims that do not involve Organ Transplant Benefits

If it is determined that the Plan will not pay 100% of the total amount of your Pre-Service Comprehensive Medical Benefit Claim and your claim does not involve Organ Transplant Benefits, you may file an appeal by sending Solxsys a written request for the Board of Trustees to review your claim. Solxsys must receive your appeal within 180 calendar days after the date that you receive notification of the adverse benefit determination (i.e., within 180 calendar days after the date that you receive the notice described in Section 9.03(a)(3)).

(ii) How to file appeals for Pre-Service Comprehensive Medical Benefit Claims that involve Organ Transplant Benefits

If it is determined that the Plan will not pay 100% of the total amount of your Pre-Service Comprehensive Medical Benefit Claim and your claim involves Organ Transplant Benefits, you or your provider may file an appeal by sending Blue KC a written request for Blue KC to review your claim. If your claim is an Urgent Care Claim, you or your provider may file a request for an expedited external review in accordance with Section 9.03(a)(8)(ii)(A)(2) at the same time that you or your provider file an appeal with Blue KC in accordance with this Section 9.03(a)(4)(ii). Blue KC must receive your appeal within 180 calendar days after the date that you or your provider receives notification of the adverse benefit determination (i.e., within 180 calendar days after the date that you or your provider receives the notice described in Section 9.03(a)(3)).

(5) Full and fair review of appeals for Pre-Service Comprehensive Medical Benefit Claims

Different rules apply depending on whether or not your Pre-Service Comprehensive Medical Benefit Claim involves Organ Transplant Benefits.

(i) Full and fair review of appeals for Pre-Service Comprehensive Medical Benefit Claims that do not involve Organ Transplant Benefits

You may request reasonable access to and copies of all documents, records, and other information relevant to your claim. You may also request the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, regardless of whether the advice was relied upon in making the adverse benefit determination. To obtain the information described in this paragraph, you must send a written request to Solxsys. If you request any of the information described in this paragraph, Solxsys will provide it free of charge.

Prior to the date that the Trustees review your claim, you may submit written comments, documents, records, and other information relating to your claim to Solxsys. If your appeal involves an adverse benefit determination that is based in whole or in part on a medical judgment, the Board of Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional consulted on appeal will not be any individual who was consulted previously with respect to your claim, nor the subordinate of any such individual. If the Trustees consult with a health care professional and/or other new or additional evidence is considered, relied upon, or generated in connection with your appeal, Solxsys will provide you with such evidence. Solxsys will provide the information described in this paragraph free of charge and sufficiently in advance of the date on which the Trustees render a determination on your appeal.

The Trustees will conduct a full and fair review of your appeal without giving deference to the initial benefit determination. The Trustees will render a determination that is based on all comments, records, and other information that you submit regardless of whether or not such information was submitted or considered in the initial benefit determination. Although the Trustees' determination will be based on all comments, records, and other information that you submit in the initial benefit determination, the Trustees will not render an adverse benefit determination that is based on a rationale that is different from the rationale that was included in the notice of adverse benefit determination (i.e., the notice described in Section 9.03(a)(3)) unless Solxsys provides you with the new rationale free of charge and sufficiently in advance of the date that the Trustees render a determination on your appeal.

(ii) Full and fair review of appeals for Pre-Service Comprehensive Medical Benefit Claims that involve Organ Transplant Benefits

You may request reasonable access to and copies of all documents, records, and other information relevant to your claim. You may also request the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, regardless of whether the advice was relied upon in making the adverse benefit determination. To obtain the information described in this paragraph, you must send a written request to Blue KC. If you request any of the information described in this paragraph, Blue KC will provide it free of charge.

Prior to the date that Blue KC reviews your claim, you may submit written comments, documents, records, and other information relating to your claim to Blue KC. If your appeal involves an adverse benefit determination that is based in whole or in part on a

medical judgment, Blue KC will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional consulted on appeal will not be any individual who was consulted previously with respect to your claim, nor the subordinate of any such individual. If Blue KC consults with a health care professional and/or other new or additional evidence is considered, relied upon, or generated in connection with your appeal, Blue KC will provide you with such evidence. Blue KC will provide the information described in this paragraph free of charge and sufficiently in advance of the date on which Blue KC renders a determination on your appeal.

Blue KC will conduct a full and fair review of your appeal without giving deference to the initial benefit determination. Any individual that was personally involved in the initial benefit determination, or a subordinate of any such individual, will not conduct or have any input in your appeal. Blue KC will render a determination that is based on all comments, records, and other information that you submit regardless of whether or not such information was submitted or considered in the initial benefit determination. Although Blue KC's determination will be based on all comments, records, and other information that you submit in the initial benefit determination, Blue KC will not render an adverse benefit determination that is based on a rationale that is different from the rationale that was included in the notice of adverse benefit determination (i.e., the notice described in Section 9.03(a)(3)) unless Blue KC provides you with the new rationale free of charge and sufficiently in advance of the date that Blue KC renders a determination on your appeal.

(6) Timing of notifications of benefit determination on appeal for Pre-Service Comprehensive Medical Benefit Claims

Different rules apply depending on whether or not your Pre-Service Comprehensive Medical Benefit Claim involves Organ Transplant Benefits.

(i) Timing of notifications of benefit determination on appeal for Pre-Service Comprehensive Medical Benefit Claims that do not involve Organ Transplant Benefits

Solxsys will provide you with notice of the Trustees' determination within a reasonable period of time appropriate to the medical circumstances but no later than 30 calendar days after the date that Solxsys receives your appeal.

If you receive the information described in Section 9.03(a)(5)(i) so late that it would be impossible for you to have a reasonable opportunity to respond, you may request that the time period for the Board of Trustees to render a determination on your appeal be suspended until you have had a reasonable opportunity to respond. After you respond, or have had a reasonable opportunity to respond but fail to do so, the Trustees will render a determination on your appeal.

(ii) Timing of notifications of benefit determination on appeal for Pre-Service Comprehensive Medical Benefit Claims that involve Organ Transplant Benefits

Different rules apply depending on whether or not your Pre-Service Comprehensive Medical Benefit Claim involving Organ Transplant Benefits is an Urgent Care Claim.

(A) Timing of notifications of benefit determination on appeal for Pre-Service Comprehensive Medical Benefit Claims that involve Organ Transplant Benefits but are not Urgent Care Claims

Blue KC will provide you with notice of its determination within a reasonable period of time appropriate to the medical circumstances but no later than 30 calendar days after the date that Blue KC receives your appeal.

If you receive the information described in Section 9.03(a)(5)(ii) so late that it would be impossible for you to have a reasonable opportunity to respond, you may request that the time period for Blue KC to render a determination on your appeal be suspended until you have had a reasonable opportunity to respond. After you respond, or have had a reasonable opportunity to respond but fail to do so, Blue KC will render a determination on your appeal.

(B) Timing of notifications of benefit determination on appeal for Pre-Service Comprehensive Medical Benefit Claims that involve Organ Transplant Benefits and are Urgent Care Claims

Blue KC will render a determination on your appeal and will notify you of its determination as soon as possible, taking into account the medical exigencies, but no later than 72 hours after Blue KC receives your appeal.

(7) Content of notifications of benefit determination on appeal for Pre-Service Comprehensive Medical Benefit Claims

If your appeal for a Pre-Service Comprehensive Medical Benefit Claim is denied, in whole or in part, you will receive a written notice of the denial. This notice will include the following information:

(i) Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);

(ii) The specific reason(s) for the denial;

(iii) Reference to the specific Plan provision(s) on which the denial is based;

(iv) A statement that reasonable access to, and copies of, all documents, records, and other information relevant to your claim will be provided to you free of charge upon request;

(v) A statement that the diagnosis code, the treatment code, and their corresponding meanings will be provided to you as soon as practicable upon request;

(vi) The denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying your appeal;

(vii) If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your appeal, the notice will either set forth the specific rule, guideline, protocol, or other similar criterion, or it will contain a statement that such a criterion was relied upon in denying your appeal and that a copy of such criterion will be provided to you free of charge upon request;

(viii) If the denial was based on Medical Necessity, experimental or investigational treatment, or a similar exclusion or limit, the notice will either include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances of your claim, or it will contain a statement that such an explanation will be provided to you free of charge upon request;

(ix) A description of the Plan's external review procedures and any time limits applicable to such procedures;

(x) A statement that you have the right to bring a civil action under Section 502(a) of ERISA;

(xi) A disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the PHSA to assist individuals with the internal claims and appeals and external review processes; and

(xii) If the notice is sent to a county where 10% or more of the population is literate only in the same non-English language, the notice will contain a statement in the non-English language which explains the manner in which you can access the Plan's oral language services and informs you that a written notice in the non-English language will be provided to you upon request.

(8) External review of Pre-Service Comprehensive Medical Benefit Claims

If you followed the Plan's internal claims and appeals procedures described in this Section 9.03(a) and you still disagree with the determination, you may request that an Independent Review Organization ("IRO") conduct an external review of your Pre-Service Comprehensive Medical Benefit Claim in accordance with this Section 9.03(a)(8). Your claim will only qualify for external review if it involves medical judgment, or your adverse benefit determination relates to compliance with the surprise billing and cost-sharing protections under Title I of the Consolidated Appropriations Act of 2021 ("No Surprises Act") as described in Section 9.10. External review is not available for other types of denials, including denials due to your failure to meet the Plan's eligibility requirements.

Different rules apply depending on whether or not your Pre-Service Comprehensive Medical Benefit Claim involves Organ Transplant Benefits.

(i) External review of Pre-Service Comprehensive Medical Benefit Claims that do not involve Organ Transplant Benefits

(A) How to file requests for external review of Pre-Service Comprehensive Medical Benefit Claims that do not involve Organ Transplant Benefits

If your Pre-Service Comprehensive Medical Benefit Claim does not involve Organ Transplant Benefits, you may file a request for external review of your claim by sending Solxsys a written request for an IRO to review your claim. This request should not be filed until after you receive notification of the benefit determination on appeal (i.e., after the date that you receive the notice described in Section 9.03(a)(7)). Solxsys must receive your request for external review within four months after the date that you receive notification of the benefit determination on appeal.

(B) Preliminary review of Pre-Service Comprehensive Medical Benefit Claims that do not involve Organ Transplant Benefits

Solxsys will render a determination on whether or not your request is eligible for external review. The time period for rendering this determination begins as soon as your request for external review is received by Solxsys in accordance with Section 9.03(a)(8)(i)(A). Your request will be eligible for external review if it meets all of the following criteria:

- You were covered by the Plan at the time the health care item or service was requested;
- Your claim involves medical judgment;
- You exhausted the Plan's internal claims and appeals procedures or your claim is deemed exhausted in accordance with Section 9.11; and
- You provided all the information and forms required to process your request for external review.

You will receive notice of Solxsys' determination within a reasonable period of time, but no later than six business days after the date that Solxsys receives your request for external review.

(C) Content of preliminary determination of requests for external review of Pre-Service Comprehensive Medical Benefit Claims that do not involve Organ Transplant Benefits

If Solxsys determines that your request qualifies for external review, you will receive a written notice that contains sufficient information to fully apprise you that your request qualifies for external review.

If Solxsys determines that your request does not qualify for external review, you will receive a written notice of this determination. This notice will include the specific reason(s) that your request is not eligible for external review and the current contact information, including the phone number, for the Employee Benefits Security Administration ("EBSA").

If Solxsys needs additional information from you to determine whether or not your request is eligible for external review, Solxsys will notify you of the information necessary to complete your request. If this occurs, your request will only be eligible for external review if it meets at least one of the following criteria:

- Solxsys receives the additional information within four calendar months after the date that you receive notification of the benefit determination on appeal (i.e., four calendar months after the date that you receive the notice described in Section 9.03(a)(7)); or
- Solxsys receives the additional information within 48 hours after you receive the notice describing the information needed to determine whether or not your request is eligible for external review (i.e., 48 hours after you receive the notice described in this Section 9.03(a)(8)(i)(C)).

(D) IRO review of requests for external review of Pre-Service Comprehensive Medical Benefit Claims that do not involve Organ Transplant Benefits

If your request is complete and eligible for external review, your request will be assigned to an IRO. Within five business days after the date of assignment of the IRO, Solxsys will provide the IRO with any information and materials considered in rendering a determination on your claim.

The IRO will timely notify you, in writing, of the acceptance of your request for external review. The IRO's initial notice will include directions on how you may submit additional information relating to your claim. You may submit such additional information during the ten business days following the date you received the initial notice from the IRO. The IRO will review all information and documents received within this time period. The IRO may, but is not required to, accept and consider any additional information that you submit after the ten business days following the date you receive the initial notice from the IRO.

The IRO will conduct a full and fair review of your appeal without giving deference to the previous benefit determinations. However, the IRO will be bound by the terms of the Plan Document.

If you submitted additional information to the IRO, the IRO will forward the information to Solxsys within one business day after the date that the IRO receives this information. Upon receipt of this information, the Board of Trustees may reconsider whether or not your Pre-Service Comprehensive Medical Benefit Claim is covered by the Plan. Reconsideration by the Trustees will not delay the external review. If the Trustees reconsider your claim and, prior to the date that the IRO renders a determination, the Trustees determine that your claim is covered by the Plan, the external review will be terminated (i.e., if the Trustees determine that your claim is covered, it will no longer be necessary for the IRO to review your claim). If this occurs, Solxsys will provide you and the IRO with notice of the Trustees' determination no later than one business day after the date that the Trustees render the determination.

(E) Timing of IRO determinations of requests for external review of Pre-Service Comprehensive Medical Benefit Claims that do not involve Organ Transplant Benefits

You will receive notice of the IRO's determination no later than 45 calendar days after the date that the IRO receives your request for external review.

(F) Content of IRO determinations of requests for external review of Pre-Service Comprehensive Medical Benefit Claims that do not involve Organ Transplant Benefits

You will receive a written notice of the IRO's determination. This notice will include the following information:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);

- The date the IRO received the assignment to conduct external review and the date of the IRO's determination;
- References to the evidence and/or documentation considered by the IRO in reaching its determination, including the specific coverage provisions and evidence based standards;
- A discussion of the principal reason(s) for the IRO's determination, including its rationale and any evidence-based standards that were relied upon in making the determination;
- A statement that the diagnosis code, the treatment code, and their corresponding meanings will be provided to you as soon as practicable upon request;
- A statement that the reason for the Trustees' denial will be provided to you as soon as practicable upon request;
- A statement that the IRO's determination is binding except to the extent that other remedies may be available under state or federal law to either you or the Plan, or to the extent the Plan voluntarily makes payment on your claim;
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA; and
- A disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the PHSA to assist individuals with the internal claims and appeals and external review processes.

(G) Effect of IRO determinations of requests for external review of Pre-Service Comprehensive Medical Benefit Claims that do not involve Organ Transplant Benefits

If the IRO reverses the Board of Trustees' determination, the Plan will immediately cover your claim.

If the IRO does not reverse the Trustees' determination, the Plan will not cover your claim.

The IRO's determination is binding upon the Plan, Solxsys, and you, except to the extent that you or the Plan may have other remedies available under applicable federal or state law. You may not file a subsequent request for external review involving the same adverse benefit determination for which you have already received an external review determination.

(ii) External review of Pre-Service Comprehensive Medical Benefit Claims that involve Organ Transplant Benefits

(A) How to file requests for external review of Pre-Service Comprehensive Medical Benefit Claims that involve Organ Transplant Benefits

Different rules apply depending on whether or not your Pre-Service Comprehensive Medical Benefit Claim involving Organ Transplant Benefits is an Urgent Care Claim.

(1) **How to file requests for external review of Pre-Service Comprehensive Medical Benefit Claims that involve Organ Transplant Benefits but are not Urgent Care Claims.**

If your Pre-Service Comprehensive Medical Benefit Claim involves Organ Transplant Benefits but is not an Urgent Care Claim, you may file a request for external review of your claim by sending Blue KC a written request for an IRO to review your claim. This request should not be filed until after you receive notification of the benefit determination on appeal (i.e., after the date that you receive the notice described in Section 9.03(a)(7)). Blue KC must receive your request for external review within four months after the date that you receive notification of the benefit determination on appeal.

(2) **How to file requests for external review of Pre-Service Comprehensive Medical Benefit Claims that involve Organ Transplant Benefits and are Urgent Care Claims.**

If your Pre-Service Comprehensive Medical Benefit Claim involves Organ Transplant Benefits and is an Urgent Care Claim, you or your provider may file a request for external review. The time period for filing the request depends on whether you are seeking an expedited external review or a normal external review.

If you are seeking an expedited external review, you or your provider may file the request by sending Blue KC a written request for an IRO to review your claim at the same time that your appeal is filed in accordance with Section 9.03(a)(4)(ii).

If you are seeking a normal external review (i.e., a review that is not expedited), you or your provider may file the request by sending Blue KC a written request for an IRO to review your claim. This request should not be filed until after you receive notification of the benefit determination on appeal (i.e., after the date that you receive the notice described in Section 9.03(a)(7)). Blue KC must receive your request for external review within four months after the date that you receive notification of the benefit determination on appeal.

(B) **Preliminary review of Pre-Service Comprehensive Medical Benefit Claims that involve Organ Transplant Benefits**

Different rules apply depending on whether or not your Pre-Service Comprehensive Medical Benefit Claim involving Organ Transplant Benefits is an Urgent Care Claim.

(1) **Preliminary review of Pre-Service Comprehensive Medical Benefit Claims that involve Organ Transplant Benefits but are not Urgent Care Claims.**

If your Pre-Service Comprehensive Medical Benefit Claim involves Organ Transplant Benefits but is not an Urgent Care Claim, Blue KC

will render a determination on whether or not your request is eligible for external review. The time period for rendering this determination begins as soon as your request for external review is received by Blue KC in accordance with Section 9.03(a)(8)(ii)(A). Your request will be eligible for external review if it meets all of the following criteria:

- You were covered by the Plan at the time the health care item or service was requested;
- Your claim involves medical judgment;
- You exhausted the Plan's internal claims and appeals procedures or your claim is deemed exhausted in accordance with Section 9.11; and
- You provided all the information and forms required to process your request for external review.

You will receive notice of Blue KC's determination within a reasonable period of time, but no later than six business days after the date that Blue KC receives your request for external review.

(2) Preliminary review of Pre-Service Comprehensive Medical Benefit Claims that involve Organ Transplant Benefits and are Urgent Care Claims.

If your Pre-Service Comprehensive Medical Benefit Claim involves Organ Transplant Benefits and is an Urgent Care Claim, Blue KC will render a determination on whether or not your request is eligible for external review. The time period for rendering this determination begins as soon as your request for external review is received by Blue KC in accordance with Section 9.03(a)(8)(ii)(A). Your request will be eligible for external review if it meets all of the following criteria:

- You were covered by the Plan at the time the health care item or service was requested;
- Your claim involves medical judgment; and
- You provided all the information and forms required to process your request for external review.

If you requested an expedited external review in accordance with Section 9.03(a)(8)(ii)(A)(2), you will receive notice of Blue KC's determination immediately. If you requested a normal external review (i.e., a review that is not expedited) in accordance with Section 9.03(a)(8)(ii)(A)(2), you will receive notice of Blue KC's determination within a reasonable period of time, but no later than six business days after the date that Blue KC receives your request for external review.

(C) Content of preliminary determination of requests for external review of Pre-Service Comprehensive Medical Benefit Claims that involve Organ Transplant Benefits

If Blue KC determines that your request qualifies for external review, you will receive a written notice that contains sufficient information to fully apprise you that your request qualifies for external review.

If Blue KC determines that your request does not qualify for external review, you will receive a written notice of this determination. This notice will include the specific reason(s) that your request is not eligible for external review and the current contact information, including the phone number, for the EBSA.

If Blue KC needs additional information from you to determine whether or not your request is eligible for external review, Blue KC will notify you of the information necessary to complete your request. If this occurs, your request will only be eligible for external review if it meets at least one of the following criteria:

- Blue KC receives the additional information within four calendar months after the date that you receive notification of the benefit determination on appeal (i.e., four calendar months after the date that you receive the notice described in Section 9.03(a)(7)); or
- Blue KC receives the additional information within 48 hours after you receive the notice describing the information needed to determine whether or not your request is eligible for external review (i.e., 48 hours after you receive the notice described in this Section 9.03(a)(8)(ii)(C)).

(D) IRO review of requests for external review of Pre-Service Comprehensive Medical Benefit Claims that involve Organ Transplant Benefits

Different rules apply depending on whether or not your Pre-Service Comprehensive Medical Benefit Claim involving Organ Transplant Benefits is an Urgent Care Claim.

(1) IRO review of requests for external review of Pre-Service Comprehensive Medical Benefit Claims that involve Organ Transplant Benefits but are not Urgent Care Claims.

If your request is complete and eligible for external review, your request will be assigned to an IRO. Within five business days after the date of assignment of the IRO, Blue KC will provide the IRO with any information and materials considered in rendering a determination on you claim.

The IRO will timely notify you, in writing, of the acceptance of your request for external review. The IRO's initial notice will include directions on how you may submit additional information relating to your claim. You may submit such additional information during the ten business days following the date you received the initial notice from the IRO. The IRO will review all information and documents received

within this time period. The IRO may, but is not required to, accept and consider any additional information that you submit after the ten business days following the date you receive the initial notice from the IRO.

The IRO will conduct a full and fair review of your appeal without giving deference to the previous benefit determinations. However, the IRO will be bound by the terms of the Plan Document.

If you submitted additional information to the IRO, the IRO will forward the information to Blue KC within one business day after the date that the IRO receives this information. Upon receipt of this information, Blue KC may reconsider whether or not your Pre-Service Comprehensive Medical Benefit Claim is covered by the Plan. Reconsideration by Blue KC will not delay the external review. If Blue KC reconsiders your claim and, prior to the date that the IRO renders a determination, Blue KC determines that your claim is covered by the Plan, the external review will be terminated (i.e., if Blue KC determines that your claim is covered, it will no longer be necessary for the IRO to review your claim). If this occurs, Blue KC will provide you and the IRO with notice of its determination no later than one business day after the date that Blue KC renders a determination.

(2) IRO review of requests for external review of Pre-Service Comprehensive Medical Benefit Claims that involve Organ Transplant Benefits and are Urgent Care Claims.

Different rules apply depending on whether your Pre-Service Comprehensive Medical Benefit Claim involving Organ Transplant Benefits is undergoing expedited external review or a normal external review.

(I) IRO review of requests for external review of Pre-Service Comprehensive Medical Benefit Claims that involve Organ Transplant Benefits, are Urgent Care Claims, and are receiving expedited external review.

If your request for expedited external review is complete and eligible for external review, your request will be immediately assigned to an IRO. Blue KC will provide or transmit all necessary documents and information considered in making the adverse benefit determination to the IRO electronically, by telephone, by facsimile, or any other available expeditious method.

The IRO will conduct a full and fair review of your appeal without giving deference to the previous benefit determinations. However, the IRO will be bound by the terms of the Plan Document.

(II) IRO review of requests for external review of Pre-Service Comprehensive Medical Benefit Claims that involve Organ Transplant Benefits, are Urgent Care Claims, and are receiving normal external review.

If your request for normal external review (i.e., a review that is not expedited) is complete and eligible for external review, your request will be assigned to an IRO. Within five business days after the date of assignment of the IRO, Blue KC will provide the IRO with any information and materials considered in rendering a determination on you claim.

The IRO will timely notify you, in writing, of the acceptance of your request for external review. The IRO's initial notice will include directions on how you may submit additional information to the IRO relating to your claim. You may submit such additional information during the ten business days following the date you received the initial notice from the IRO. The IRO will review all information and documents received within this time period. The IRO may, but is not required to, accept and consider any additional information that you submit after the ten business days following the date you receive the initial notice from the IRO.

The IRO will conduct a full and fair review of your appeal without giving deference to the previous benefit determinations. However, the IRO will be bound by the terms of the Plan Document.

If you submitted additional information to the IRO, the IRO will forward the information to Blue KC within one business day after the date that the IRO receives this information. Upon receipt of this information, Blue KC may reconsider whether or not your Pre-Service Comprehensive Medical Benefit Claim is covered by the Plan. Reconsideration by Blue KC will not delay the external review. If Blue KC reconsiders your claim and, prior to the date that the IRO renders a determination, Blue KC determines that your claim is covered by the Plan, the external review will be terminated (i.e., if Blue KC determines that your claim is covered, it will no longer be necessary for the IRO to review your claim). If this occurs, Blue KC will provide you and the IRO with notice of its determination no later than one business day after the date that Blue KC renders a determination.

(E) Timing of IRO determinations of requests for external review of Pre-Service Comprehensive Medical Benefit Claims that involve Organ Transplant Benefits

Different rules apply depending on whether or not your Pre-Service Comprehensive Medical Benefit Claim involving Organ Transplant Benefits is an Urgent Care Claim.

(1) Timing of IRO determinations of requests for external review of Pre-Service Comprehensive Medical Benefit Claims that involve Organ Transplant Benefits but are not Urgent Care Claims.

If your Pre-Service Comprehensive Medical Benefit Claim involves Organ Transplant Benefits but is not an Urgent Care Claim, you will receive notice of the IRO's determination no later than 45 calendar days after the date that the IRO receives your request for external review.

(2) Timing of IRO determinations of requests for external review of Pre-Service Comprehensive Medical Benefit Claims that involve Organ Transplant Benefits and are Urgent Care Claims.

If you requested an expedited external review in accordance with Section 9.03(a)(8)(ii)(A)(2), the IRO will render a determination on your request and you will receive notice of the IRO's determination as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives your request for expedited external review.

If you requested a normal external review (i.e., a review that is not expedited) in accordance with Section 9.03(a)(8)(ii)(A)(2), you will receive notice of the IRO's determination no later than 45 calendar days after the date that the IRO receives your request for external review.

(F) Content of IRO determinations of requests for external review of Pre-Service Comprehensive Medical Benefit Claims that involve Organ Transplant Benefits

You will receive a written notice of the IRO's determination. This notice will include the following information:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);
- The date the IRO received the assignment to conduct external review and the date of the IRO's determination;
- References to the evidence and/or documentation considered by the IRO in reaching its determination, including the specific coverage provisions and evidence based standards;
- A discussion of the principal reason(s) for the IRO's determination, including its rationale and any evidence-based standards that were relied upon in making the determination;

- A statement that the diagnosis code, the treatment code, and their corresponding meanings will be provided to you as soon as practicable upon request;
- A statement that the reason for Blue KC's denial will be provided to you as soon as practicable upon request;
- A statement that the IRO's determination is binding except to the extent that other remedies may be available under state or federal law to either you or the Plan, or to the extent the Plan voluntarily makes payment on your claim;
- A statement that you have the right to bring civil action under Section 502(a) of ERISA; and
- A disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the PHSA to assist individuals with the internal claims and appeals and external review processes.

(G) Effect of IRO determinations of requests for external review of Pre-Service Comprehensive Medical Benefit Claims that involve Organ Transplant Benefits

If the IRO reverses Blue KC's determination, the Plan will immediately cover your claim.

If the IRO does not reverse Blue KC's determination, the Plan will not cover your claim.

The IRO's determination is binding upon the Plan, Blue KC, and you, except to the extent that you or the Plan may have other remedies available under applicable federal or state law. You may not file a subsequent request for external review involving the same adverse benefit determination for which you have already received an external review determination.

(b) Post-Service Comprehensive Medical Benefit Claims

(1) How to file Post-Service Comprehensive Medical Benefit Claims

Your Post-Service Comprehensive Medical Benefit Claim must be filed with Blue KC at the address shown on your identification card. In-network providers will usually file a claim with Blue KC on your behalf. You should always present your identification card to your provider at the time services are rendered.

If your provider does not file a claim on your behalf, you must file a claim for reimbursement with Blue KC or Solxsys. You can file your claim in paper format using either your provider's form or a standard health claim form. A claim for reimbursement must be submitted to either Blue KC or Solxsys and must contain all of the information that is necessary for Solxsys to process your claim, including the patient's name, the patient's date of birth, the patient's diagnosis, the provider's name, the provider's address, the services that were rendered, the CPT codes and amount billed for each service. Your claim must be filed by the last day of the calendar

year following the calendar year in which you incur the expense. An expense is incurred at the time a product or service is actually provided.

If this Plan is secondary, you or your provider should still file your Post-Service Comprehensive Medical Benefit Claim with Blue KC at the address shown on your identification card.

(2) Timing of benefit determinations for Post-Service Comprehensive Medical Benefit Claims

Solxsys will render a determination on whether, and/or to what extent, your Post-Service Comprehensive Medical Benefit Claim is payable by the Plan. The time period for rendering this determination begins as soon as your claim is received by Blue KC in accordance with Section 9.03(b)(1), regardless of whether or not Solxsys has all the information necessary to render the determination. You will receive notice of Solxsys' determination within a reasonable period of time, but no later than 30 calendar days after the date that Blue KC receives your claim. Solxsys may extend this period once by up to 15 calendar days if both of the following criteria are met:

- Solxsys determines that an extension of time is necessary due to matters beyond Solxsys' control; and
- Solxsys notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension and the date by which Solxsys expects to render a determination.

If the extension is necessary because Solxsys needs additional information from you to determine whether, and/or to what extent, benefits are payable by the Plan, the notice of the extension will specifically describe the required information and you will be allowed at least 45 calendar days from receipt of the notice to provide the specified information. The time period for rendering a determination on your claim will be suspended (i.e., tolled) from the date on which the notice is sent until the earlier of the following dates:

- The date Solxsys receives your response; or
- 45 calendar days have passed since the date that the notice was sent.

(3) Content of notifications of benefit determination for Post-Service Comprehensive Medical Benefit Claims

If the determination is that the Plan will pay 100% of the total amount of your Post-Service Comprehensive Medical Benefit Claim, you will receive a written notice that contains sufficient information to fully apprise you of the approval of your requested benefit.

If the determination is that the Plan will not pay 100% of the total amount of your Post-Service Comprehensive Medical Benefit Claim, you will receive a written notice of the adverse benefit determination. This notice will include the following information:

(i) Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);

(ii) The specific reason(s) for the adverse benefit determination;

(iii) Reference to the specific Plan provision(s) on which the adverse benefit determination is based;

(iv) A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;

(v) A statement that the diagnosis code, the treatment code, and their corresponding meanings will be provided to you as soon as practicable upon request;

(vi) The denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying your claim;

(vii) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, the notice will either set forth the specific rule, guideline, protocol, or other similar criterion, or it will contain a statement that such a criterion was relied upon in making the adverse benefit determination and that a copy of such criterion will be provided to you free of charge upon request;

(viii) If the adverse benefit determination was based on Medical Necessity, experimental or investigational treatment, or a similar exclusion or limit, the notice will either include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances of your claim, or it will contain a statement that such an explanation will be provided to you free of charge upon request;

(ix) A description of the Plan's internal appeal and external review procedures and any time limits applicable to such procedures;

(x) A statement that you have the right to bring a civil action under Section 502(a) of ERISA if there is an adverse benefit determination on appeal;

(xi) A disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the PHSA to assist individuals with the internal claims and appeals and external review processes; and

(xii) If the notice is sent to a county where 10% or more of the population is literate only in the same non-English language, the notice will contain a statement in the non-English language which explains the manner in which you can access the Plan's oral language services and informs you that a written notice in the non-English language will be provided to you upon request.

(4) How to file appeals for Post-Service Comprehensive Medical Benefit Claims

If it is determined that the Plan will not pay 100% of the total amount of your Post-Service Comprehensive Medical Benefit Claim, you may file an appeal by sending Solxsys a written request for the Board of Trustees to review your claim. Solxsys must receive your appeal within 180 calendar days after the date that you receive notification of the adverse benefit determination (i.e., within 180 calendar days after the date that you receive the notice described in Section 9.03(b)(3)).

(5) Full and fair review of appeals for Post-Service Comprehensive Medical Benefit Claims

You may request reasonable access to and copies of all documents, records, and other information relevant to your claim. You may also request the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse

benefit determination, regardless of whether the advice was relied upon in making the adverse benefit determination. To obtain the information described in this paragraph, you must send a written request to Solxsys. If you request any of the information described in this paragraph, Solxsys will provide it free of charge.

Prior to the date that the Trustees review your claim, you may submit written comments, documents, records, and other information relating to your claim to Solxsys. If your appeal involves an adverse benefit determination that is based in whole or in part on a medical judgment, the Board of Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional consulted on appeal will not be any individual who was consulted previously with respect to your claim, nor the subordinate of any such individual. If the Trustees consult with a health care professional and/or other new or additional evidence is considered, relied upon, or generated in connection with your appeal, Solxsys will provide you with such evidence. Solxsys will provide the information described in this paragraph free of charge and sufficiently in advance of the date on which the Trustees render a determination on your appeal.

The Trustees will conduct a full and fair review of your appeal without giving deference to the initial benefit determination. The Trustees will render a determination that is based on all comments, records, and other information that you submit regardless of whether or not such information was submitted or considered in the initial benefit determination. Although the Trustees' determination will be based on all comments, records, and other information that you submit in the initial benefit determination, the Trustees will not render an adverse benefit determination that is based on a rationale that is different from the rationale that was included in the notice of adverse benefit determination (i.e., the notice described in Section 9.03(b)(3)) unless Solxsys provides you with the new rationale free of charge and sufficiently in advance of the date that the Trustees render a determination on your appeal.

(6) Timing of notifications of benefit determination on appeal for Post-Service Comprehensive Medical Benefit Claims

The Trustees will render a determination on your appeal no later than the date of the regularly scheduled quarterly meeting immediately after the date that Solxsys receives your appeal unless it is received within the 30 calendar days prior to the date of the next regularly scheduled quarterly meeting. In this case, the Trustees will render a determination no later than the second quarterly meeting after the date that Solxsys receives your appeal. The Trustees and/or Solxsys may extend this period until no later than the third quarterly meeting after the date that Solxsys receives your appeal if both of the following criteria are met:

- The Trustees and/or Solxsys determines that special circumstances (e.g., the need to hold a hearing) require a further extension of time for processing your appeal; and
- Solxsys notifies you, prior to the commencement of the extension, of the circumstances requiring the extension and the date by which the Trustees expect to render a determination.

Solxsys will provide you with notice of the Trustees' determination no later than five calendar days after the date that the Trustees render the determination.

If you receive the information described in Section 9.03(b)(5) so late that it would be impossible for you to have a reasonable opportunity to respond, you may request that the time period for the Board of Trustees to render a determination on your appeal be suspended until you have

had a reasonable opportunity to respond. After you respond, or have had a reasonable opportunity to respond but fail to do so, the Trustees will render a determination on your appeal.

(7) Content of notifications of benefit determination on appeal for Post-Service Comprehensive Medical Benefit Claims

If your appeal for a Post-Service Comprehensive Medical Benefit Claim is denied, in whole or in part, you will receive a written notice of the denial. This notice will include the following information:

(i) Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);

(ii) The specific reason(s) for the denial;

(iii) Reference to the specific Plan provision(s) on which the denial is based;

(iv) A statement that reasonable access to, and copies of, all documents, records, and other information relevant to your claim will be provided to you free of charge upon request;

(v) A statement that the diagnosis code, the treatment code, and their corresponding meanings will be provided to you as soon as practicable upon request;

(vi) The denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying your appeal;

(vii) If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your appeal, the notice will either set forth the specific rule, guideline, protocol, or other similar criterion, or it will contain a statement that such a criterion was relied upon in denying your appeal and that a copy of such criterion will be provided to you free of charge upon request;

(viii) If the denial was based on Medical Necessity, experimental or investigational treatment, or a similar exclusion or limit, the notice will either include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances of your claim, or it will contain a statement that such an explanation will be provided to you free of charge upon request;

(ix) A description of the Plan's external review procedures and any time limits applicable to such procedures;

(x) A statement that you have the right to bring a civil action under Section 502(a) of ERISA;

(xi) A disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the PHSA to assist individuals with the internal claims and appeals and external review processes; and

(xii) If the notice is sent to a county where 10% or more of the population is literate only in the same non-English language, the notice will contain a statement in the non-English language which explains the manner in which you can access the Plan's oral language

services and informs you that a written notice in the non-English language will be provided to you upon request.

(8) External review of Post-Service Comprehensive Medical Benefit Claims

If you followed the Plan's internal claims and appeals procedures described in this Section 9.03(b) and you still disagree with the determination, you may request that an IRO conduct an external review of your Post-Service Comprehensive Medical Benefit Claim in accordance with this Section 9.03(b)(8). Your claim will only qualify for external review if it involves medical judgment, a Rescission of Coverage (as defined in Section 9.09), or your adverse benefit determination relates to compliance with the surprise billing and cost-sharing protections under the No Surprises Act (as described in Section 9.10). External review is not available for other types of denials, including denials due to your failure to meet the Plan's eligibility requirements.

(i) How to file requests for external review of Post-Service Comprehensive Medical Benefit Claims

You may file a request for external review of your Post-Service Comprehensive Medical Benefit Claim by sending Solxsys a written request for an IRO to review your claim. This request should not be filed until after you receive notification of the benefit determination on appeal (i.e., after the date that you receive the notice described in Section 9.03(b)(7)). Solxsys must receive your request for external review within four months after the date that you receive notification of the benefit determination on appeal.

(ii) Preliminary review of Post-Service Comprehensive Medical Benefit Claims

Solxsys will render a determination on whether or not your request is eligible for external review. The time period for rendering this determination begins as soon as your request for external review is received by Solxsys in accordance with Section 9.03(b)(8)(i). Your request will be eligible for external review if it meets all of the following criteria:

- You were covered by the Plan at the time the health care item or service was requested;
- Your claim involves medical judgment;
- You exhausted the Plan's internal claims and appeals procedures or your claim is deemed exhausted in accordance with Section 9.11; and
- You provided all the information and forms required to process your request for external review.

You will receive notice of Solxsys' determination within a reasonable period of time, but no later than six business days after the date that Solxsys receives your request for external review.

(iii) Content of preliminary determination of requests for external review of Post-Service Comprehensive Medical Benefit Claims

If Solxsys determines that your request qualifies for external review, you will receive a written notice that contains sufficient information to fully apprise you that your request qualifies for external review.

If Solxsys determines that your request does not qualify for external review, you will receive a written notice of this determination. This notice will include the specific reason(s) that your request is not eligible for external review and the current contact information, including the phone number, for the EBSA.

If Solxsys needs additional information from you to determine whether or not your request is eligible for external review, Solxsys will notify you of the information necessary to complete your request. If this occurs, your request will only be eligible for external review if it meets at least one of the following criteria:

- Solxsys receives the additional information within four calendar months after the date that you receive notification of the benefit determination on appeal (i.e., four calendar months after the date that you receive the notice described in Section 9.03(b)(7)); or
- Solxsys receives the additional information within 48 hours after you receive the notice describing the information needed to determine whether or not your request is eligible for external review (i.e., 48 hours after you receive the notice described in this Section 9.03(b)(8)(iii)).

(iv) IRO review of requests for external review of Post-Service Comprehensive Medical Benefit Claims

If your request is complete and eligible for external review, your request will be assigned to an IRO. Within five business days after the date of assignment of the IRO, Solxsys will provide the IRO with any information and materials considered in rendering a determination on your claim.

The IRO will timely notify you, in writing, of the acceptance of your request for external review. The IRO's initial notice will include directions on how you may submit additional information relating to your claim. You may submit such additional information during the ten business days following the date you received the initial notice from the IRO. The IRO will review all information and documents received within this time period. The IRO may, but is not required to, accept and consider any additional information that you submit after the ten business days following the date you receive the initial notice from the IRO.

The IRO will conduct a full and fair review of your appeal without giving deference to the previous benefit determinations. However, the IRO will be bound by the terms of the Plan Document.

If you submitted additional information to the IRO, the IRO will forward the information to Solxsys within one business day after the date that the IRO receives this information. Upon receipt of this information, the Board of Trustees may reconsider whether or not your Post-Service Comprehensive Medical Benefit Claim is covered by the Plan. Reconsideration by the Trustees will not delay the external review. If the Trustees reconsider your claim and, prior to the date that the IRO renders a determination, the Trustees determine that your claim is covered by the Plan, the external review will be terminated (i.e., if the Trustees determine that your claim is covered, it will no longer be necessary for the IRO to review your claim). If this occurs,

Solxsys will provide you and the IRO with notice of the Trustees' determination no later than one business day after the date that the Trustees render the determination.

(v) Timing of IRO determinations of requests for external review of Post-Service Comprehensive Medical Benefit Claims

You will receive notice of the IRO's determination no later than 45 calendar days after the date that the IRO receives your request for external review.

(vi) Content of IRO determinations of requests for external review of Post-Service Comprehensive Medical Benefit Claims

You will receive a written notice of the IRO's determination. This notice will include the following information:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);
- The date the IRO received the assignment to conduct external review and the date of the IRO's determination;
- References to the evidence and/or documentation considered by the IRO in reaching its determination, including the specific coverage provisions and evidence based standards;
- A discussion of the principal reason(s) for the IRO's determination, including its rationale and any evidence-based standards that were relied upon in making the determination;
- A statement that the diagnosis code, the treatment code, and their corresponding meanings will be provided to you as soon as practicable upon request;
- A statement that the reason for the Trustees' denial will be provided to you as soon as practicable upon request;
- A statement that the IRO's determination is binding except to the extent that other remedies may be available under state or federal law to either you or the Plan, or to the extent the Plan voluntarily makes payment on your claim;
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA; and
- A disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the PHSA to assist individuals with the internal claims and appeals and external review processes.

(vii) Effect of IRO determinations of requests for external review of Post-Service Comprehensive Medical Benefit Claims

If the IRO reverses the Board of Trustees' determination, the Plan will immediately cover your claim.

If the IRO does not reverse the Trustees' determination, the Plan will not cover your claim.

The IRO's determination is binding upon the Plan, Solxsys, and you, except to the extent that you or the Plan may have other remedies available under applicable federal or state law. You may not file a subsequent request for external review involving the same adverse benefit determination for which you have already received an external review determination.

Section 9.04 - Prescription Drug Benefit Claims and Appeals

Your request for Plan benefits is considered a claim if it is made in accordance with this Section 9.04. For example, if you or your provider file a Pre-Service Prescription Drug Benefit Claim in accordance with Section 9.04(a)(1), that request is considered a claim. However, presentation of a prescription at a pharmacy is not considered a claim.

As explained in Section 9.04(a) and Section 9.04(b), different rules apply depending on whether your Prescription Drug Benefit claim is a Pre-Service Prescription Drug Benefit Claim or a Post-Service Prescription Drug Benefit Claim.

Different rules also apply if you are enrolled in the UnitedHealthcare ("UHC") MAPD that provides prescription drug benefits to Medicare eligible Covered Persons. If you are enrolled in the MAPD, UHC will process your claims and appeals in accordance with procedures set forth by federal regulations and guidance set forth by the Centers for Medicare & Medicaid Services ("CMS"). If UHC determines that your prescription drug is not covered by the MAPD or you disagree with the amount that you are required to pay for a prescription drug, you may file a claim with the Plan in accordance with Section 9.04(a) or Section 9.04(b) below, as applicable.

(a) Pre-Service Prescription Drug Benefit Claims

(1) How to file Pre-Service Prescription Drug Benefit Claims

There are certain prescription drugs that must be reviewed by Sav-Rx to determine whether or not the prescribed drug is covered by the Plan. For such drugs, you or your provider may submit a request for prior authorization to Sav-Rx in accordance with Section 3.06. A request for prior authorization is a service provided by the Plan to enable you to get an advance determination that the drug you were prescribed is covered by the Plan. A request for prior authorization is not a pre-requisite for receiving a Prescription Drug Benefit and is not considered a claim.

If you or your provider submits a request for prior authorization and Sav-Rx determines that the prescribed drug is not covered by the Plan, you will receive written notice from Sav-Rx indicating that the drug is not covered. After receiving this written notice, you or your provider may file a Pre-Service Prescription Drug Benefit Claim in accordance with this Section 9.04(a)(1). You or your provider must file the Pre-Service Prescription Drug Benefit Claim with Solxsys by using a claim form available from Solxsys.

If your Pre-Service Prescription Drug Benefit Claim is filed incorrectly but received by Solxsys at the appropriate location and names a specific Claimant, a specific medical condition or symptom, and a specific prescription drug, Solxsys will inform you that your claim was filed incorrectly and will let you know the procedures you should follow to file your claim. This notice will be provided to you as soon as possible, but no later than five calendar days after Solxsys receives your claim. This notice may be oral, unless written notice is requested.

(2) Timing of benefit determinations for Pre-Service Prescription Drug Benefit Claims

Solxsys will render a determination on whether, and/or to what extent, your Pre-Service Prescription Drug Benefit Claim is payable by the Plan. The time period for rendering this determination begins as soon as your claim is received by Solxsys in accordance with Section 9.04(a)(1), regardless of whether or not Solxsys has all the information necessary to render the determination. You will receive notice of Solxsys' determination within a reasonable period of time appropriate to the medical circumstances, but no later than 15 calendar days after the date that Solxsys receives your claim. Solxsys may extend this period once by up to 15 calendar days if both of the following criteria are met:

- Solxsys determines that an extension of time is necessary due to matters beyond Solxsys' control; and
- Solxsys notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension and the date by which Solxsys expects to render a determination.

If the extension is necessary because Solxsys needs additional information from you to determine whether, and/or to what extent, benefits are payable by the Plan, the notice of the extension will specifically describe the required information and you will be allowed at least 45 calendar days from receipt of the notice to provide the specified information. The time period for rendering a determination on your claim will be suspended (i.e., tolled) from the date on which the notice is sent until the earlier of the following dates:

- The date Solxsys receives your response; or
- 45 calendar days have passed since the date that the notice was sent.

(3) Content of notifications of benefit determination for Pre-Service Prescription Drug Benefit Claims

If the determination is that the Plan will pay 100% of the total amount of your Pre-Service Prescription Drug Benefit Claim, you will receive a written notice that contains sufficient information to fully apprise you of the approval of your requested benefit.

If the determination is that the Plan will not pay 100% of the total amount of your Pre-Service Prescription Drug Benefit Claim, you will receive a written notice of the adverse benefit determination. This notice will include the following information:

(i) Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);

(ii) The specific reason(s) for the adverse benefit determination;

(iii) Reference to the specific Plan provision(s) on which the adverse benefit determination is based;

(iv) A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;

(v) A statement that the diagnosis code, the treatment code, and their corresponding meanings will be provided to you as soon as practicable upon request;

(vi) The denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying your claim;

(vii) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, the notice will either set forth the specific rule, guideline, protocol, or other similar criterion, or it will contain a statement that such a criterion was relied upon in making the adverse benefit determination and that a copy of such criterion will be provided to you free of charge upon request;

(viii) If the adverse benefit determination was based on Medical Necessity, experimental or investigational treatment, or a similar exclusion or limit, the notice will either include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances of your claim, or it will contain a statement that such an explanation will be provided to you free of charge upon request;

(ix) A description of the Plan's internal appeal and external review procedures and any time limits applicable to such procedures;

(x) A statement that you have the right to bring a civil action under Section 502(a) of ERISA if there is an adverse benefit determination on appeal;

(xi) A disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the PHSA to assist individuals with the internal claims and appeals and external review processes; and

(xii) If the notice is sent to a county where 10% or more of the population is literate only in the same non-English language, the notice will contain a statement in the non-English language which explains the manner in which you can access the Plan's oral language services and informs you that a written notice in the non-English language will be provided to you upon request.

(4) How to file appeals for Pre-Service Prescription Drug Benefit Claims

If it is determined that the Plan will not pay 100% of the total amount of your Pre-Service Prescription Drug Benefit Claim, you may file an appeal by sending Solxsys a written request for the Board of Trustees to review your claim. Solxsys must receive your appeal within 180 calendar days after the date that you receive notification of the adverse benefit determination (i.e., within 180 calendar days after the date that you receive the notice described in Section 9.04(a)(3)).

(5) Full and fair review of appeals for Pre-Service Prescription Drug Benefit Claims

You may request reasonable access to and copies of all documents, records, and other information relevant to your claim. You may also request the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, regardless of whether the advice was relied upon in making the adverse benefit determination. To obtain the information described in this paragraph, you must send a written request to Solxsys. If you request any of the information described in this paragraph, Solxsys will provide it free of charge.

Prior to the date that the Trustees review your claim, you may submit written comments, documents, records, and other information relating to your claim to Solxsys. If your appeal involves an adverse benefit determination that is based in whole or in part on a medical judgment, the Board of Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional consulted on appeal will not be any individual who was consulted previously with respect to your claim, nor the subordinate of any such individual. If the Trustees consult with a health care professional and/or other new or additional evidence is considered, relied upon, or generated in connection with your appeal, Solxsys will provide you with such evidence. Solxsys will provide the information described in this paragraph free of charge and sufficiently in advance of the date on which the Trustees render a determination on your appeal.

The Trustees will conduct a full and fair review of your appeal without giving deference to the initial benefit determination. The Trustees will render a determination that is based on all comments, records, and other information that you submit regardless of whether or not such information was submitted or considered in the initial benefit determination. Although the Trustees' determination will be based on all comments, records, and other information that you submit in the initial benefit determination, the Trustees will not render an adverse benefit determination that is based on a rationale that is different from the rationale that was included in the notice of adverse benefit determination (i.e., the notice described in Section 9.04(a)(3)) unless Solxsys provides you with the new rationale free of charge and sufficiently in advance of the date that the Trustees render a determination on your appeal.

(6) Timing of notifications of benefit determination on appeal for Pre-Service Prescription Drug Benefit Claims

Solxsys will provide you with notice of the Trustees' determination within a reasonable period of time appropriate to the medical circumstances but no later than 30 calendar days after the date that Solxsys receives your appeal.

If you receive the information described in Section 9.04(a)(5) so late that it would be impossible for you to have a reasonable opportunity to respond, you may request that the time period for the Board of Trustees to render a determination on your appeal be suspended until you have had a reasonable opportunity to respond. After you respond, or have had a reasonable opportunity to respond but fail to do so, the Trustees will render a determination on your appeal.

(7) Content of notifications of benefit determination on appeal for Pre-Service Prescription Drug Benefit Claims

If your appeal for a Pre-Service Prescription Drug Benefit Claim is denied, in whole or in part, you will receive a written notice of the denial. This notice will include the following information:

(i) Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);

(ii) The specific reason(s) for the denial;

(iii) Reference to the specific Plan provision(s) on which the denial is based;

(iv) A statement that reasonable access to, and copies of, all documents, records, and other information relevant to your claim will be provided to you free of charge upon request;

(v) A statement that the diagnosis code, the treatment code, and their corresponding meanings will be provided to you as soon as practicable upon request;

(vi) The denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying your appeal;

(vii) If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your appeal, the notice will either set forth the specific rule, guideline, protocol, or other similar criterion, or it will contain a statement that such a criterion was relied upon in denying your appeal and that a copy of such criterion will be provided to you free of charge upon request;

(viii) If the denial was based on Medical Necessity, experimental or investigational treatment, or a similar exclusion or limit, the notice will either include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances of your claim, or it will contain a statement that such an explanation will be provided to you free of charge upon request;

(ix) A description of the Plan's external review procedures and any time limits applicable to such procedures;

(x) A statement that you have the right to bring a civil action under Section 502(a) of ERISA;

(xi) A disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the PHSA to assist individuals with the internal claims and appeals and external review processes; and

(xii) If the notice is sent to a county where 10% or more of the population is literate only in the same non-English language, the notice will contain a statement in the non-English language which explains the manner in which you can access the Plan's oral language services and informs you that a written notice in the non-English language will be provided to you upon request.

(8) External review of Pre-Service Prescription Drug Benefit Claims

If you followed the Plan's internal claims and appeals procedures described in this Section 9.04(a) and you still disagree with the determination, you may request that an IRO conduct an external review of your Pre-Service Prescription Drug Benefit Claim in accordance with this Section 9.04(a)(8). Your claim will only qualify for external review if it involves medical judgment. External review is not available for other types of denials, including denials due to your failure to meet the Plan's eligibility requirements.

(i) How to file requests for external review of Pre-Service Prescription Drug Benefit Claims

You may file a request for external review of your Pre-Service Prescription Drug Benefit Claim by sending Solxsys a written request for an IRO to review your claim. This request should not be filed until after you receive notification of the benefit determination on appeal (i.e., after the date that you receive the notice described in Section 9.04(a)(7)). Solxsys must receive your request for external review within four

months after the date that you receive notification of the benefit determination on appeal.

(ii) Preliminary review of Pre-Service Prescription Drug Benefit Claims

Solxsys will render a determination on whether or not your request is eligible for external review. The time period for rendering this determination begins as soon as your request for external review is received by Solxsys in accordance with Section 9.04(a)(8)(i). Your request will be eligible for external review if it meets all of the following criteria:

- You were covered by the Plan at the time the health care item or service was requested;
- Your claim involves medical judgment;
- You exhausted the Plan's internal claims and appeals procedures or your claim is deemed exhausted in accordance with Section 9.11; and
- You provided all the information and forms required to process your request for external review.

You will receive notice of Solxsys' determination within a reasonable period of time, but no later than six business days after the date that Solxsys receives your request for external review.

(iii) Content of preliminary determination of requests for external review of Pre-Service Prescription Drug Benefit Claims

If Solxsys determines that your request qualifies for external review, you will receive a written notice that contains sufficient information to fully apprise you that your request qualifies for external review.

If Solxsys determines that your request does not qualify for external review, you will receive a written notice of this determination. This notice will include the specific reason(s) that your request is not eligible for external review and the current contact information, including the phone number, for the EBSA.

If Solxsys needs additional information from you to determine whether or not your request is eligible for external review, Solxsys will notify you of the information necessary to complete your request. If this occurs, your request will only be eligible for external review if it meets at least one of the following criteria:

- Solxsys receives the additional information within four calendar months after the date that you receive notification of the benefit determination on appeal (i.e., four calendar months after the date that you receive the notice described in Section 9.04(a)(7)); or
- Solxsys receives the additional information within 48 hours after you receive the notice describing the information needed to determine whether or not your request is eligible for external review (i.e., 48 hours after you receive the notice described in this Section 9.04(a)(8)(iii)).

(iv) IRO review of requests for external review of Pre-Service Prescription Drug Benefit Claims

If your request is complete and eligible for external review, your request will be assigned to an IRO. Within five business days after the date of assignment of the IRO, Solxsys will provide the IRO with any information and materials considered in rendering a determination on your claim.

The IRO will timely notify you, in writing, of the acceptance of your request for external review. The IRO's initial notice will include directions on how you may submit additional information relating to your claim. You may submit such additional information during the ten business days following the date you received the initial notice from the IRO. The IRO will review all information and documents received within this time period. The IRO may, but is not required to, accept and consider any additional information that you submit after the ten business days following the date you receive the initial notice from the IRO.

The IRO will conduct a full and fair review of your appeal without giving deference to the previous benefit determinations. However, the IRO will be bound by the terms of the Plan Document.

If you submitted additional information to the IRO, the IRO will forward the information to Solxsys within one business day after the date that the IRO receives this information. Upon receipt of this information, the Board of Trustees may reconsider whether or not your Pre-Service Prescription Drug Benefit Claim is covered by the Plan. Reconsideration by the Trustees will not delay the external review. If the Trustees reconsider your claim and, prior to the date that the IRO renders a determination, the Trustees determine that your claim is covered by the Plan, the external review will be terminated (i.e., if the Trustees determine that your claim is covered, it will no longer be necessary for the IRO to review your claim). If this occurs, Solxsys will provide you and the IRO with notice of the Trustees' determination no later than one business day after the date that the Trustees render the determination.

(v) Timing of IRO determinations of requests for external review of Pre-Service Prescription Drug Benefit Claims

You will receive notice of the IRO's determination no later than 45 calendar days after the date that the IRO receives your request for external review.

(vi) Content of IRO determinations of requests for external review of Pre-Service Prescription Drug Benefit Claims

You will receive a written notice of the IRO's determination. This notice will include the following information:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);
- The date the IRO received the assignment to conduct external review and the date of the IRO's determination;

- References to the evidence and/or documentation considered by the IRO in reaching its determination, including the specific coverage provisions and evidence based standards;
- A discussion of the principal reason(s) for the IRO's determination, including its rationale and any evidence-based standards that were relied upon in making the determination;
- A statement that the diagnosis code, the treatment code, and their corresponding meanings will be provided to you as soon as practicable upon request;
- A statement that the reason for the Trustees' denial will be provided to you as soon as practicable upon request;
- A statement that the IRO's determination is binding except to the extent that other remedies may be available under state or federal law to either you or the Plan, or to the extent the Plan voluntarily makes payment on your claim;
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA; and
- A disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the PHSA to assist individuals with the internal claims and appeals and external review processes.

(vii) Effect of IRO determinations of requests for external review of Pre-Service Prescription Drug Claims

If the IRO reverses the Board of Trustees' determination, the Plan will immediately cover your claim.

If the IRO does not reverse the Trustees' determination, the Plan will not cover your claim.

The IRO's determination is binding upon the Plan, Solxsys, and you, except to the extent that you or the Plan may have other remedies available under applicable federal or state law. You may not file a subsequent request for external review involving the same adverse benefit determination for which you have already received an external review determination.

(b) Post-Service Prescription Drug Benefit Claims

(1) How to file Post-Service Prescription Drug Benefit Claims

Presentation of a prescription at a pharmacy does not constitute a claim for Prescription Drug Benefits. However, if you went to the pharmacy to fill a prescription and you were required to pay the entire cost of the prescription (i.e., you paid 100% of the cost of the prescription drug) or you disagree with the amount that you paid for the prescription, you may file a claim with Sav-Rx. Your Post-Service Prescription Drug Benefit Claim must be filed with Sav-Rx at the address shown on your identification card or by faxing your claim to (888) 810-1394. You must file a claim with Sav-Rx using Sav-Rx's reimbursement request form, which is available from Sav-Rx.

Your claim must be filed by the last day of the calendar year following the calendar year in which you incur the expense. An expense is incurred at the time a prescription drug is purchased.

(2) Timing of benefit determinations for Post-Service Prescription Drug Benefit Claims

Sav-Rx will render a determination on whether, and/or to what extent, your Post-Service Prescription Drug Benefit Claim is payable by the Plan. The time period for rendering this determination begins as soon as your claim is received by Sav-Rx in accordance with Section 9.04(b)(1), regardless of whether or not Sav-Rx has all the information necessary to render the determination. You will receive notice of Sav-Rx's determination within a reasonable period of time, but no later than 30 calendar days after the date that Sav-Rx receives your claim. Sav-Rx may extend this period once by up to 15 calendar days if both of the following criteria are met:

- Sav-Rx determines that an extension of time is necessary due to matters beyond Sav-Rx's control; and
- Sav-Rx notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension and the date by which Sav-Rx expects to render a determination.

If the extension is necessary because Sav-Rx needs additional information from you to determine whether, and/or to what extent, benefits are payable by the Plan, the notice of the extension will specifically describe the required information and you will be allowed at least 45 calendar days from receipt of the notice to provide the specified information. The time period for rendering a determination on your claim will be suspended (i.e., tolled) from the date on which the notice is sent until the earlier of the following dates:

- The date Sav-Rx receives your response; or
- 45 calendar days have passed since the date that the notice was sent.

(3) Content of notifications of benefit determination for Post-Service Prescription Drug Benefit Claims

If the determination is that the Plan will not pay 100% of the total amount of your Post-Service Prescription Drug Benefit Claim, you will receive a written notice of the adverse benefit determination. This notice will include the following information:

(i) Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);

(ii) The specific reason(s) for the adverse benefit determination;

(iii) Reference to the specific Plan provision(s) on which the adverse benefit determination is based;

(iv) A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;

(v) A statement that the diagnosis code, the treatment code, and their corresponding meanings will be provided to you as soon as practicable upon request;

(vi) The denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying your claim;

(vii) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, the notice will either set forth the specific rule, guideline, protocol, or other similar criterion, or it will contain a statement that such a criterion was relied upon in making the adverse benefit determination and that a copy of such criterion will be provided to you free of charge upon request;

(viii) If the adverse benefit determination was based on Medical Necessity, experimental or investigational treatment, or a similar exclusion or limit, the notice will either include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances of your claim, or it will contain a statement that such an explanation will be provided to you free of charge upon request;

(ix) A description of the Plan's internal appeal and external review procedures and any time limits applicable to such procedures;

(x) A statement that you have the right to bring a civil action under Section 502(a) of ERISA if there is an adverse benefit determination on appeal;

(xi) A disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the PHSA to assist individuals with the internal claims and appeals and external review processes; and

(xii) If the notice is sent to a county where 10% or more of the population is literate only in the same non-English language, the notice will contain a statement in the non-English language which explains the manner in which you can access the Plan's oral language services and informs you that a written notice in the non-English language will be provided to you upon request.

(4) How to file appeals for Post-Service Prescription Drug Benefit Claims

If it is determined that the Plan will not pay 100% of the total amount of your Post-Service Prescription Drug Benefit Claim, you may file an appeal by sending Solxsys a written request for the Board of Trustees to review your claim. Solxsys must receive your appeal within 180 calendar days after the date that you receive notification of the adverse benefit determination (i.e., within 180 calendar days after the date that you receive the notice described in Section 9.04(b)(3)).

(5) Full and fair review of appeals for Post-Service Prescription Drug Benefit Claims

You may request reasonable access to and copies of all documents, records, and other information relevant to your claim. You may also request the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, regardless of whether the advice was relied upon in making the adverse benefit determination. To obtain the information described in this paragraph, you must send a written request to Solxsys. If you request any of the information described in this paragraph, Solxsys will provide it free of charge.

Prior to the date that the Trustees review your claim, you may submit written comments, documents, records, and other information relating to your claim to Solxsys. If your appeal involves an adverse benefit determination that is based in whole or in part on a medical judgment, the Board of Trustees will consult with a health care professional who has appropriate

training and experience in the field of medicine involved in the medical judgment. The health care professional consulted on appeal will not be any individual who was consulted previously with respect to your claim, nor the subordinate of any such individual. If the Trustees consult with a health care professional and/or other new or additional evidence is considered, relied upon, or generated in connection with your appeal, Solxsys will provide you with such evidence. Solxsys will provide the information described in this paragraph free of charge and sufficiently in advance of the date on which the Trustees render a determination on your appeal.

The Trustees will conduct a full and fair review of your appeal without giving deference to the initial benefit determination. The Trustees will render a determination that is based on all comments, records, and other information that you submit regardless of whether or not such information was submitted or considered in the initial benefit determination. Although the Trustees' determination will be based on all comments, records, and other information that you submit in the initial benefit determination, the Trustees will not render an adverse benefit determination that is based on a rationale that is different from the rationale that was included in the notice of adverse benefit determination (i.e., the notice described in Section 9.04(b)(3)) unless Solxsys provides you with the new rationale free of charge and sufficiently in advance of the date that the Trustees render a determination on your appeal.

(6) Timing of notifications of benefit determination on appeal for Post-Service Prescription Drug Benefit Claims

The Trustees will render a determination on your appeal no later than the date of the regularly scheduled quarterly meeting immediately after the date that Solxsys receives your appeal unless it is received within the 30 calendar days prior to the date of the next regularly scheduled quarterly meeting. In this case, the Trustees will render a determination no later than the second quarterly meeting after the date that Solxsys receives your appeal. The Trustees and/or Solxsys may extend this period until no later than the third quarterly meeting after the date that Solxsys receives your appeal if both of the following criteria are met:

- The Trustees and/or Solxsys determines that special circumstances (e.g., the need to hold a hearing) require a further extension of time for processing your appeal; and
- Solxsys notifies you, prior to the commencement of the extension, of the circumstances requiring the extension and the date by which the Trustees expect to render a determination.

Solxsys will provide you with notice of the Trustees' determination no later than five calendar days after the date that the Trustees render the determination.

If you receive the information described in Section 9.04(b)(5) so late that it would be impossible for you to have a reasonable opportunity to respond, you may request that the time period for the Board of Trustees to render a determination on your appeal be suspended until you have had a reasonable opportunity to respond. After you respond, or have had a reasonable opportunity to respond but fail to do so, the Trustees will render a determination on your appeal.

(7) Content of notifications of benefit determination on appeal for Post-Service Prescription Drug Benefit Claims

If your appeal for a Post-Service Prescription Drug Benefit Claim is denied, in whole or in part, you will receive a written notice of the denial. This notice will include the following information:

(i) Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);

(ii) The specific reason(s) for the denial;

(iii) Reference to the specific Plan provision(s) on which the denial is based;

(iv) A statement that reasonable access to, and copies of, all documents, records, and other information relevant to your claim will be provided to you free of charge upon request;

(v) A statement that the diagnosis code, the treatment code, and their corresponding meanings will be provided to you as soon as practicable upon request;

(vi) The denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying your appeal;

(vii) If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your appeal, the notice will either set forth the specific rule, guideline, protocol, or other similar criterion, or it will contain a statement that such a criterion was relied upon in denying your appeal and that a copy of such criterion will be provided to you free of charge upon request;

(viii) If the denial was based on Medical Necessity, experimental or investigational treatment, or a similar exclusion or limit, the notice will either include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances of your claim, or it will contain a statement that such an explanation will be provided to you free of charge upon request;

(ix) A description of the Plan's external review procedures and any time limits applicable to such procedures;

(x) A statement that you have the right to bring a civil action under Section 502(a) of ERISA;

(xi) A disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the PHSA to assist individuals with the internal claims and appeals and external review processes; and

(xii) If the notice is sent to a county where 10% or more of the population is literate only in the same non-English language, the notice will contain a statement in the non-English language which explains the manner in which you can access the Plan's oral language services and informs you that a written notice in the non-English language will be provided to you upon request.

(8) External review of Post-Service Prescription Drug Benefit Claims

If you followed the Plan's internal claims and appeals procedures described in this Section 9.04(b) and you still disagree with the determination, you may request that an IRO conduct an external review of your Post-Service Prescription Drug Benefit Claim in accordance with this Section 9.04(b)(8). Your claim will only qualify for external review if it involves medical judgment or a Rescission of Coverage (as defined in Section 9.09). External review is not

available for other types of denials, including denials due to your failure to meet the Plan's eligibility requirements.

(i) How to file requests for external review of Post-Service Prescription Drug Benefit Claims

You may file a request for external review of your Post-Service Prescription Drug Benefit Claim by sending Solxsys a written request for an IRO to review your claim. This request should not be filed until after you receive notification of the benefit determination on appeal (i.e., after the date that you receive the notice described in Section 9.04(a)(7)). Solxsys must receive your request for external review within four months after the date that you receive notification of the benefit determination on appeal.

(ii) Preliminary review of Post-Service Prescription Drug Benefit Claims

Solxsys will render a determination on whether or not your request is eligible for external review. The time period for rendering this determination begins as soon as your request for external review is received by Solxsys in accordance with Section 9.04(b)(8)(i). Your request will be eligible for external review if it meets all of the following criteria:

- You were covered by the Plan at the time the health care item or service was requested;
- Your claim involves medical judgment;
- You exhausted the Plan's internal claims and appeals procedures or your claim is deemed exhausted in accordance with Section 9.11; and
- You provided all the information and forms required to process your request for external review.

You will receive notice of Solxsys' determination within a reasonable period of time, but no later than six business days after the date that Solxsys receives your request for external review.

(iii) Content of preliminary determination of requests for external review of Post-Service Prescription Drug Benefit Claims

If Solxsys determines that your request qualifies for external review, you will receive a written notice that contains sufficient information to fully apprise you that your request qualifies for external review.

If Solxsys determines that your request does not qualify for external review, you will receive a written notice of this determination. This notice will include the specific reason(s) that your request is not eligible for external review and the current contact information, including the phone number, for the EBSA.

If Solxsys needs additional information from you to determine whether or not your request is eligible for external review, Solxsys will notify you of the information necessary to complete your request. If this occurs, your request will only be eligible for external review if it meets at least one of the following criteria:

- Solxsys receives the additional information within four calendar months after the date that you receive notification of the benefit determination on appeal (i.e., four calendar months after the date that you receive the notice described in Section 9.04(b)(7)); or
- Solxsys receives the additional information within 48 hours after you receive the notice describing the information needed to determine whether or not your request is eligible for external review (i.e., 48 hours after you receive the notice described in this Section 9.04(b)(8)(iii)).

(iv) IRO review of requests for external review of Post-Service Prescription Drug Benefit Claims

If your request is complete and eligible for external review, your request will be assigned to an IRO. Within five business days after the date of assignment of the IRO, Solxsys will provide the IRO with any information and materials considered in rendering a determination on your claim.

The IRO will timely notify you, in writing, of the acceptance of your request for external review. The IRO's initial notice will include directions on how you may submit additional information relating to your claim. You may submit such additional information during the ten business days following the date you received the initial notice from the IRO. The IRO will review all information and documents received within this time period. The IRO may, but is not required to, accept and consider any additional information that you submit after the ten business days following the date you receive the initial notice from the IRO.

The IRO will conduct a full and fair review of your appeal without giving deference to the previous benefit determinations. However, the IRO will be bound by the terms of the Plan Document.

If you submitted additional information to the IRO, the IRO will forward the information to Solxsys within one business day after the date that the IRO receives this information. Upon receipt of this information, the Board of Trustees may reconsider whether or not your Post-Service Prescription Drug Benefit Claim is covered by the Plan. Reconsideration by the Trustees will not delay the external review. If the Trustees reconsider your claim and, prior to the date that the IRO renders a determination, the Trustees determine that your claim is covered by the Plan, the external review will be terminated (i.e., if the Trustees determine that your claim is covered, it will no longer be necessary for the IRO to review your claim). If this occurs, Solxsys will provide you and the IRO with notice of the Trustees' determination no later than one business day after the date that the Trustees render the determination.

(v) Timing of IRO determinations of requests for external review of Post-Service Prescription Drug Benefit Claims

You will receive notice of the IRO's determination no later than 45 calendar days after the date that the IRO receives your request for external review.

(vi) Content of IRO determinations of requests for external review of Post-Service Prescription Drug Benefit Claims

You will receive a written notice of the IRO's determination. This notice will include the following information:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);
- The date the IRO received the assignment to conduct external review and the date of the IRO's determination;
- References to the evidence and/or documentation considered by the IRO in reaching its determination, including the specific coverage provisions and evidence based standards;
- A discussion of the principal reason(s) for the IRO's determination, including its rationale and any evidence-based standards that were relied upon in making the determination;
- A statement that the diagnosis code, the treatment code, and their corresponding meanings will be provided to you as soon as practicable upon request;
- A statement that the reason for the Trustees' denial will be provided to you as soon as practicable upon request;
- A statement that the IRO's determination is binding except to the extent that other remedies may be available under state or federal law to either you or the Plan, or to the extent the Plan voluntarily makes payment on your claim;
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA; and
- A disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the PHSA to assist individuals with the internal claims and appeals and external review processes.

(vii) Effect of IRO determinations of requests for external review of Post-Service Prescription Drug Benefit Claims

If the IRO reverses the Board of Trustees' determination, the Plan will immediately cover your claim.

If the IRO does not reverse the Trustees' determination, the Plan will not cover your claim.

The IRO's determination is binding upon the Plan, Solxsys, and you, except to the extent that you or the Plan may have other remedies available under applicable federal or state law. You may not file a subsequent request for external review involving the same adverse benefit determination for which you have already received an external review determination.

Section 9.05 - Dental Benefit Claims and Appeals

(a) How to File Dental Benefit Claims

Your Dental Benefit Claim must be filed with Delta Dental at the address shown on your identification card. Participating Dentists and many other Dentists may file a claim with Delta Dental on your behalf. You should always present your identification card to your provider at the time services are rendered.

If your provider does not file a claim on your behalf, you must file a claim form with Delta Dental using Delta Dental's claim form, which is available from Solxsys. Your claim must be filed by the last day of the calendar year following the calendar year in which you incur the expense. An expense is incurred at the time a product or service is actually provided.

If this Plan is secondary, you or your provider should still file your Dental Benefit Claim with Delta Dental, along with a copy of the primary plan or carrier's explanation of benefits, at the address shown on your identification card.

(b) Timing of Benefit Determinations for Dental Benefit Claims

Delta Dental will render a determination on whether, and/or to what extent, your Dental Benefit Claim is payable by the Plan. The time period for rendering this determination begins as soon as your claim is received by Delta Dental in accordance with Section 9.05(a), regardless of whether or not Delta Dental has all the information necessary to render the determination. You will receive notice of Delta Dental's determination within a reasonable period of time, but no later than 30 calendar days after the date that Delta Dental receives your claim. Delta Dental may extend this period once by up to 15 calendar days if both of the following criteria are met:

- Delta Dental determines that an extension of time is necessary due to matters beyond Delta Dental's control; and
- Delta Dental notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension and the date by which Delta Dental expects to render a determination.

If the extension is necessary because Delta Dental needs additional information from you to determine whether, and/or to what extent, benefits are payable by the Plan, the notice of the extension will specifically describe the required information and you will be allowed at least 45 calendar days from receipt of the notice to provide the specified information. The time period for rendering a determination on your claim will be suspended (i.e., tolled) from the date on which the notice is sent until the earlier of the following dates:

- The date Delta Dental receives your response; or
- 45 calendar days have passed since the date that the notice was sent.

(c) Content of Notifications of Benefit Determination for Dental Benefit Claims

If the determination is that the Plan will pay 100% of the total amount of your Dental Benefit Claim, you will receive a written notice that contains sufficient information to fully apprise you of the approval of your requested benefit.

If the determination is that the Plan will not pay 100% of the total amount of your Dental Benefit Claim, you will receive a written notice of the adverse benefit determination. This notice will include the following information:

(1) Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);

(2) The specific reason(s) for the adverse benefit determination;

(3) The reason code on which the adverse benefit determination is based;

(4) A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary. If additional information is necessary to complete the claims processing, the denial reason will request the dentist provide the information necessary. This denial information is also shared with the Delta Dental network dentist;

(5) The procedure code and its corresponding meaning;

(6) The denial code and its corresponding meaning, as well as a description of the standard, if any, that was used in denying your claim;

(7) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, the notice will either set forth the specific rule, guideline, protocol, or other similar criterion, or it will contain a statement that such a criterion was relied upon in making the adverse benefit determination and that a copy of such criterion will be provided to you free of charge upon request;

(8) If the adverse benefit determination was based on Medical Necessity, experimental or investigational treatment, or a similar exclusion or limit, the notice will either include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances of your claim, or it will contain a statement that such an explanation will be provided to you free of charge upon request.

(9) A description of the Plan's internal appeal and external review procedures and any time limits applicable to such procedures;

(10) A statement that you have the right to bring a civil action under Section 502(a) of ERISA if there is an adverse benefit determination on appeal;

(11) A disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the PHSA to assist individuals with the internal claims and appeals and external review processes; and

(12) If the notice is sent to a county where 10% or more of the population is literate only in the same non-English language, the notice will contain a statement in the non-English language which explains the manner in which you can access the Plan's oral language services and informs you that a written notice in the non-English language will be provided to you upon request.

(d) How to File Appeals for Dental Benefit Claims

If it is determined that the Plan will not pay 100% of the total amount of your Dental Benefit Claim, you may file an appeal by sending Solxsys a written request for the Board of Trustees to review your claim. Solxsys must receive your appeal within 180 calendar days after the date that you receive notification of the adverse benefit determination (i.e., within 180 calendar days after the date that you receive the notice described in Section 9.05(c)).

(e) Full and Fair Review of Appeals for Dental Benefit Claims

You may request reasonable access to and copies of all documents, records, and other information relevant to your claim. To obtain the information described in this paragraph, you must send a written request to Solxsys. If you request any of the information described in this paragraph, Solxsys will provide it free of charge.

Prior to the date that the Trustees review your claim, you may submit written comments, documents, records, and other information relating to your claim to Solxsys. If your appeal involves an adverse benefit determination that is based in whole or in part on a medical judgment, the Board of Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional consulted on appeal will not be any individual who was consulted previously with respect to your claim, nor the subordinate of any such individual. If the Trustees consult with a health care professional and/or other new or additional evidence is considered, relied upon, or generated in connection with your appeal, Solxsys will provide you with such evidence. Solxsys will provide the information described in this paragraph free of charge and sufficiently in advance of the date on which the Trustees render a determination on your appeal.

The Trustees will conduct a full and fair review of your appeal without giving deference to the initial benefit determination. The Trustees will render a determination that is based on all comments, records, and other information that you submit regardless of whether or not such information was submitted or considered in the initial benefit determination. Although the Trustees' determination will be based on all comments, records, and other information that you submit in the initial benefit determination, the Trustees will not render an adverse benefit determination that is based on a rationale that is different from the rationale that was included in the notice of adverse benefit determination (i.e., the notice described in Section 9.05(c)) unless Solxsys provides you with the new rationale free of charge and sufficiently in advance of the date that the Trustees render a determination on your appeal.

(f) Timing of Notifications of Benefit Determination on Appeal for Dental Benefit Claims

The Trustees will render a determination on your appeal no later than the date of the regularly scheduled quarterly meeting immediately after the date that Solxsys receives your appeal unless it is received within the 30 calendar days prior to the date of the next regularly scheduled quarterly meeting. In this case, the Trustees will render a determination no later than the second quarterly meeting after the date that Solxsys receives your appeal. The Trustees and/or Solxsys may extend this period until no later than the third quarterly meeting after the date that Solxsys receives your appeal if both of the following criteria are met:

- The Trustees and/or Solxsys determines that special circumstances (e.g., the need to hold a hearing) require a further extension of time for processing your appeal; and
- Solxsys notifies you, prior to the commencement of the extension, of the circumstances requiring the extension and the date by which the Trustees expect to render a determination.

Solxsys will provide you with notice of the Trustees' determination no later than five calendar days after the date that the Trustees render the determination.

If you receive the information described in Section 9.05(e) so late that it would be impossible for you to have a reasonable opportunity to respond, you may request that the time period for the Board of Trustees to render a determination on your appeal be suspended until you have had a reasonable opportunity to respond. After you respond, or have had a reasonable opportunity to respond but fail to do so, the Trustees will render a determination on your appeal.

(g) Content of Notifications of Benefit Determination on Appeal for Dental Benefit Claims

If your appeal for a Dental Benefit Claim is denied, in whole or in part, you will receive a written notice of the denial. This notice will include the following information:

(1) Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);

(2) The specific reason(s) for the denial;

(3) Reference to the specific Plan provision(s) on which the denial is based;

(4) A statement that reasonable access to, and copies of, all documents, records, and other information relevant to your claim will be provided to you free of charge upon request;

(5) A statement that the procedure code and its corresponding meaning will be provided to you as soon as practicable upon request;

(6) The denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying your appeal;

(7) If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your appeal, the notice will either set forth the specific rule, guideline, protocol, or other similar criterion, or it will contain a statement that such a criterion was relied upon in denying your appeal and that a copy of such criterion will be provided to you free of charge upon request;

(8) If the denial was based on Medical Necessity, experimental or investigational treatment, or a similar exclusion or limit, the notice will either include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances of your claim, or it will contain a statement that such an explanation will be provided to you free of charge upon request;

(9) A description of the Plan's external review procedures and any time limits applicable to such procedures;

(10) A statement that you have the right to bring a civil action under Section 502(a) of ERISA;

(11) A disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the PHSA to assist individuals with the internal claims and appeals and external review processes; and

(12) If the notice is sent to a county where 10% or more of the population is literate only in the same non-English language, the notice will contain a statement in the non-English language which explains the manner in which you can access the Plan's oral language services and informs you that a written notice in the non-English language will be provided to you upon request.

(h) External review of Dental Benefit Claims

If you followed the Plan's internal claims and appeals procedures described in this Section 9.05 and you still disagree with the determination, you may request that an IRO conduct an external review of your Dental Benefit Claim in accordance with this Section 9.05(h). Your claim will only qualify for external review if it involves medical judgment. External review is not available for other types of denials, including denials due to your failure to meet the Plan's eligibility requirements.

(1) How to file requests for external review of Dental Benefit Claims

You may file a request for external review of your Dental Benefit Claim by sending Solxsys a written request for an IRO to review your claim. This request should not be filed until after you receive notification of the benefit determination on appeal (i.e., after the date that you receive the notice described in Section 9.05(g)). Solxsys must receive your request for external review within four months after the date that you receive notification of the benefit determination on appeal.

(2) Preliminary review of Dental Benefit Claims

Solxsys will render a determination on whether or not your request is eligible for external review. The time period for rendering this determination begins as soon as your request for external review is received by Solxsys in accordance with Section 9.05(h)(1). Your request will be eligible for external review if it meets all of the following criteria:

- You were covered by the Plan at the time the health care item or service was requested;
- Your claim involves medical judgment;
- You exhausted the Plan's internal claims and appeals procedures or your claim is deemed exhausted in accordance with Section 9.11; and
- You provided all the information and forms required to process your request for external review.

You will receive notice of Solxsys' determination within a reasonable period of time, but no later than six business days after the date that Solxsys receives your request for external review.

(3) Content of preliminary determination of requests for external review of Dental Benefit Claims

If Solxsys determines that your request qualifies for external review, you will receive a written notice that contains sufficient information to fully apprise you that your request qualifies for external review.

If Solxsys determines that your request does not qualify for external review, you will receive a written notice of this determination. This notice will include the specific reason(s) that your request is not eligible for external review and the current contact information, including the phone number, for the EBSA.

If Solxsys needs additional information from you to determine whether or not your request is eligible for external review, Solxsys will notify you of the information necessary to complete your request. If this occurs, your request will only be eligible for external review if it meets at least one of the following criteria:

- Solxsys receives the additional information within four calendar months after the date that you receive notification of the benefit determination on appeal (i.e., four calendar months after the date that you receive the notice described in Section 9.05(g)); or
- Solxsys receives the additional information within 48 hours after you receive the notice describing the information needed to determine whether or not your request is eligible for external review (i.e., 48 hours after you receive the notice described in this Section 9.05(h)(3)).

(4) IRO review of requests for external review of Dental Benefit Claims

If your request is complete and eligible for external review, your request will be assigned to an IRO. Within five business days after the date of assignment of the IRO, Solxsys will provide the IRO with any information and materials considered in rendering a determination on your claim.

The IRO will timely notify you, in writing, of the acceptance of your request for external review. The IRO's initial notice will include directions on how you may submit additional information relating to your claim. You may submit such additional information during the ten business days following the date you received the initial notice from the IRO. The IRO will review all information and documents received within this time period. The IRO may, but is not required to, accept and consider any additional information that you submit after the ten business days following the date you receive the initial notice from the IRO.

The IRO will conduct a full and fair review of your appeal without giving deference to the previous benefit determinations. However, the IRO will be bound by the terms of the Plan Document.

If you submitted additional information to the IRO, the IRO will forward the information to Solxsys within one business day after the date that the IRO receives this information. Upon receipt of this information, the Board of Trustees may reconsider whether or not your Dental Benefit Claim is covered by the Plan. Reconsideration by the Trustees will not delay the external review. If the Trustees reconsider your claim and, prior to the date that the IRO renders a determination, the Trustees determine that your claim is covered by the Plan, the external review will be terminated (i.e., if the Trustees determine that your claim is covered, it will no longer be necessary for the IRO to review your claim). If this occurs, Solxsys will provide you and the IRO with notice of the Trustees' determination no later than one business day after the date that the Trustees render the determination.

(5) Timing of IRO determinations of requests for external review of Dental Benefit Claims

You will receive notice of the IRO's determination no later than 45 calendar days after the date that the IRO receives your request for external review.

(6) Content of IRO determinations of requests for external review of Dental Benefit Claims

You will receive a written notice of the IRO's determination. This notice will include the following information:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);
- The date the IRO received the assignment to conduct external review and the date of the IRO's determination;
- References to the evidence and/or documentation considered by the IRO in reaching its determination, including the specific coverage provisions and evidence based standards;
- A discussion of the principal reason(s) for the IRO's determination, including its rationale and any evidence-based standards that were relied upon in making the determination;
- A statement that the diagnosis code, the treatment code, and their corresponding meanings will be provided to you as soon as practicable upon request;

- A statement that the reason for the Trustees' denial will be provided to you as soon as practicable upon request;
- A statement that the IRO's determination is binding except to the extent that other remedies may be available under state or federal law to either you or the Plan, or to the extent the Plan voluntarily makes payment on your claim;
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA; and
- A disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the PHSA to assist individuals with the internal claims and appeals and external review processes.

(7) Effect of IRO determinations of requests for external review of Dental Benefit Claims

If the IRO reverses the Board of Trustees' determination, the Plan will immediately cover your claim.

If the IRO does not reverse the Trustees' determination, the Plan will not cover your claim.

The IRO's determination is binding upon the Plan, Solxsys, Delta Dental, and you, except to the extent that you or the Plan may have other remedies available under applicable federal or state law. You may not file a subsequent request for external review involving the same adverse benefit determination for which you have already received an external review determination.

Section 9.06 - Vision Benefit Claims and Appeals

(a) How to File Vision Benefit Claims

Your Vision Benefit Claim must be filed with Solxsys at the address shown on your identification card. You must file a claim by using a claim form, which is available from Solxsys. Your claim must be filed by the last day of the calendar year following the calendar year in which you incur the expense. An expense is incurred at the time a product or service is actually provided.

If this Plan is secondary, you should still file a Vision Benefit Claim with Solxsys at the address shown on your identification card.

(b) Timing of Benefit Determinations for Vision Benefit Claims

Solxsys will render a determination on whether, and/or to what extent, your Vision Benefit Claim is payable by the Plan. The time period for rendering this determination begins as soon as your claim is received by Solxsys in accordance with Section 9.06(a), regardless of whether or not Solxsys has all the information necessary to render the determination. You will receive notice of Solxsys' determination within a reasonable period of time, but no later than 30 calendar days after the date that Solxsys receives your claim. Solxsys may extend this period once by up to 15 calendar days if both of the following criteria are met:

- Solxsys determines that an extension of time is necessary due to matters beyond Solxsys' control; and
- Solxsys notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension and the date by which Solxsys expects to render a determination.

If the extension is necessary because Solxsys needs additional information from you to determine whether, and/or to what extent, benefits are payable by the Plan, the notice of the extension will specifically describe the required information and you will be allowed at least 45 calendar days from receipt of the notice to provide the specified information. The time period for rendering a determination on your claim will be suspended (i.e., tolled) from the date on which the notice is sent until the earlier of the following dates:

- The date Solxsys receives your response; or
- 45 calendar days have passed since the date that the notice was sent.

(c) Content of Notifications of Benefit Determination for Vision Benefit Claims

If the determination is that the Plan will not pay 100% of the total amount of your Vision Benefit Claim, you will receive a written notice of the adverse benefit determination. This notice will include the following information:

(1) Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);

(2) The specific reason(s) for the adverse benefit determination;

(3) Reference to the specific Plan provision(s) on which the adverse benefit determination is based;

(4) A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;

(5) A statement that the diagnosis code, the treatment code, and their corresponding meanings will be provided to you as soon as practicable upon request;

(6) The denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying your claim;

(7) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, the notice will either set forth the specific rule, guideline, protocol, or other similar criterion, or it will contain a statement that such a criterion was relied upon in making the adverse benefit determination and that a copy of such criterion will be provided to you free of charge upon request;

(8) A description of the Plan's internal appeal procedures and any time limits applicable to such procedures;

(9) A statement that you have the right to bring a civil action under Section 502(a) of ERISA if there is an adverse benefit determination on appeal;

(10) A disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the PHSA to assist individuals with the internal claims and appeals processes; and

(11) If the notice is sent to a county where 10% or more of the population is literate only in the same non-English language, the notice will contain a statement in the non-English language which explains the manner in which you can access the Plan's oral language services and informs you that a written notice in the non-English language will be provided to you upon request.

(d) How to File Appeals for Vision Benefit Claims

If it is determined that the Plan will not pay 100% of the total amount of your Vision Benefit Claim. you may file an appeal by sending Solxsys a written request for the Board of Trustees to review your claim. Solxsys must receive your appeal within 180 calendar days after the date that you receive notification of the adverse benefit determination (i.e., within 180 calendar days after the date that you receive the notice described in Section 9.06(c)).

(e) Full and Fair Review of Appeals for Vision Benefit Claims

You may request reasonable access to and copies of all documents, records, and other information relevant to your claim. You may also request the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, regardless of whether the advice was relied upon in making the adverse benefit determination. To obtain the information described in this paragraph, you must send a written request to Solxsys. If you request any of the information described in this paragraph, Solxsys will provide it free of charge.

Prior to the date that the Trustees review your claim, you may submit written comments, documents, records, and other information relating to your claim to Solxsys. If new or additional evidence is considered, relied upon, or generated in connection with your appeal, Solxsys will provide you with such evidence. Solxsys will provide the information described in this paragraph free of charge and sufficiently in advance of the date on which the Trustees render a determination on your appeal.

The Trustees will conduct a full and fair review of your appeal without giving deference to the initial benefit determination. The Trustees will render a determination that is based on all comments, records, and other information that you submit regardless of whether or not such information was submitted or considered in the initial benefit determination. Although the Trustees' determination will be based on all comments, records, and other information that you submit in the initial benefit determination, the Trustees will not render an adverse benefit determination that is based on a rationale that is different from the rationale that was included in the notice of adverse benefit determination (i.e., the notice described in Section 9.06(c)) unless Solxsys provides you with the new rationale free of charge and sufficiently in advance of the date that the Trustees render a determination on your appeal.

(f) Timing of Notifications of Benefit Determination on Appeal for Vision Benefit Claims

The Trustees will render a determination on your appeal no later than the date of the regularly scheduled quarterly meeting immediately after the date that Solxsys receives your appeal unless it is received within the 30 calendar days prior to the date of the next regularly scheduled quarterly meeting. In this case, the Trustees will render a determination no later than the second quarterly meeting after the date that Solxsys receives your appeal. The Trustees and/or Solxsys may extend this period until no later than the third quarterly meeting after the date that Solxsys receives your appeal if both of the following criteria are met:

- The Trustees and/or Solxsys determines that special circumstances (e.g., the need to hold a hearing) require a further extension of time for processing your appeal; and
- Solxsys notifies you, prior to the commencement of the extension, of the circumstances requiring the extension and the date by which the Trustees expect to render a determination.

Solxsys will provide you with notice of the Trustees' determination no later than five calendar days after the date that the Trustees render the determination.

If you receive the information described in Section 9.06(e) so late that it would be impossible for you to have a reasonable opportunity to respond, you may request that the time period for the Board of Trustees to render a determination on your appeal be suspended until you have had a reasonable opportunity to respond. After you respond, or have had a reasonable opportunity to respond but fail to do so, the Trustees will render a determination on your appeal.

(g) Content of Notifications of Benefit Determination on Appeal for Vision Benefit Claims

If your appeal for a Vision Benefit Claim is denied, in whole or in part, you will receive a written notice of the denial. This notice will include the following information:

(1) Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);

(2) The specific reason(s) for the denial;

(3) Reference to the specific Plan provision(s) on which the denial is based;

(4) A statement that reasonable access to, and copies of, all documents, records, and other information relevant to your claim will be provided to you free of charge upon request;

(5) A statement that the diagnosis code, the treatment code, and their corresponding meanings will be provided to you as soon as practicable upon request;

(6) The denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying your appeal;

(7) If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your appeal, the notice will either set forth the specific rule, guideline, protocol, or other similar criterion, or it will contain a statement that such a criterion was relied upon in denying your appeal and that a copy of such criterion will be provided to you free of charge upon request;

(8) A statement that you have the right to bring a civil action under Section 502(a) of ERISA;

(9) A disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the PHSA to assist individuals with the internal claims and appeals processes; and

(10) If the notice is sent to a county where 10% or more of the population is literate only in the same non-English language, the notice will contain a statement in the non-English language which explains the manner in which you can access the Plan's oral language services and informs you that a written notice in the non-English language will be provided to you upon request.

Section 9.07 - Accident and Sickness Loss of Time Benefit Claims and Appeals

(a) How to File Accident and Sickness Loss of Time Benefit Claims

Your Accident and Sickness Loss of Time Benefit Claim must be filed with Solxsys. You must file your claim by using the Plan's claim form, which is available from Solxsys. Generally, your claim must be filed with Solxsys within the calendar year in which your Period of Disability (as defined by Section 8.01(b)) ends (i.e., by December 31 of the calendar year in which your Period of Disability ends). However, if your Period of Disability ends on or after October 4th of the calendar year, your claim must be filed within 90 calendar days after the end of your Period of Disability.

(b) Timing of Benefit Determinations for Accident and Sickness Loss of Time Benefit Claims

Solxsys will render a determination on whether or not you qualify for Accident and Sickness Loss of Time Benefits from the Plan. The time period for rendering this determination begins as soon as your claim is received by Solxsys in accordance with Section 9.07(a), regardless of whether or not Solxsys has all the information necessary to render the determination. You will receive notice of Solxsys' determination within a reasonable period of time, but no later than 45 calendar days after the date that Solxsys receives your claim. Solxsys may extend this period once by up to 30 calendar days if both of the following criteria are met:

- Solxsys determines that an extension of time is necessary due to matters beyond Solxsys' control; and
- Solxsys notifies you, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension, the date by which Solxsys expects to render a determination, the standards on which your entitlement to a benefit are based, the unresolved issues that prevent a determination on your claim, and any additional information required to resolve those issues.

Solxsys may extend this period one additional time for up to 30 calendar days if both of the following criteria are met:

- Solxsys is unable to render a determination on your claim within the extended 30-day period due to matters beyond Solxsys' control; and
- Solxsys notifies you, prior to the expiration of the extended 30-day period, of the circumstances requiring the additional extension and the date by which Solxsys expects to render a determination, the standards on which your entitlement to a benefit are based, the unresolved issues that prevent a determination on your claim, and any additional information required to resolve those issues.

If an extension is necessary because Solxsys needs additional information from you to determine whether or not you qualify for benefits from the Plan, the notice of the extension will specifically describe the required information and you will be allowed at least 45 calendar days from receipt of the notice to provide the specified information. The time period for rendering a determination on your claim will be suspended (i.e., tolled) from the date on which the notice is sent until the earlier of the following dates:

- The date Solxsys receives your response; or
- 45 calendar days have passed since the date that the notice was sent.

(c) Content of Notifications of Benefit Determination for Accident and Sickness Loss of Time Benefit Claims

If the determination is that you do not qualify for Accident and Sickness Loss of Time Benefits from the Plan, you will receive a written notice of the adverse benefit determination. This notice will include the following information:

(1) The specific reason(s) for the adverse benefit determination;

(2) Reference to the specific Plan provision(s) on which the adverse benefit determination is based;

(3) A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;

(4) A statement that reasonable access to, and copies of, all documents, records, and other information relevant to your claim will be provided to you free of charge upon request;

(5) A discussion of the determination, including an explanation of the basis for disagreeing with or not following information you provided regarding the views of health care professionals and/or vocational professionals who treated you and/or evaluated your condition;

(6) An explanation of the basis for disagreeing with or not following the views of medical or vocational experts whose advice was obtained by the Plan in connection with your adverse benefit determination, regardless of whether or not the advice was relied upon in making the benefit determination;

(7) An explanation of the basis for disagreeing with or not following information provided by you regarding a disability determination made by the Social Security Administration;

(8) The specific internal rules, guidelines, protocols, standards, or other similar criterion relied upon in making the adverse benefit determination or a statement that such criterion does not exist;

(9) If the adverse benefit determination was based on Medical Necessity, experimental or investigational treatment, or a similar exclusion or limit, the notice will either include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances of your claim, or it will contain a statement that such an explanation will be provided to you free of charge upon request;

(10) A description of the Plan's internal appeal procedures and any time limits applicable to such procedures;

(11) A statement that you have the right to bring a civil action under Section 502(a) of ERISA if there is an adverse benefit determination on appeal; and

(12) If the notice is sent to a county where 10% or more of the population is literate only in the same non-English language, the notice will contain a statement in the non-English language which explains the manner in which you can access the Plan's oral language services and informs you that a written notice in the non-English language will be provided to you upon request.

(d) How to File Appeals for Accident and Sickness Loss of Time Benefit Claims

If it is determined that you do not qualify for Accident and Sickness Loss of Time Benefits from the Plan, you may file an appeal by sending Solxsys a written request for the Board of Trustees to review your claim. Solxsys must receive your appeal within 180 calendar days after the date that you receive notification of the adverse benefit determination (i.e., within 180 calendar days after the date that you receive the notice described in Section 9.07(c)).

(e) Full and Fair Review of Appeals for Accident and Sickness Loss of Time Benefit Claims

You may request reasonable access to and copies of all documents, records, and other information relevant to your claim. You may also request the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, regardless of whether the advice was relied upon in making the adverse benefit determination. To obtain the information described in this paragraph, you must send a written request to Solxsys. If you request any of the information described in this paragraph, Solxsys will provide it free of charge.

Prior to the date that the Trustees review your claim, you may submit written comments, documents, records, and other information relating to your claim to Solxsys. If your appeal involves an adverse benefit determination that is based in whole or in part on a medical judgment, the Board of Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional consulted on appeal will not be any individual who was consulted previously with respect to your claim, nor the subordinate of any such individual. If the Trustees consult with a health care professional and/or other new or additional evidence is considered, relied upon, or generated in connection with your appeal, Solxsys will provide you with such evidence. Solxsys will provide the information described in this paragraph free of charge and sufficiently in advance of the date on which the Trustees render a determination on your appeal.

The Trustees will conduct a full and fair review of your appeal without giving deference to the initial benefit determination. The Trustees will render a determination that is based on all comments, records, and other information that you submit regardless of whether or not such information was submitted or considered in the initial benefit determination. Although the Trustees' determination will be based on all comments, records, and other information that you submit in the initial benefit determination, the Trustees will not render an adverse benefit determination that is based on a rationale that is different from the rationale that was included in the notice of adverse benefit determination (i.e., the notice described in Section 9.07(c)) unless Solxsys provides you with the new rationale free of charge and sufficiently in advance of the date that the Trustees render a determination on your appeal.

(f) Timing of Notifications of Benefit Determination on Appeal for Accident and Sickness Loss of Time Benefit Claims

The Trustees will render a determination on your appeal no later than the date of the regularly scheduled quarterly meeting immediately after the date that Solxsys receives your appeal unless it is received within the 30 calendar days prior to the date of the next regularly scheduled quarterly meeting. In this case, the Trustees will render a determination no later than the second quarterly meeting after the date that Solxsys receives your appeal. The Trustees and/or Solxsys may extend this period until no later than the third quarterly meeting after the date that Solxsys receives your appeal if both of the following criteria are met:

- The Trustees and/or Solxsys determines that special circumstances (e.g., the need to hold a hearing) require a further extension of time for processing your appeal; and
- Solxsys notifies you, prior to the commencement of the extension, of the circumstances requiring the extension and the date by which the Trustees expect to render a determination.

Solxsys will provide you with notice of the Trustees' determination no later than five calendar days after the date that the Trustees render the determination.

If you receive the information described in Section 9.07(e) so late that it would be impossible for you to have a reasonable opportunity to respond, you may request that the time period for the Board of Trustees to render a determination on your appeal be suspended until you have had a reasonable opportunity to respond. After you respond, or have had a reasonable opportunity to respond but fail to do so, the Trustees will render a determination on your appeal.

(g) Content of Notifications of Benefit Determination on Appeal for Accident and Sickness Loss of Time Benefit Claims

If your appeal for an Accident and Sickness Loss of Time Benefit Claim is denied, you will receive a written notice of the denial. This notice will include the following information:

(1) The specific reason(s) for the denial;

(2) Reference to the specific Plan provision(s) on which the denial is based;

(3) A statement that reasonable access to, and copies of, all documents, records, and other information relevant to your claim will be provided to you free of charge upon request;

(4) A discussion of the determination, including an explanation of the basis for disagreeing with or not following information you provided regarding the views of health care professionals and/or vocational professionals who treated you and/or evaluated your condition;

(5) An explanation of the basis for disagreeing with or not following the views of medical or vocational experts whose advice was obtained by the Plan in connection with your claim or appeal, regardless of whether or not the advice was relied upon in making the benefit determination;

(6) An explanation of the basis for disagreeing with or not following information provided by you regarding a disability determination made by the Social Security Administration;

(7) The specific internal rules, guidelines, protocols, standards, or other similar criterion relied upon in denying your appeal or a statement that such criterion does not exist;

(8) If the denial was based on Medical Necessity, experimental or investigational treatment, or a similar exclusion or limit, the notice will either include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances of your claim, or it will contain a statement that such an explanation will be provided to you free of charge upon request;

(9) A statement that you have a right to bring a civil action under Section 502(a) of ERISA and a description of any contractual limitations period that applies to your right to bring such action, including the calendar date on which the contractual limitations period expires, if applicable; and

(10) If the notice is sent to a county where 10% or more of the population is literate only in the same non-English language, the notice will contain a statement in the non-English language which explains the manner in which you can access the Plan's oral language services and informs you that a written notice in the non-English language will be provided to you upon request.

Section 9.08 - Death Benefit and AD&D Benefit Claims and Appeals

(a) How to File Death Benefit Claims and AD&D Benefit Claims

Your Death Benefit Claim or AD&D Benefit Claim, as applicable, must be filed with Solxsys. You must file your claim by using the Plan's claim form, which is available from Solxsys. All Death Benefit Claims must be accompanied by proof of death (e.g., a death certificate). All AD&D Benefit Claims must be accompanied by proof of the accident (e.g., a police report). Your Death Benefit Claim or AD&D Benefit Claim, as applicable, must be filed within one year from the date of death or loss, as applicable.

(b) Timing of Benefit Determinations for Death Benefit Claims and AD&D Benefit Claims

Solxsys will render a determination on whether or not you qualify for Death Benefits or AD&D Benefits, as applicable, from the Plan. The time period for rendering this determination begins as soon as your claim is received by Solxsys in accordance with Section 9.08(a), regardless of whether or not Solxsys has all the information necessary to render the determination. You will receive notice of Solxsys' determination within a reasonable period of time, but no later than 90 calendar days after the date that Solxsys receives your claim. Solxsys may extend this period once by up to 90 calendar days if both of the following criteria are met:

- Solxsys determines that special circumstances require an extension of time for processing your claim; and
- Solxsys notifies you, prior to the expiration of the initial 90-day period, of the circumstances requiring the extension and the date by which Solxsys expects to render a determination.

(c) Content of Notifications of Benefit Determination for Death Benefit Claims and AD&D Benefit Claims

If the determination is that you do not qualify for Death Benefits or AD&D Benefits, as applicable, from the Plan, you will receive a written notice of the adverse benefit determination. This notice will include the following information:

(1) The specific reason(s) for the adverse benefit determination;

(2) Reference to the specific Plan provision(s) on which the adverse benefit determination is based;

(3) A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;

(4) A description of the Plan's internal appeal procedures and any time limits applicable to such procedures; and

(5) A statement that you have the right to bring a civil action under Section 502(a) of ERISA if there is an adverse benefit determination on appeal.

(d) How to File Appeals for Death Benefit Claims and AD&D Benefit Claims

If it is determined that you do not qualify for Death Benefits or AD&D Benefits, as applicable, from the Plan, you may file an appeal by sending Solxsys a written request for the Board of Trustees to review your claim. Solxsys must receive your appeal within 60 calendar days after the date that you receive notification of the adverse benefit determination (i.e., within 60 calendar days after the date that you receive the notice described in Section 9.08(c)).

(e) Full and Fair Review of Appeals for Death Benefit Claims and AD&D Benefit Claims

You may request reasonable access to and copies of all documents, records, and other information relevant to your claim. To obtain the information described in this paragraph, you must send a written request to Solxsys. If you request any of the information described in this paragraph, Solxsys will provide it free of charge.

Prior to the date that the Trustees review your claim, you may submit written comments, documents, records, and other information relating to your claim to Solxsys. The Trustees will conduct a full and fair review of your appeal without giving deference to the initial benefit determination. The Trustees

will render a determination that is based on all comments, records, and other information that you submit.

(f) Timing of Notifications of Benefit Determination on Appeal for Death Benefit Claims and AD&D Benefit Claims

The Trustees will render a determination on your appeal no later than the date of the regularly scheduled quarterly meeting immediately after the date that Solxsys receives your appeal unless it is received within the 30 calendar days prior to the date of the next regularly scheduled quarterly meeting. In this case, the Trustees will render a determination no later than the second quarterly meeting after the date that Solxsys receives your appeal. The Trustees and/or Solxsys may extend this period until no later than the third quarterly meeting after the date that Solxsys receives your appeal if both of the following criteria are met:

- The Trustees and/or Solxsys determines that special circumstances (e.g., the need to hold a hearing) require a further extension of time for processing your appeal; and
- Solxsys notifies you, prior to the commencement of the extension, of the circumstances requiring the extension and the date by which the Trustees expect to render a determination.

Solxsys will provide you with notice of the Trustees' determination no later than five calendar days after the date that the Trustees render the determination.

If you receive the information described in Section 9.08(e) so late that it would be impossible for you to have a reasonable opportunity to respond, you may request that the time period for the Board of Trustees to render a determination on your appeal be suspended until you have had a reasonable opportunity to respond. After you respond, or have had a reasonable opportunity to respond but fail to do so, the Trustees will render a determination on your appeal.

(g) Content of Notifications of Benefit Determination on Appeal for Death Benefit Claims and AD&D Benefit Claims

If your appeal for a Death Benefit Claim or AD&D Benefit Claim, as applicable, is denied, you will receive a written notice of the denial. This notice will include the following information:

(1) The specific reason(s) for the denial;

(2) Reference to the specific Plan provision(s) on which the denial is based;

(3) A statement that reasonable access to, and copies of, all documents, records, and other information relevant to your claim will be provided to you free of charge upon request; and

(4) A statement that you have the right to bring a civil action under Section 502(a) of ERISA.

Section 9.09 - Rescission of Coverage

A Rescission of Coverage is an adverse benefit determination that involves a retroactive cancellation or discontinuance of coverage, regardless of whether or not there is an adverse effect on any particular benefit in connection with the rescission. A cancellation or discontinuance of coverage is not a Rescission of Coverage if any of the following criteria are met:

- The cancellation or discontinuance only has a prospective effect;
- The cancellation or discontinuance is only effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions (including COBRA premiums); or

- The cancellation or discontinuance is initiated by you and the Plan does not directly or indirectly take action to influence your decision to cancel or discontinue your coverage.

Once you are covered by the Plan, you will not have a Rescission of Coverage unless you make an intentional misrepresentation of material fact or you perform an act, practice, or omission that constitutes fraud. The Board of Trustees has the right to determine, in their sole discretion, whether there has been fraud or a misrepresentation of material fact. If it is determined that there will be a Rescission of Coverage, Solxsys will provide you with notice of the Rescission of Coverage at least 30 calendar days prior to the date of the Rescission of Coverage. A Rescission of Coverage constitutes an adverse benefit determination and is eligible for internal appeal and external review, regardless of whether or not the Rescission of Coverage has an adverse effect on a particular benefit. If the rescission of Coverage has an adverse effect on a particular benefit (e.g., the Plan demands that you repay amounts that the Plan previously paid for a Comprehensive Medical Benefit due to the Rescission of Coverage), the internal appeal and external review rules applicable to that benefit will also apply to the Rescission of Coverage for that benefit (e.g., the internal appeal and external review rules of Section 9.03(b) apply if, due to the Rescission of Coverage, the Plan demands that you repay amounts that the Plan previously paid for a Post-Service Comprehensive Medical Benefit).

Section 9.10 - Surprise Billing and Cost-Sharing Protections under the No Surprises Act

A claim relates to compliance with the surprise billing and cost-sharing protections under the No Surprises Act if the claim is either for a service or supply that is rendered by an out-of-network provider and described in Section 2.02(c) or a service or supply that is considered a Hospital - Emergency Service that is described in Section 2.03(j) and covered by the Plan solely due to the requirements found in the No Surprises Act.

Section 9.11 - Judicial Review

The Board of Trustees has the sole and exclusive power and discretion to rule on all appeals of benefit claims and the Trustees' determination will be final and binding upon all parties except to the extent that the Trustees' determination is reversed by an IRO or to the extent that you have other remedies available under applicable federal or state law. For any lawsuit filed, the determination of the Trustees is subject to judicial review only for abuse of discretion.

If the Plan fails to strictly adhere to all the requirements of this Article IX, you are deemed to have exhausted the internal claims and appeals process of the Plan except as provided in this Section 9.11. Accordingly, you are entitled to pursue any available remedies under Section 502(a) of ERISA or under state law, as applicable, on the basis that the Plan failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of your claim. If you choose to pursue remedies under Section 502(a) of ERISA, your claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. If your claim involves medical judgment or a Rescission of Coverage, you may also be entitled to initiate an external review.

Notwithstanding this Section 9.11, the Plan's internal claims and appeals process will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between you and the Plan. This exception is not available if the violation is part of a pattern or practice of violations by the Plan. If the Plan can demonstrate the violation would not cause the internal claims and appeals process to be deemed exhausted, you may request a written explanation, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted, from Solxsys. Solxsys will provide such explanation within ten calendar days.

If an external reviewer or a court rejects your request for immediate review on the basis that the Plan met the standards for the exception under this Section 9.11, you have the right to resubmit and pursue the appeal of your claim. In such a case, within a reasonable time not to exceed ten calendar days after the external reviewer or court rejects your claim for immediate review, the Plan will provide you with notice of the opportunity to resubmit and pursue the appeal of your claim. Time periods for re-filing your claim shall begin to run upon your receipt of such notice.

Section 9.12 - Suspension of Certain Deadlines Due to COVID-19

The rules in this Section 9.12 are temporary and only apply during what is referred to as the "Outbreak Period." Outbreak Period refers to the period that began on March 1, 2020 and ends on the date 60 days after the end of the national emergency declared by the President concerning the COVID-19 outbreak. During the Outbreak Period, the following deadlines are suspended:

- Deadlines that apply to claims and appeals for Comprehensive Medical Benefits (i.e., the days in the Outbreak Period do not count towards these deadlines), including:
  - The deadline to submit a claim (i.e., the requirement that a claim must be filed by the last day of the calendar year following the calendar year in which the expense is incurred);
  - The 180-day deadline to submit an appeal;
  - The four-month deadline to submit a request for external review; and
  - The four-month deadline (if the initial external review request has not expired) or 48-hour deadline (if the initial external review request has expired) to submit the rest of the information necessary for a request for external review to be considered complete.
- Deadlines that apply to claims and appeals for Prescription Drug Benefits (i.e., the days in the Outbreak Period do not count towards these deadlines), including:
  - The deadline to submit a claim (i.e., the requirement that a claim must be filed by the last day of the calendar year following the calendar year in which the expense is incurred);
  - The 180-day deadline to submit an appeal;
  - The four-month deadline to submit a request for external review; and
  - The four-month deadline (if the initial external review request has not expired) or 48-hour deadline (if the initial external review request has expired) to submit the rest of the information necessary for a request for external review to be considered complete.
- Deadlines that apply to claims and appeals for Dental Benefits (i.e., the days in the Outbreak Period do not count towards these deadlines), including:
  - The deadline to submit a claim (i.e., the requirement that a claim must be filed by the last day of the calendar year following the calendar year in which the expense is incurred);
  - The 180-day deadline to submit an appeal;
  - The four-month deadline to submit a request for external review; and
  - The four-month deadline (if the initial external review request has not expired) or 48-hour deadline (if the initial external review request has expired) to submit the rest of the information necessary for a request for external review to be considered complete.

- Deadlines that apply to claims and appeals for Vision Benefits (i.e., the days in the Outbreak Period do not count towards these deadlines), including:
  - The deadline to submit a claim (i.e., the requirement that a claim must be filed by the last day of the calendar year following the calendar year in which the expense is incurred); and
  - The 180-day deadline to submit an appeal.
- Deadlines that apply to claims and appeals for Accident and Sickness Loss of Time Benefits (i.e., the days in the Outbreak Period do not count towards these deadlines), including:
  - The deadline to submit a claim (i.e., the requirement that a claim must be filed within the calendar year in which the claimant's Period of Disability ends or, if the Period of Disability ends on or after October 4th of the calendar year, within 90 calendar days after the end of the claimant's Period of Disability); and
  - The 180-day deadline to submit an appeal.
- Deadlines that apply to claims and appeals for Death Benefits and Accidental Death and Dismemberment Benefits (i.e., the days in the Outbreak Period do not count towards these deadlines), including:
  - The one-year deadline to submit a claim; and
  - The 60-day deadline to submit an appeal.

ARTICLE X - COORDINATION OF BENEFITS

The following topics are discussed under this Article on Coordination of Benefits:

10.01 Definitions for this Article X Only
10.02 Rules for Coordination of Benefits
10.03 Order of Benefit Determination
10.04 Coordination of Benefits with Medicare
10.05 Right to Receive and Release Needed Information
10.06 Facility of Payment
10.07 Right of Recovery
10.08 Claims Involving Third-Party Liability

The coordination of benefits rules explained in this Article limit the duplication of benefits when a Covered Person has coverage under more than one health plan. If you or your Dependents have health care coverage available under this Plan and "Another Plan," your benefits will be coordinated in accordance with this Article.

To understand the Plan's coordination of benefits rules, there are two definitions you need to know about. You need to know (1) the definition of "Primary Plan" and (2) the definition of "Secondary Plan."

The plan that pays benefits first is called the "Primary Plan." The "Primary Plan" must pay benefits without regard to the possibility that another plan may cover some expenses.

The "Secondary Plan" may reduce the benefits it pays so that no more than 100% of the "Allowable Expense" is paid through the combined coverage of the plans.

The rules that determine which plan is primary and which is secondary are explained in greater detail below.

Section 10.01 - Definitions for this Article X Only

The following terms will have a specific meaning when they are used within this Article:

(a) **"Another Plan"** means any form of coverage with which coordination is allowed.

(1) "Another Plan" shall include, but not be limited to, any of the following that provides benefits or services for medical, prescription, dental, or vision care or treatment:

i. Group and non-group insurance contracts and subscriber contracts;
ii. Uninsured arrangements of group or group-type coverage;
iii. Health Maintenance Organization contracts;
iv. Group and non-group coverage through "Closed Panel Plans";
v. "Group-Type Contracts";
vi. The medical care component of long-term care contracts, such as skilled nursing care;
vii. The medical benefits coverage in automobile "no fault" and traditional automobile "fault" contracts; and
viii. Medicare or other governmental benefits as permitted by law (this does not include Medicaid).

(2) "Another Plan" does not include:

i. Hospital indemnity coverage benefits or other fixed indemnity coverage;
ii. Accident-only coverage;
iii. Specified disease or specified accident coverage;
iv. School accident-type coverage;
v. Benefits for non-medical components of long-term care policies;

vi. Medicare supplement policies;
vii. Medicaid policies; or
viii. A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

(3) The term "Another Plan" shall be construed separately as to each policy, contract, or other arrangement for benefits or services. If "Another Plan" has two parts and the coordination of benefits rules only apply to one of the two, each of the parts shall be treated separately.

(b) **"Allowable Expense"** means any health care expense, including deductibles, coinsurance, or copays, that is covered at least in part under any of the health plans covering the Covered Person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an "Allowable Expense" and a benefit paid. An expense that is not covered by any plan covering the Covered Person is not an "Allowable Expense." In addition, any expense that a provider, by law or in accordance with a contractual agreement, is prohibited from charging a Covered Person is not an "Allowable Expense." The following are examples of expenses that are **not** "Allowable Expenses."

(1) The difference between the cost of a semi-private Hospital room and a private Hospital room is not an "Allowable Expense" unless one of the plans provides coverage for private Hospital room expenses.

(2) When both the "Primary Plan" and the "Secondary Plan" compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an "Allowable Expense."

(3) When benefits are reduced by both the "Primary Plan" and the "Secondary Plan" due to negotiated reductions with a PPO, any amount in excess of the Primary Plan's allowable amount for a specific service is not an "Allowable Expense."

(4) When one plan calculates benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and the other Plan provides benefits services on the basis of negotiated fees, the payment arrangement of the "Primary Plan" shall be the "Allowable Expense" for all plans. However, if this Plan is the "Secondary Plan" and this Plan has a negotiated fee or payment amount that is lower than the payment arrangement of the "Primary Plan," the negotiated fee or payment shall be the "Allowable Expense."

(5) When benefits are reduced by the "Primary Plan" because a Covered Person does not comply with the plan provisions, the amount of this reduction is excluded from the "Allowable Expense." Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements (e.g., if benefits are reduced by the "Primary Plan" because a Covered Person did not obtain a second surgical opinion or obtain a required pre-certification, the extra amount the Covered Person is required to pay will not be considered an "Allowable Expense").

(c) **"Closed Panel Plan"** means a plan that provides health benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

(d) **"Custodial Parent"** means the parent awarded custody of a child by a court decree, or in the absence of a court decree, the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

(e) **"Group-Type Contract"** means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. "Group-Type Contract" does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

(f) **"Primary Plan"** means a plan whose benefits for a Covered Person's health care coverage must be determined without taking the existence of any other plan into consideration. Whether a plan is the "Primary Plan" shall be determined in accordance with the Order of Benefit Determination rules in Section 10.03 and the Coordination of Benefits with Medicare rules in Section 10.04, as applicable.

(g) **"Secondary Plan"** means any plan that is not a "Primary Plan" and whose benefits are determined after those of another plan and are reduced so that all plan benefits do not exceed 100% of the total "Allowable Expense."

Section 10.02 - Rules for Coordination of Benefits

When a Covered Person is also covered by "Another Plan," the following rules shall apply:

(a) If this Plan is the "Primary Plan," it shall determine benefits as if the "Secondary Plan(s)" do not exist.

(b) If this Plan is the "Secondary Plan," and a "Closed Panel Plan" is the "Primary Plan," this Plan shall pay or provide benefits as if it were the "Primary Plan" when a Covered Person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the "Primary Plan."

(c) If this Plan is the "Secondary Plan," it will calculate the benefits it would have paid on a claim in the absence of other health care coverage and will apply that calculated amount to any "Allowable Expense" under the Plan that is unpaid by the "Primary Plan." This Plan may reduce its payment by an amount so that, when combined with the amount paid by the "Primary Plan," the total benefits paid or provided by all plans for the claim do not exceed 100% of the total "Allowable Expense" for that claim. In addition, this Plan shall credit to its Plan Deductible and its Comprehensive Medical Benefit Annual Out-of-Pocket Maximum any amounts that it would have credited in the absence of other health care coverage.

(d) If a Covered Person has coverage from "Another Plan" as defined by Section 10.01(a)(1)(i), (ii), (iii), (iv), (v), (vi), or (vii) (i.e., the Covered Person is covered by this Plan and "Another Plan" and the other plan is not Medicare), this Plan will coordinate benefits with "Another Plan" or the portion of "Another Plan," that provides the same type of benefits that are the subject of the claim. For example, in the case of a Comprehensive Medical Benefits, this Plan will coordinate with "Another Plan(s)" providing the same type of medical benefits (i.e., the type of medical benefits that are the subject of the claim) to the Covered Person.

(e) If "Another Plan's" coordination of benefits provisions are inconsistent with the provisions in this Article, the following rules shall apply:

(1) Except as provided in Section 10.02(e)(2) below, if "Another Plan" contains order of benefit determination provisions that are inconsistent with the rules set forth in Section 10.03, "Another Plan" shall always be the "Primary Plan" unless the provisions of both this Plan and "Another Plan" state that this Plan is the "Primary Plan."

(2) Coverage that is obtained by virtue of membership in a group and is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of such supplementary coverage are major medical coverage that is superimposed over base plan Hospital and surgical benefits and insurance-type coverage written in connection with a "Closed Panel Plan" to provide out-of-network benefits.

Section 10.03 - Order of Benefit Determination

If a Covered Person has coverage from "Another Plan" as defined by Section 10.01(a)(1)(viii) (i.e., the Covered Person is also covered by Medicare), the Plan will determine whether it is the "Primary Plan" or the "Secondary Plan" in accordance with Section 10.04.

If a Covered Person has coverage from "Another Plan" as defined by Section 10.01(a)(1)(i), (ii), (iii), (iv), (v), (vi), or (vii) (i.e., the Covered Person is covered by this Plan and "Another Plan" and the other plan is not Medicare), the Plan will determine whether it is the "Primary Plan" or the "Secondary Plan" using the first of the following rules that applies:

(a) Dependent/Nondependent

(1) Except as provided in Section 10.03(a)(3) below, if a Participant is covered under "Another Plan" as a dependent, this Plan shall be the "Primary Plan" and "Another Plan" shall be the "Secondary Plan."

(2) Except as provided in Section 10.03(a)(3) below, if a Dependent is covered under "Another Plan" other than as a dependent (for example, as an employee, member, policyholder, subscriber, or retiree), this Plan shall be the "Secondary Plan" and "Another Plan" shall be the "Primary Plan."

(3) Notwithstanding Sections 10.03(a)(1) and (2), if the Covered Person is a Medicare beneficiary and as a result of Federal law, Medicare is secondary to the plan covering the Covered Person as a dependent, and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the Covered Person as a dependent is the "Primary Plan" and the other plan is the "Secondary Plan."

(b) Dependent Child Covered Under More Than One Plan

If a Dependent child is covered under more than one plan, and there is no court decree stating otherwise, the order of benefits is determined as follows:

(1) For a Dependent child whose parents are married or are living together, whether or not they have ever been married, the plan of the parent whose birthday falls earlier in the calendar year is the "Primary Plan"; or if both parents have the same birthday, the plan that has covered one of the parents the longest is the "Primary Plan."

(2) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

i. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is the "Primary Plan." If the parent with responsibility has no health care coverage for the Dependent child's health care expenses, but that parent's spouse does have health care coverage, that parent's spouse's plan is the "Primary Plan." This rule shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

ii. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the plan of the parent whose birthday falls earlier in the calendar year is the "Primary Plan;" or if both parents have the same birthday, the plan that has covered one of the parents the longest is the "Primary Plan."

iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the plan of the parent whose birthday falls earlier in the calendar year is the "Primary Plan"; or if both parents have the same birthday, the plan that has covered one of the parents the longest is the "Primary Plan."

iv. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the Dependent child is as follows:

(A) The plan covering the "Custodial Parent";

(B) The plan covering the "Custodial Parent's" spouse;

(C) The plan covering the noncustodial parent; and then

(D) The plan covering the noncustodial parent's spouse.

(3) For a Dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Section 10.03(b)(1) or (2) as if those individuals were the parents of the child.

(c) Active Employee or Retired or Laid-Off Employee

If the rules in Section 10.03(a) do not determine the order of benefits, the following rules apply:

(1) If an Eligible Employee is covered by the Plan because (s)he worked sufficient hours in Covered Employment (i.e., (s)he is covered by the Plan in accordance with Section 1.02 or Section 1.03(a)) and (s)he is covered under "Another Plan" as a laid-off or retired employee, this Plan shall be the "Primary Plan" for the Eligible Employee and his/her Dependents and "Another Plan" shall be the "Secondary Plan."

(2) If an Eligible Employee is covered by the Plan through self-payments in accordance with Section 1.03(b) and (s)he is covered under "Another Plan" as an active employee (i.e., an employee who is neither laid off nor retired), this Plan shall be the "Secondary Plan" for the Eligible Employee and his/her Dependents and "Another Plan" shall be the "Primary Plan."

(3) If a Retiree is covered under "Another Plan" as an active employee (i.e., an employee who is neither laid off nor retired), this Plan shall be the "Secondary Plan" for the Retiree and his/her Dependents and "Another Plan" shall be the "Primary Plan."

(4) If “Another Plan” does not have the rules provided in this Section 10.03(c), and as a result, this Plan and “Another Plan” do not agree on the order of benefits, the rules in this Section 10.03(c) shall be ignored and the order of benefits shall be determined in accordance with Section 10.03(e) or (f) as applicable.

(d) COBRA or State Continuation Coverage

If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other Federal law is covered under “Another Plan,” the plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the “Primary Plan” and the COBRA or state or other federal continuation coverage is the “Secondary Plan.” If “Another Plan” does not have this rule, and as a result, this Plan and “Another Plan” do not agree on the order of benefits, this rule is ignored, and the order of benefits shall be determined in accordance with Section 10.03(e) or (f) as applicable. This rule does not apply if the rule in Section 10.03(a) can determine the order of benefits.

(e) Longer or Shorter Length of Coverage

If the rules in Sections 10.03(a) - (d) do not determine the order of benefits, the plan that covered the person for the longer period of time is the “Primary Plan” and the plan that covered the person for the shorter period of time is the “Secondary Plan.”

(f) Rule if None of the Preceding Rules Apply

If the rules in Sections 10.03(a) - (e) do not determine the order of benefits, the “Allowable Expense” shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid had it been the “Primary Plan.”

Section 10.04 - Coordination of Benefits with Medicare

Important: If Medicare would be the “Primary Plan” for you or your Dependents, but you (or your Dependents) have not enrolled in Medicare Parts A or B, the Plan will reduce the benefits it pays by the amount that would have been paid by Medicare Parts A and B.

The following chart summarizes when Medicare will be the “Primary Plan” for you and your Dependents. You should look at the categories on the left-column of the chart and see which one describes you. Some of these descriptions contain an * at the end of the description. **If you fit into a category with an *, it means you should be enrolled in Medicare Parts A and B. If you are in a category with an * and you are not enrolled in Medicare Parts A and B, the Plan will reduce the benefits it pays by the amount that would have been paid by Medicare Parts A and B.** This means that if you fit in one of these categories and you are not enrolled in both Medicare Part A and Medicare Part B you will be responsible for the amount that would have been paid by Medicare.

The chart is solely for the purpose of providing a summary of the rules regarding the Plan’s coordination of benefits with Medicare. The chart is not intended to (and should not be used to) inform you of the rules regarding when and if you are eligible for Medicare. For a more detailed description of the rules regarding the Plan’s coordination of benefits with Medicare, you should read the language below the chart and/or contact the Plan Administrator. For information regarding whether you are entitled to Medicare, contact the Center for Medicare and Medicaid Services at 1-800-MEDICARE or www.MyMedicare.gov.

If you are…	Your Primary Plan will be…	Your Secondary Plan will be…
An Eligible Employee and you are eligible for Medicare based on disability or age	This Plan	Medicare
A Dependent of an Eligible Employee and you are eligible for Medicare based on disability or age	This Plan	Medicare
A Retiree and you are eligible for Medicare based on disability or age*	Medicare	This Plan
A Dependent of a Retiree and you are entitled to Medicare based on disability or age*	Medicare	This Plan
A qualified beneficiary (i.e., you are covered by COBRA) and you are eligible for Medicare based on disability or age*	Medicare	This Plan
A Covered Person, you are eligible for Medicare based on End Stage Renal Disease, and you have been eligible for Medicare for less than 31 months	This Plan	Medicare
A Covered Person, you are eligible for Medicare based on End State Renal Disease, and you have been eligible for Medicare for more than 30 months*	Medicare	This Plan

If a Covered Person has coverage from "Another Plan" as defined by Section 10.01(a)(1)(viii) (i.e., the Covered Person is also covered by Medicare), the Plan will determine whether it is the "Primary Plan" or the "Secondary Plan" in accordance with the rules listed below in this Section 10.04.

These Medicare coordination rules shall apply with respect to any Covered Person who is entitled to benefits under Part A or Part B of Medicare, regardless of whether (s)he is enrolled.

The Plan does not coordinate with Medicare Part D, and the rules below do not apply to coordination with Medicare Part D. You should only enroll in Medicare Part D if you want to have your prescription drug coverage provided through Medicare and not through this Plan. If a Covered Person enrolls in Medicare Part D, (s)he will no longer be eligible for Prescription Drug Benefits from the Plan.

(a) Notwithstanding the order of benefit determination rules in Section 10.03, the following rules shall determine the order of benefits payable in the circumstances described below:

(1) If an Eligible Employee is eligible for Medicare based on disability or age, this Plan shall be the "Primary Plan" for the Eligible Employee and his/her Dependents and Medicare shall be the "Secondary Plan."

(2) If a Dependent of an Eligible Employee is eligible for Medicare based on disability or age, this Plan shall be the "Primary Plan" for the Dependent and Medicare shall be the "Secondary Plan."

(3) If a Retiree is eligible for Medicare based on disability or age, this Plan shall be the "Secondary Plan" for the Retiree and Medicare shall be the "Primary Plan."

(4) If a Dependent of a Retiree is eligible for Medicare based on disability or age, this Plan shall be the "Secondary Plan" for the Dependent and Medicare shall be the "Primary Plan."

(5) If a qualified beneficiary is eligible for Medicare based on disability or age, and is covered under this Plan's COBRA continuation coverage, this Plan shall be the "Secondary Plan" and Medicare shall be the "Primary Plan." Nothing in this Section 10.04(a)(5) shall be construed to mean that

a qualified beneficiary is entitled to continue to receive coverage under this Plan's COBRA continuation coverage once (s)he is entitled to Medicare.

(6) If any Covered Person is eligible for Medicare based on End Stage Renal Disease, this Plan shall be the "Primary Plan" for the first 30 months of such person's eligibility or entitlement to Medicare and Medicare shall be the "Secondary Plan" during those first 30 months. After the Covered Person's first 30 months of Medicare eligibility or entitlement, this Plan shall be the "Secondary Plan" and Medicare shall be the "Primary Plan."

(b) In the case of any Medicare-entitled Covered Person who is not enrolled in Medicare Parts A and B, the Plan shall determine the benefit amount that would have been payable by Medicare Parts A and B, and shall reduce its secondary payments accordingly. In other words, if Medicare would be your "Primary Plan" but you have not enrolled in Medicare Parts A and B, this Plan will still reduce the benefits it pays by the amount that would have been paid by Medicare Parts A and B.

(c) If Medicare is the "Primary Plan" and a Covered Person's benefits are not payable by Medicare because the Covered Person failed to follow Medicare's claim filing procedures, such as by seeking care from a provider who does not participate with the Medicare plan in which the Covered Person is enrolled, this Plan will coordinate with the amount that would have been payable under the original Medicare plan.

Section 10.05 - Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these coordination of benefits rules and to determine benefits payable under this Plan and "Another Plan." The Plan may get the facts it needs from, or may provide necessary facts to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and "Another Plan" covering the Covered Person. This Plan does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Plan any facts it needs to apply these coordination of benefits rules and determine benefits payable.

Section 10.06 - Facility of Payment

A payment made under "Another Plan" may include an amount that should have been paid under the Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Plan will not have to pay that amount again and, to the extent of such payment, the Plan shall be fully discharged from any liability. The term payment made includes providing benefits in the form of services, in which case payment made means the reasonable cash value of the benefits provided in the form of services.

Section 10.07 - Right of Recovery

If the amount of the payments made by the Plan is more than it should have paid under the coordination of benefits rules in this Article, the Plan may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided to or for the Covered Person. The amount of payments made includes the reasonable cash value of any benefits provided in the form of services. The Plan may also recover any overpayments in accordance with Section 13.18.

Section 10.08 - Claims Involving Third-Party Liability

Any liability arising out of a third party's responsibility for the Sickness or Injury suffered by a Covered Person shall be addressed in accordance with Article XI - Subrogation and Reimbursement and will not be paid in accordance with this Article.

ARTICLE XI - SUBROGATION AND REIMBURSEMENT

The following topics are discussed under this Article on Subrogation and Reimbursement:

11.01	Definition of Allowable Expense	11.04	Work-Related Claims
11.02	Subrogation	11.05	Duty of Cooperation and the Right to Obtain and Release Information
11.03	Recovery and Reimbursement		

If you or your Dependent incurs medical expenses as a result of an Injury or accident, a third party may be liable for those expenses. In this case, the Plan may make advance payments to cover your health benefits in accordance with the subrogation and reimbursement rules in this Article.

To understand the Plan's subrogation and reimbursement rules, you need to understand the meaning of the terms "subrogation" and "reimbursement."

Subrogation allows the Plan to "stand in your shoes" to recover benefits paid by this Plan from any other plan or person who should have properly paid those benefits. For example, if you are injured in an auto accident due to another driver's fault, and the Plan pays expenses for the treatment of your injuries, the Plan can "stand in your shoes" and make a claim to recover those expenses from either the responsible driver or the responsible driver's insurance company. In subrogation, the Plan is asserting your rights to collect against a responsible party.

With reimbursement, the Plan is not asserting your rights, but instead is requiring repayment of the benefits paid on your behalf. For example, say you are crossing the street and are hit by a car that failed to stop for the crosswalk. The Plan pays expenses for the treatment of your injuries. You hire an attorney and file suit against the driver, eventually arriving at a settlement. Under the Plan's reimbursement provisions, you must use the proceeds of your settlement to repay the Plan for the expenses it has paid for the treatment of your injuries. With reimbursement, you have asserted your rights to collect against the responsible party, and you must use the money that you collected to repay the Plan.

These rules are explained in greater detail below.

Section 11.01 - Definition of Allowable Expense

When the term, "Allowable Expense" is used in this Article, it shall mean any health care expense, including deductibles, coinsurance or copays that is covered at least in part under any of the health plans covering the Covered Person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any plan covering the Covered Person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense. For examples of expenses that are not Allowable Expenses, see Section 10.01(b).

Section 11.02 - Subrogation

(a) If a Covered Person is injured by a third party, (s)he must complete a subrogation agreement and provide any requested information to the Plan Administrator before the Plan will pay any benefits for such Injury or Sickness.

(b) This Plan shall be subrogated to the extent of benefits paid under this Plan to any monies recovered from any other plan or person by reason of the Injury or Sickness which occasioned the payment of benefits under this Plan. This Plan shall also be subrogated to the extent of benefits paid under this Plan to any claim the Covered Person may have against any other plan or person for the Injury or Sickness which occasioned the payment of benefits under this Plan. Upon written notification to the Claimant, this Plan may (but shall not be required to) collect on the claim directly from the other plan or person in any manner this plan chooses without the consent of the Covered Person.

(c) This Plan shall apply any monies collected from any other plan or person to payments made under this Plan and to any reasonable costs and expenses (including attorneys' fees) incurred by this Plan in connection with the collection of the claim up to the amount of the award or settlement. Any balance remaining shall be paid to the Covered Person as soon as administratively practicable. In other words, if the Plan recovers money in a subrogation action, the Plan will use the money to cover payments made by the Plan and any reasonable costs and expenses the Plan incurred collecting that money (including attorneys' fees) up to the amount of the award or settlement. If there is any money remaining, it will be paid to you.

(d) The Plan's rights to subrogation and reimbursement take priority over any other use of monies that a Covered Person recovers, including payment of attorney's fees and expenses, and regardless of whether the Covered Person obtains a full or partial recovery for the Injury or Sickness. The Plan's subrogation and reimbursement rights under this Article are not limited by the "common fund" doctrine. The characterization of any amount recovered by a Covered Person from another plan or person, whether through settlement agreement or otherwise, shall not affect the Plan's priority right to recover the full amount of benefits paid to or on behalf of such Covered Person, or to characterize otherwise Covered Charges as excludable expenses pursuant to the provisions of this Article. Nor will the amount of the Plan's recovery right be limited simply because the amount recovered by the Covered Person from the responsible third party is insufficient to reimburse the Covered Person for all of his/her damages, including non-medical expense items, such as "pain and suffering" or property damage. This Plan's subrogation and reimbursement rights are not limited by the "make whole" doctrine that is sometimes applicable in other legal contexts. The Trustees or their designee may, within their sole discretion, apportion the monies such that this Plan receives less than full reimbursement.

(e) This Plan shall not be responsible for any costs or expenses incurred in connection with any recovery from any other plan or person unless this Plan agrees in writing to pay a part of those expenses.

(f) The Board of Trustees, within its sole discretion, shall determine which of this Plan's rights and remedies is within the best interests of this Plan to pursue. The Trustees may decide to recover less than the full amount of excess payments or to accept less than full reimbursement if:

(1) This Plan has made, or caused to be made, such reasonable, diligent, and systematic collection efforts as are appropriate under the circumstances; and

(2) Such decision is reasonable under the circumstances based on the likelihood of collecting such monies in full or the approximate expenses this Plan would incur in an attempt to collect such monies.

Section 11.03 - Recovery and Reimbursement

(a) Whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount that at any time is in excess of the maximum amount of payment necessary at that time to satisfy the intent of these rules, this Plan shall have a right to recover these payments, to the extent of any excess, in accordance with Section 13.18.

(b) The Trustees may, in their discretion, elect to set-off any amounts paid by this Plan that are in excess of the amounts for which this Plan is liable under this Article in accordance with Section 13.18. The Trustees, in their discretion, may also elect to set-off any amounts paid by this Plan that are in excess of the amounts for which the Plan is liable under this Article against any amount owed by the Plan at that time or in the future, to the same insurance company, or other organization to whom the overpayment was made. The Trustees have sole and absolute discretion whether to recover or set-off, and from whom to recover.

(c) If the Plan makes payment of Allowable Expenses incurred for treatment of an Injury or Sickness for which another plan or person (a responsible third party) is or may be liable, and in which this Plan's subrogation provisions do not provide this Plan with a right to recover amounts this Plan pays for treatment of the Injury or Sickness, the Plan may elect to set-off any payments in accordance with Section 13.18. The Plan may also elect to set-off any excess payments against any amount owed by the Plan at that time or in the future to the same insurance company, or other organization to whom payment was made. If the responsible third party, or such person's insurer (or anyone else on behalf of the responsible third party), makes payment to a Covered Person, or on behalf of a Covered Person, as compensation for an Injury or Sickness, and this Plan is not subrogated with respect to that payment, this Plan is entitled to reimbursement from the Covered Person in an amount equal to the lesser of the benefits paid by this Plan for treatment of that Injury or Sickness, or the amount paid to or on behalf of the Covered Person by the responsible third party or its insurer. This Section 11.03(c) shall not apply when the responsible third party or its insurer is Another Plan (as that term is defined in Section 10.01(a)(1)) with respect to which this Plan is the primary payer of an Allowable Expense in accordance with the coordination of benefits rules in Article X - Coordination of Benefits.

(d) If a responsible third party or its insurer pays compensation to or on behalf of a Covered Person for an Injury or Sickness for which the responsible third party is or may be liable, and the Covered Person incurs (either before or after payment of such compensation) otherwise Allowable Expenses for treatment of that Injury or Sickness, such otherwise Allowable Expenses incurred after the date on which the compensation was paid, or incurred prior to such date but not paid by this Plan as of that date, shall be excluded from coverage to the extent of the excess (if any) of the compensation the Covered Person receives over the Allowable Expenses which the Plan has already paid for treatment of the Sickness or Injury that is the subject of the compensation from the responsible third party, and as to which expenses the Plan has already received reimbursement. This rule shall not apply with respect to Allowable Expenses incurred by a Covered Person for treatment of asbestosis and/or its related conditions after the Covered Person's receipt of compensation from a responsible third party or such party's insurer related to the Covered Person's claim against such responsible third party for compensation on account of having contracted asbestosis.

The following example illustrates how this Section 11.03(d) works:

> On June 1, 2023, Betty gets injured in a car accident. The driver of the other car is Chris and the car accident is Chris' fault. On June 1, 2023, Betty incurs $1,000 of Allowable Expenses for injuries caused by the car accident. On June 10, 2023, the Fund Office requests information from Betty regarding the Injury and sends her a subrogation agreement to sign. On June 15, 2023, Betty provides the Fund Office the requested information and a signed subrogation agreement. On June 16, 2023, the Fund Office pays the $1,000 of Allowable Expenses. On June 20, 2023, Chris' insurance company pays Betty $11,000. On June 22, 2023, Betty pays the Plan $1,000 to reimburse Plan for the expenses that the Plan paid on June 16, 2023. On July 1, 2023, Betty incurs $15,000 of additional Allowable Expenses for injuries caused by the car accident. The Plan will not pay $10,000 of Betty's additional Allowable Expenses.

(e) The Plan's right to reimbursement takes priority over any other uses of monies recovered, including payment of attorneys' fees and expenses, and regardless of whether the Covered Person obtains a full or partial recovery for his/her Injury or Sickness, or for other damages sustained as a result of an action by a responsible third party that also resulted in the Covered Person's Injury or Sickness. This Plan shall not be responsible for any costs or expenses incurred in connection with any recovery from any other plan or person unless this Plan agrees in writing to pay a part of those expenses. This Plan's reimbursement rights are not limited by the "common fund" doctrine. The characterization of any amount a Covered Person recovers from another plan or person, whether through settlement agreement or otherwise, shall not affect the Plan's priority right to recover the full amount of benefits paid to or on behalf of a Covered Person, or the Plan's right to characterize otherwise Covered Charges as excludable expenses pursuant to the provisions of Section 11.03(b). Nor will the amount of this Plan's recovery right be limited simply because the amount a Covered Person recovers from another plan or person is insufficient to reimburse the Covered Person for all of his/her damages, including non-medical expense items such as "pain and suffering" or property damage. This Plan's reimbursement rights are not limited by the "make whole" doctrine that is sometimes applicable in other legal contexts.

Section 11.04 - Work-Related Claims

In general, the Plan does not cover charges relating to any Injury or Sickness for which a Covered Person has received or is entitled to receive compensation under any Workers' Compensation or occupational disease or similar law or program. However, an exception exists if a Covered Person has a work-related Injury or Sickness for which a claim has been filed with a Workers' Compensation insurance carrier or with a federal or state court or agency. In the event that claim was initially denied, then the Plan may pay benefits arising from the work-related Injury or Sickness in accordance with this Section 11.04.

A Covered Person must complete a subrogation agreement and provide any requested information to the Plan Administrator before the Plan will pay any benefits in accordance with this Section 11.04. Benefits paid in accordance with this Section 11.04 are subject to the subrogation and reimbursement provisions in this Article (i.e., all of the Plan's rights with respect to subrogation and reimbursements shall apply to benefits paid in accordance with this Section 11.04).

Section 11.05 - Duty of Cooperation and the Right to Obtain and Release Information

Each Covered Person has a duty to cooperate with this Plan and, at the request of the Board of Trustees or its designee and as a condition of receiving benefits under this Plan, a Covered Person shall take any action, give information and assistance and execute documents required by this Plan to enforce its rights under this Article. The Plan will make no payments to or on behalf of a Covered Person until the Plan is satisfied that the Claimant has complied with the requirements of this Article. The Board of Trustees or its designee, without the consent of or notice to any person may release to or obtain from any person any information, with respect to any person, which the Board of Trustees or its designee deems necessary to make payment for medical care, to determine and enforce any applicable cost sharing requirements of this Plan and to enforce this Plan's rights to recovery, reimbursement and/or subrogation.

ARTICLE XII - PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION

The following topics are discussed under this Article on Privacy and Security of Protected Health Information:

12.01	Definitions for this Article XII Only	12.04	Conditions of Disclosure of PHI to the Board of Trustees and Agreement by the Board of Trustees
12.02	Use and Disclosure of Protected Health Information by the Plan	12.05	Adequate Separation between the Plan and the Board of Trustees
12.03	Use and Disclosure of PHI to and by the Board of Trustees	12.06	Compliance with the HITECH Act

This Article provides a summary of the Plan's legal obligations and your legal rights regarding your Protected Health Information ("PHI") held by the Plan under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

In general, PHI is Individually Identifiable Health Information, including demographic information, that is created or received by the Plan that relates to: (1) your past, present or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present or future payment for the provision of health care to you.

The Plan has a separate Notice of Privacy Practices that provides a complete description of your rights and the Plan's legal duties with respect to your PHI. The Notice of Privacy Practices also tells you when the Plan may Use or Disclose your PHI, when your permission or written authorization is required, how you can get access to your PHI and what actions you can take regarding your PHI. You can obtain a copy of the Notice of Privacy Practices by contacting the Fund Office.

Section 12.01 - Definitions for this Article XII Only

The terms in this Section 12.01 are specifically defined in the Standards for Privacy of Individually Identifiable Health Information found at 45 C.F.R. Part 160 and Subparts A and E of Part 164 (the "Privacy Rule") and the Security Standards for the Protection of Electronic Protected Health Information found at 45 C.F.R. Part 160 and Subparts A and C of Part 164 (the "Security Rule"). The definitions set forth in the HIPAA Privacy Rule and the HIPAA Security Rule shall govern the meaning of the following terms when they are used in this Article:

(a) Business Associate
(b) Covered Entity
(c) Disclosure
(d) Electronic Protected Health Information (ePHI)
(e) Health Care Options
(f) Health Care Provider
(g) Individually Identifiable Health Information
(h) Payment
(i) Protected Health Information (PHI)
(j) Required By Law
(k) Secretary
(l) Security Measures
(m) Security Incident
(n) Treatment
(o) Use

Section 12.02 - Use and Disclosure of Protected Health Information by the Plan

The Plan may Use and Disclose PHI for the purposes listed in this Section 12.02 to the extent such Use or Disclosure is permitted by and in accordance with the provisions of the HIPAA Privacy Rule, the HIPAA Security Rule and all other applicable law.

(a) Use and Disclosure of PHI to a Covered Person or his/her Personal Representative

The Plan is required to and will Disclose your PHI to you or your personal representative upon written request. You (or your personal representative) may request your PHI by sending a written request to the Fund Office. If your personal representative is requesting your PHI, (s)he must also submit documentation demonstrating that (s)he has the authority to act on your behalf (for example, a power of attorney).

For purposes of this Section 12.02(a), an individual is considered your personal representative if under applicable law, (s)he has the authority to act on your behalf in making decisions related to health care. For example, state law will determine the extent to which a parent may act on behalf of a minor child with regard to the child's PHI.

The Plan will provide your personal representative with access to your PHI in the same manner as it would provide you with access unless, in the exercise of professional judgment, the Plan decides that treating an individual as your personal representative would not be in your best interest and the Plan has a reasonable belief that:

(1) You have been or may be subjected to domestic violence, abuse or neglect by the person seeking to be treated as your personal representative; or

(2) Treating the individual as your personal representative could endanger you.

(b) Use and Disclosure of PHI Pursuant to a Valid Authorization

The Plan will Disclose your PHI to your authorized representative upon receipt of a completed written Protected Health Information Authorization Form. Protected Health Information Authorization Forms are available at the Fund Office.

The Plan will provide your authorized representative PHI in accordance with the Protected Health Information Authorization Form, HIPAA, and all other applicable law. You can revoke a Protected Health Information Authorization Form at any time by sending a written request for revocation to the Fund Office. A request for revocation will become effective on the date that it is received by the Fund Office.

(c) Use and Disclosure of PHI for Treatment, Payment or Health Care Operations

The Plan does not perform any Treatment activities, but may Disclose PHI to Health Care Providers treating a Covered Person in order to facilitate the providers' Treatment of the Covered Person. For example, the Plan may disclose the name of your treating radiologist to your treating primary care Physician so that your primary care Physician may ask your radiologist for your x-rays.

The Plan may Use and Disclose the minimum necessary PHI for Payment activities and Health Care Operations in accordance with the following rules:

(1) The Plan may Use and Disclose the minimum necessary PHI for the Plan's Payment activities.

Payment generally means the activities of the Plan to collect contributions, premiums and self-payment amounts; to fulfill its coverage responsibilities and provide benefits under the Plan; and to obtain or provide reimbursement for the provision of health care. Payment may include, but is not limited to the following:

- **Determining your eligibility and coverage for Plan benefits**

  For example, the Plan may Use information obtained from your Employer to determine whether you are an Eligible Employee.

- **Determining and fulfilling the Plan's responsibility to provide benefits**

  For example, the Plan may Use your healthcare claims to determine if services provided by your Physician are covered by the Plan.

- **Enforcing the Plan's rights to recovery, reimbursement and/or subrogation**

  For example, if you are in an auto accident due to another driver's fault and the Plan pays expenses for the treatment of your injuries, the Plan may Use and Disclose information regarding the accident, expenses and treatment in order to enforce the Plan's subrogation rights.

- **Providing Determinations on Pre-Service Claims**

  For example, if you are scheduled to have surgery and prior to your surgery your provider submits a Pre-Service Claim to the Plan, the Plan may Disclose the Pre-Service Claim determination to your provider (i.e., the Plan may let your provider know whether or not the surgery is covered by the Plan).

- **Coordinating benefits with other plans under which you have health coverage**

  For example, the Plan may Use information about your benefits from another group health plan to determine the benefits that this Plan will pay for a specific claim.

(2) The Plan may Use and Disclose the minimum necessary PHI for the Plan's Health Care Operations.

Health Care Operations generally means certain administrative, financial, legal and quality improvement activities of the Plan that are necessary to run its business and to support the core functions of Treatment and Payment. These specific activities are limited to those listed in the definition of Health Care Operations found at 45 C.F.R. Section 164.501. The following is a summary of these activities:

- **Conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, case management and care coordination and contacting Health Care Providers and patients with information about Treatment alternatives and related functions that do not include Treatment.**

  For example, a case manager may contact you or your provider to discuss Treatment alternatives.

- **Reviewing the competence or qualifications of health care professionals, evaluating provider and Plan performance, training health care and non-health care professionals, accreditation, certification, licensing or credentialing activities**.

  For example, the Plan may train new claims processors by having them process health benefit claims under close supervision.

- **Underwriting and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to health care claims.**

  For example, if the Plan decides to purchase stop-loss insurance, it may disclose your demographic information (such as your age) to carriers to obtain quotes.

- **Conducting or arranging for medical review, legal and auditing services, including fraud and abuse detection and compliance programs**.

  For example, the Plan's auditor (who is a Business Associate) may review your health care claims to determine if they were paid correctly.

- **Business planning and development, such as conducting cost-management and planning analysis related to managing and operating the Plan**.

  For example, the Plan's consultant (who is a Business Associate) may review PHI to project future benefit costs.

- **Business management and general administrative activities, including those related to implementing and complying with the Privacy Rule and other administrative simplification rules, customer service, resolution of internal grievances, sale or transfer of assets, creating de-identified health information or a limited data set and fundraising for the benefit of the Plan.**

  For example, the Plan may Use your PHI for the purpose of creating de-identified information.

(3) The Plan may Use and Disclose the minimum necessary PHI for the Payment activities of another Covered Entity or Health Care Provider.

For example if you have secondary coverage from another plan, this Plan may disclose information to that other plan regarding this Plan's Payment for your health care.

(4) The Plan may Use and Disclose the minimum necessary PHI for certain (but not all) Health Care Operations of another Covered Entity if the Covered Entity has a relationship with the Covered Person, the PHI pertains to that relationship, and the Disclosure is permitted by and made in accordance with 45 C.F.R. Section 164.506.

For example, the Plan may Disclose your PHI to another Covered Entity for quality assessment and improvement, case management, performance evaluation and fraud abuse and detection.

(d) Use and Disclosure of PHI for Notification and Involvement in a Covered Person's Care

The Plan may Disclose your PHI to a family member, other relative, close personal friend or other person that you identify, to the extent the PHI is directly relevant to such person's involvement with

your care or the Payment is related to your care, and the Disclosure is in accordance with this Section 12.02(d) and 45 C.F.R. Section 164.510.

The Plan may also Disclose your PHI to notify (or assist in the notification of, including identifying or locating), a family member, your personal representative or another person responsible for your care of your location, general condition or death in accordance with this Section 12.02(d) and 45 C.F.R. Section 164.510.

The following rules apply to Disclosures made pursuant to this Section 12.02(d);

(1) Uses and Disclosures with the Covered Person Present

If you are present for, or otherwise available prior to, a Use or Disclosure permitted by this Section 12.02(d), and you have the capacity to make health care decisions, the Plan may Use or Disclose your PHI if the Plan:

- obtains your agreement;
- provides you with the opportunity to object to the Disclosure and you do not express an objection; or
- exercises professional judgment and reasonably infers from the circumstances that you do not object to the Disclosure.

(2) Uses and Disclosures if the Covered Person is not Present

If you are not present, or you cannot agree or object to a Use or Disclosure because you are incapacitated or there is an emergency circumstance, the Plan may, in the exercise of professional judgment, determine whether the Use or Disclosure is in your best interests, and, if so, Disclose only the PHI that is directly relevant to the person's involvement with your health care.

(e) Use and Disclosure of PHI Required by Law

The Plan may Use or Disclose your PHI to the extent that such Use or Disclosure is Required By Law and the Use or Disclosure complies with and is limited to the relevant requirements of such law.

(f) Disclosures About Victims of Abuse, Neglect or Domestic Violence

Except for reports of child abuse or neglect that are permitted to be Disclosed to a public health authority in accordance with Section 12.02(i)(2) below, the Plan may Disclose your PHI to a government authority (including a social service or protective services agency) that is authorized by law to receive reports of such abuse, neglect or domestic violence if the Plan reasonably believes that you are a victim of abuse, neglect or domestic violence and you agree to the Disclosure.

Even if you have not agreed to the Disclosure, the Plan may Disclose your PHI to a government authority to the extent the Disclosure is Required By Law and the Disclosure complies with and is limited to the relevant requirements of such law. The Plan may also Disclose your PHI to a government authority if the Disclosure is expressly authorized by statute or regulation and at least one of the following applies:

- The Plan, in the exercise of professional judgment, believes the Disclosure is necessary to prevent serious harm to you or other potential victims; or

- You do not have the capacity to agree and law enforcement (or other public official authorized to receive the report) represents that the information is not intended to be used against you and immediate law enforcement activity depends on the Disclosure.

If the Plan makes a Disclosure permitted by this Section 12.02(f), the Plan will promptly notify you that the Disclosure has or will be made unless, in the exercise of professional judgment, (i) the Plan believes informing you would place you at risk of serious harm; or (ii) the Plan would be informing a personal representative and, in the exercise of professional judgment, the Plan reasonably believes that the personal representative is responsible for abuse, neglect or other Injury and informing such person would not be in your best interests.

(g) Disclosures for Judicial and Administrative Proceedings

The Plan may Disclose your PHI in the course of any judicial or administrative proceeding in response to:

- an order of a court or administrative tribunal so long as the Plan only Discloses the PHI that is expressly authorized by such order; or
- a subpoena, discovery request or other lawful process that is not accompanied by an order of a court or an administrative tribunal if the Plan receives satisfactory assurances (as defined by 45 C.F.R. Section 164.512) from the party seeking the information that reasonable efforts have been made by such party to ensure that you have been given notice of the request or that the party seeking the PHI has made reasonable efforts to secure a qualified protective order.

(h) Disclosures for Law Enforcement Purposes

The Plan may Disclose your PHI to a law enforcement official for a law enforcement purpose in accordance with this Section 12.02(h) and 45 C.F.R. Section 164.512.

- The Plan may Disclose your PHI as Required By Law, including laws that require the reporting of certain types of wounds or other physical injuries (except for Disclosures for public health reporting and Disclosures about victims of abuse, neglect or domestic violence which are governed by the more specific rules in Section 12.02(f) and Section 12.02(i)(2)).
- The Plan may Disclose your PHI in compliance with, and as limited by, the relevant requirements of a court order, a court-ordered warrant, a subpoena or summons, or an investigative demand or similar process so long as the information sought is relevant and material to a legitimate law enforcement inquiry, the request is specific and limited to the extent reasonably practicable in light of the purpose for which the information is sought and de-identified information could not reasonably be used.
- The Plan may Disclose your PHI in response to a law enforcement official's request for the information for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. The information the Plan may Disclose for this purpose is limited to your name, address, date and place of birth, Social Security number, ABO blood type and Rh factor, type of Injury, date and time of treatment, date and time of death (if applicable) and certain distinguishing characteristics (for example, height, weight and gender).
- The Plan may Disclose your PHI in response to a law enforcement official's request for the information if you are (or are suspected to be) a victim of a crime and you agree to the Disclosure or the Plan is unable to obtain your agreement because of your incapacity or an emergency

circumstance and the law enforcement official represents that the information is needed to determine whether a person (other than you) has violated the law, the information is not intended to be used against you, immediate law enforcement activity depends on the Disclosure and in the exercise of professional judgment the Plan determines that the Disclosure is in your best interest.

- The Plan may Disclose your PHI to law enforcement officials after your death for the purpose of alerting them of your death if the Plan has a suspicion that your death may have resulted from criminal conduct.
- The Plan may Disclose your PHI that the Plan believes in good faith constitutes evidence of criminal conduct that occurred on the Plan's premises.

(i) Use and Disclosure of PHI for Public Health Activities

The Plan may Disclose your PHI to the following entities for the public health activities and purposes described in this Section 12.02(i) in accordance with 45 C.F.R. Section 164.512:

(1) The Plan may Disclose your PHI to a public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, such as the reporting of disease, injury or vital events (e.g. birth, or death), and conducting public health surveillance, public health investigations and public health interventions.

(2) The Plan may Disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect.

(3) The Plan may Disclose your PHI to a person who has responsibility to the Food and Drug Administration (FDA) regarding the quality, safety or effectiveness of such FDA-regulated product or activity.

(4) The Plan may Disclose your PHI to a person who may have been exposed to a communicable disease or who may otherwise be at risk of contracting or spreading a disease or condition if the Plan is authorized by law to notify such person.

(j) Use and Disclosure of PHI for Health Care Oversight Activities

The Plan may Disclose your PHI to a health oversight agency for oversight activities authorized by law, including audits; civil administrative or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other appropriate oversight activities. This Section 12.02(j) does not apply if you are the subject of an investigation or other activity that does not arise out of and is not directly related to the receipt of health care, a claim for public benefits related to health, or the qualification for or receipt of public benefits or services when a patient's health is integral to the claim for public benefits or services.

(k) Use and Disclosure of a Decedent's PHI

The Plan may Disclose your PHI to a coroner or medical examiner after your death for the purpose of identifying you, determining your cause of death or other duties as authorized by law. The Plan may also Disclose your PHI to funeral directors either upon your death or before and in reasonable anticipation of your death, consistent with applicable law, and as necessary for the funeral director to carry out his/her duties.

(l) Use and Disclosure of PHI for Cadaveric Organ, Eye or Tissue Donation Purposes

The Plan may Disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of cadaveric organs, eyes or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

(m) Use and Disclosure of PHI to Avert a Serious Threat to Health or Safety

The Plan may, consistent with 45 C.F.R. Section 164.512, all other applicable law(s) and standards of ethical conduct, Use or Disclose your PHI if the Plan in good faith believes that the Use or Disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. The Plan may only Disclose PHI for this purpose if the Disclosure is to a person reasonably able to prevent or reduce the threat, including the target of the threat.

(n) Use and Disclosure of PHI for Specialized Government Functions

The Plan may Disclose your PHI if you are in the Armed Forces and the PHI is deemed necessary by the appropriate military command authorities. The Plan may also Disclose your PHI to authorized federal officials for the conduct of national security activities and protection of the President, and to a correctional institution where you are being held.

(o) Use and Disclose of PHI for Workers' Compensation

The Plan may Disclose your PHI as authorized by and to the extent necessary to comply with laws relating to Workers' Compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

(p) Disclosure of PHI to the Secretary of Health and Human Services

The Plan is required to and will Disclose your PHI to the Secretary of Health and Human Services ("HHS"), or his/her designee, when such PHI is required by the Secretary to investigate or determine the Plan's compliance with the Privacy Rule.

Section 12.03 - Use and Disclosure of PHI to and by the Board of Trustees

The Board of Trustees has delegated the daily responsibility for administering the Plan to Business Associates. The Plan's Business Associates will carry out their administrative duties on behalf of the Plan, such as claims processing and regular Plan administration, without Disclosing PHI to the Board of Trustees unless such Disclosure is necessary, and then shall Disclose only the minimum information necessary to carry out the purpose of the Disclosure to the Board of Trustees, and only in accordance with the terms of the Privacy Rule, the Security Rule and this Plan document.

The Plan and its Business Associates may Disclose the minimum necessary Individually Identifiable Health Information to the Board of Trustees for the Plan administrative functions that the Board of Trustees performs for the Plan. The Board may Use and Disclose only the minimum Individually Identifiable Health Information necessary for the Board to perform the Plan administrative functions described in this Section 12.03 or as otherwise permitted or required by HIPAA. Notwithstanding any provisions of this Plan to the contrary, in no event shall the Board of Trustees (or any member of the Board of Trustees) be permitted to Use or Disclose PHI in a manner that is inconsistent with 45 C.F.R. Section 164.504(f).

(a) Payment

The Plan and its Business Associates may Disclose the minimum necessary PHI to the Board of Trustees in order for the Board to perform Payment activities (as the term Payment is defined in 45 C.F.R. Section 164.501) that the Board has not delegated to a Business Associate (in other words, Payment activities that the Board of Trustees performs for the Plan). The Board of Trustees may Use and Disclose only the minimum information necessary to perform such Payment activities. The Payment activities that the Board of Trustees performs for the Plan include, but are not limited to the following:

(1) Benefit Determinations on Review (i.e., Appeals)

The Plan and its Business Associates may Disclose the minimum necessary PHI to the Board of Trustees in order for the Board to render determinations on appeals. The Board may Use and Disclose only the minimum information necessary to decide the appeal, and shall avoid making any Disclosure of the information unless necessary to the claim determination, such as for the purpose of obtaining medical, legal or actuarial advice regarding the appeal. When Disclosing any such information, the Board shall obtain adequate assurances from the party to whom the information is being Disclosed that such party will protect the privacy of the information. In order to accomplish this purpose efficiently, the Board shall avoid making any Disclosure of PHI to any entity that has not entered into a Business Associate Agreement with the Plan. Any Business Associate Agreement entered into between the third party and the Plan shall protect the Board of Trustees to the same extent it protects the Plan.

(2) Collection Activities and Subrogation

The Plan and its Business Associates may Disclose the minimum necessary PHI to the Board of Trustees in order for the Board to make determinations related to collection activities and subrogation, such as for the purpose of deciding whether or not the Plan should attempt to recover an overpayment or whether or not the Plan should settle with a Covered Person or outside party in a collection or subrogation matter. The Board may Use and Disclose only the minimum information necessary to render determinations regarding collection activities and subrogation, and shall avoid making any Disclosure of the information unless necessary, such as for the purpose of obtaining legal or actuarial advice regarding the collection activity or subrogation matter. When Disclosing any such information, the Board shall obtain adequate assurances from the party to whom the information is being Disclosed that such party will protect the privacy of the information. In order to accomplish this purpose efficiently, the Board shall avoid making any Disclosure of PHI to any entity that has not entered into a Business Associate Agreement with the Plan. Any Business Associate Agreement entered into between the third party and the Plan shall protect the Board of Trustees to the same extent it protects the Plan.

(b) Health Care Operations

The Plan and its Business Associates may Disclose the minimum necessary PHI to the Board of Trustees in order for the Board to perform Health Care Operations (as the term Health Care Operations is defined in 45 C.F.R. Section 164.501) that the Board has not delegated to a Business Associate (in other words, Health Care Operations that the Board performs for the Plan). The Board of Trustees may Use and Disclose only the minimum information necessary to perform such Health Care Operations.

Section 12.04 - Conditions of Disclosure of PHI to the Board of Trustees and Agreement by the Board of Trustees

Neither the Plan nor any Business Associate servicing the Plan will Disclose PHI to the Board of Trustees unless and until the Plan receives a certification by the Board of Trustees that the Plan documents have been amended to incorporate the following provisions, and that the Board of Trustees agrees to each of the provisions in this Section 12.04. By adopting this Plan, the Board of Trustees agrees:

(a) Not to Use or Disclose PHI other than as permitted or required by the Plan documents or as required by law;

(b) To ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Board of Trustees with respect to such information and that such agent (including a subcontractor) agrees to implement reasonable and appropriate Security Measures to protect the PHI;

(c) Not to Use or Disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan that receives contributions in accordance with the Collective Bargaining Agreement;

(d) To report to the Plan any Use or Disclosure of the PHI that is inconsistent with the Uses or Disclosures provided for of which it becomes aware;

(e) To make available PHI in accordance with 45 C.F.R. Section 164.524 to the extent that the Board of Trustees, rather than a Business Associate, has control of such PHI;

(f) To make available PHI for amendment and to incorporate any amendments to PHI in accordance with 45 C.F.R. Section 164.526 to the extent that the Board of Trustees, rather than a Business Associate, has control of such PHI;

(g) To make available the information required to provide an accounting of Disclosures in accordance with 45 C.F.R. Section 164.528, to the extent that the Board of Trustees rather than a Business Associate has control of such information;

(h) To make its internal practices, books and records relating to the Use and Disclosure of PHI received from the Plan available to the Secretary for purposes of determining compliance with the Privacy Rule by the Plan;

(i) If feasible, to return or destroy all PHI received from the Plan that the Board of Trustees still maintains in any form and to retain no copies of such information when it is no longer needed for the purpose which the Disclosure was made, except that, if such destruction is not feasible, to limit future Uses and Disclosures to those purposes that make the return or destruction of the information infeasible;

(j) To ensure that adequate separation required by 45 C.F.R. Section 164.504(f)(2)(iii) is established and is supported by reasonable and appropriate Security Measures;

(k) To implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that the Trustees create, receive, maintain or transmit on behalf of the Plan; and

(l) To report to the Plan any Security Incident of which the Board of Trustees becomes aware.

Section 12.05 - Adequate Separation between the Plan and the Board of Trustees

Adequate separation will exist at all times between the Plan and the Board of Trustees. All members of the Board of Trustees may have access to PHI when such access is required to perform the Plan administrative functions that the Board of Trustees performs for the Plan. No member of the Board of Trustees shall have any access to PHI except as provided for in Section 12.03 or as otherwise permitted or required by HIPAA (for example, the Plan will Disclose PHI to the Board of Trustees if the Disclosure is necessary for the Board of Trustees to comply with its obligations under Section 12.04).

The Board of Trustees does not have any employees, thus it is not possible for any employee of the Board of Trustees to have access to PHI. The Board of Trustees shall protect the privacy of Individually Identifiable Health Information received, created or maintained and shall Use and/or Disclose such information only in accordance with the terms of this Plan document. The Board of Trustees has developed a privacy policy that includes an effective mechanism for resolving any issues of noncompliance with this Article. Any member of the Board of Trustees that does not comply with this Article will be subject to the privacy policy's disciplinary provisions for noncompliance.

The Board has delegated the daily responsibility for administering the Plan to Business Associates, including a third-party administrator, a prescription benefit manager and a PPO. These Business Associates and their employees do and shall have access to PHI in the course of the services they perform for the Plan. The Plan has entered into contracts with its Business Associates in accordance with the Privacy Rule, the Security Rule and the Health Information Technology for Economic and Clinical Health ("HITECH") Act.

Section 12.06 - Compliance with the HITECH Act

The Plan shall comply with the provisions of the HITECH Act and its implementing regulations.

ARTICLE XIII - MISCELLANEOUS PROVISIONS

The following topics are discussed under this Article on Miscellaneous Provisions:

13.01	Name of Plan	13.10	Amendment or Elimination of Benefits and Termination of the Plan
13.02	Type of Plan	13.11	Source of Financing of the Plan and Identity of any Organization through Which Benefits are Provided
13.03	Type of Administration	13.12	Interpretation
13.04	Plan Sponsor	13.13	Non-Alienation
13.05	Employer Identification Number and Plan Number	13.14	Exclusive Benefit
13.06	Plan Year	13.15	Gender and Number
13.07	Name and Address of the Person Designated as Agent for Service of Legal Process	13.16	Plan not in Place of Workers' Compensation
13.08	Names, Titles, and Addresses of the Compensation	13.17	Governing Law
13.09	Collective Bargaining Agreements	13.18	Recovery of Overpayments

Section 13.01 - Name of Plan

The name of the Plan is the "Pipe Fitters Local No. 533 Health and Welfare Plan."

Section 13.02 - Type of Plan

The Plan is a welfare benefit Plan that provides medical, prescription drug, dental, vision, short-term disability, death, and accidental death and dismemberment benefits to Participants and their Beneficiaries.

Section 13.03 - Type of Administration

The Plan is self-funded and is administered by a joint Board of Trustees, one-half of whom are appointed by the Union and one-half of whom are appointed by the Association.

The Board of Trustees retains ultimate authority as the Plan Administrator for this Plan, but it has delegated responsibility for performing the day-to-day administrative functions to Solxsys Administrative Solutions. The phone number and address for the administrative office of the Fund (i.e., the Fund Office) is:

Solxsys Administrative Solutions
755 W. Big Beaver Rd., Suite 2020
Troy, MI 48084
Phone: (586) 271-7066

Satellite Office Maintained At:
8600 Hillcrest Rd., Suite A
Kansas City, MO 64138
Phone: (816) 361-0206

Section 13.04 - Plan Sponsor

The Plan Sponsor is the Board of Trustees of the Pipe Fitters Local No. 533 Health and Welfare Fund.

Section 13.05 - Employer Identification Number and Plan Number

The Employer Identification Number ("EIN") assigned to the Board of Trustees by the Internal Revenue Service is 44-0651452. The Plan number is 501.

Section 13.06 - Plan Year

The Plan Year is the 12-month period that begins on June 1 and ends on May 31, and the Plan's records are kept on a Plan Year basis.

Section 13.07 - Name and Address of the Person Designated as Agent for Service of Legal Process

The agent for service of legal process is:

George Buhalis
Solxsys Administrative Solutions
755 W. Big Beaver Rd., Suite 2020
Troy, MI 48084
Phone: (586) 271-7066

Service of legal process may also be made upon the Board of Trustees or any individual Trustee.

Section 13.08 - Names, Titles, and Addresses of the Trustees

Union Trustees	Employer Trustees
Luke Moylan Pipefitters Local Union No. 533 8600 Hillcrest Road Kansas City, MO 64138	Michael Gossman P1 Group, Inc. 13605 W 96th Terrace Lenexa, KS 66215
J. Kevin Hendrickson Pipefitters Local Union No. 533 8600 Hillcrest Road Kansas City, MO 64138	Bryan D. Taylor U.S. Engineering Construction 3433 Roanoke Road Kansas City, MO 64111
Jeremiah Bull Pipefitters Local Union No. 533 8600 Hillcrest Road Kansas City, MO 64138	Chris Hutchings MMC Contractors 13800 Wyandotte Street Kansas City MO 64145

The Board of Trustees may be contacted at the following Fund Office addresses and phone numbers:

Solxsys Administrative Solutions
755 W. Big Beaver Rd., Suite 2020
Troy, MI 48084
Phone: (586) 271-7066

Satellite Office Maintained At:
8600 Hillcrest Rd., Suite A
Kansas City, MO 64138
Phone: (816) 361-0206

Section 13.09 - Collective Bargaining Agreements

The Plan is maintained pursuant to Collective Bargaining Agreements. A Participant or Beneficiary may obtain a copy of any Collective Bargaining Agreement by submitting a written request to the Plan Administrator. The Collective Bargaining Agreements are also available for inspection at the Fund Office.

Section 13.10 - Amendment or Elimination of Benefits and Termination of the Plan

The Board of Trustees has complete power and discretion to amend the Plan, in whole or in part, at any time. This means that the Trustees can reduce or eliminate benefits, terminate all benefits for certain Participants (for example Retirees), or modify the availability, nature, and extent of benefits and the conditions for and method of payment of benefits. The Trustees may also modify the eligibility and coverage requirements.

The Board of Trustees also has complete power and discretion to determine when and if the Plan should be terminated. The Plan may be terminated by a document in writing executed by all of the Trustees if:

- In the opinion of the Trustees, the Fund is not adequate to carry out the intent and purpose of the Trust Agreement, or is not adequate to meet the payments due or to become due under the Plan;
- There are no individuals living who can qualify as Participants or Beneficiaries under the Plan;
- There is no longer any Collective Bargaining Agreement requiring contributions to the Fund; or
- Termination is otherwise provided by law.

If the Plan is terminated, the Trustees will:

- Make provision out of the Fund for the payment of expenses incurred up to the date of termination of the Plan and the expenses incidental to such termination;
- Arrange for a final audit and report of their transactions and accounts for the purposes of termination of their trusteeship;
- Give any notice and prepare and file any reports which may be required by law; and
- Apply the Fund in accordance with the provisions of ERISA and this Summary Plan Description.

No part of the corpus or income of the Fund shall be used for or diverted to purposes other than the exclusive benefit of Participants and their Beneficiaries, or the administration expenses of the Fund. Under no circumstances shall any portion of the Fund, either directly or indirectly, revert or inure to the benefit of any Employer, the Association or the Union.

Upon termination of the Plan, the Trustees will promptly notify the Employers, the Association, the Union, and all other interested parties. The Trustees will continue to serve as Trustees for the purpose of winding up the affairs of the Plan.

Section 13.11 - Source of Financing of the Plan and Identity of any Organization through Which Benefits are Provided

The Plan is funded through Employer contributions and by investment income earned on a portion of the Fund's assets. In addition, Employees, Retirees, Dependents and individuals continuing coverage under COBRA or as a surviving spouse may be required to make contributions in order to maintain coverage under the Plan. The funds are held in Trust until disbursed. The amount of Employer contributions and the Employees on whose behalf contributions are made are determined by the provisions of the Collective Bargaining Agreements. The amount of any contributions or premiums required to be paid by Employees, Retirees, Dependents, or other Beneficiaries (including a surviving spouse or a qualified beneficiary continuing

coverage under the COBRA provisions) is determined by the Board of Trustees and may be based on an actuarial determination of the cost to the Plan to provide benefits.

The Fund Office will provide any Plan Participant or Beneficiary, upon written request, information as to whether a particular employer is contributing to this Fund, and if so, that Employer's address.

Benefits under this Plan are paid directly from the Fund. Benefits under this Plan are not financed or guaranteed under a contract or policy of insurance issued by a health insurance issuer, except as provided either through a contract for stop-loss insurance or through the fully-insured Medicare Advantage and Prescription Drug Plan. There is no liability on the Trustees or any other individual or entity to provide payment over and beyond the amount in the Fund.

The Plan has entered into arrangements with various organizations for purposes such as claims processing and case management. The following is a list of those organizations and the services they provide the Plan:

- **Solxsys Administrative Solutions ("Solxsys")**: Provides day-to-day administration for the Plan as its third-party administrator. This day-to-day administration includes, but is not limited to, determining whether an individual is eligible for coverage, issuing Certificates of Creditable Group Health Plan Coverage, and administering COBRA. Solxsys also processes Pre-Service Comprehensive Medical Benefit Claims (as that term is defined in Section 9.01(a)), Post-Service Comprehensive Medical Benefit Claims (as that term is defined in Section 9.01(c)), Vision Benefit Claims (as that term is defined in Section 9.01(g)), Accident and Sickness Loss of Time Benefit Claims (as that term is defined in Section 9.01(h)), Death Benefit Claims (as that term is defined in Section 9.01(i)), and Accidental Death and Dismemberment Benefit Claims (as that term is defined in 9.01(j)).
- **Blue Cross and Blue Shield of Kansas City ("Blue KC")**: Provides case management services, processes Urgent Care Organ Transplant Benefit Claims (as that term is defined in Section 9.01(b)), and processes Pre-Service Organ Transplant Benefit Claims (as described in Section 9.03(a)). Blue KC also administers the Plan's Preferred Provider Organization, which means that it obtains discounts from medical providers and applies those discounts to claims for Comprehensive Medical Benefits. After Blue KC applies discounts to these claims, Blue KC receives money from the Fund to pay the claims. This means that Comprehensive Medical Benefits are funded by the Trust Fund, and Blue KC does not guarantee payment of Comprehensive Medical Benefits (in other words, the Fund actually pays for Comprehensive Medical Benefits, not Blue KC).
- **Sav-Rx Prescription Services ("Sav-Rx")**: Administers the Prescription Drug Benefits for the Plan as its Prescription Benefit Manager. Sav-Rx processes claims for Prescription Drug Benefits and then requests and receives money from the Fund to pay the claims. This means that Prescription Drug Benefits are funded by the Trust Fund and Sav-Rx does not guarantee payment of Prescription Drug Benefits.
- **Delta Dental of Missouri ("Delta Dental")**: Administers the Dental Benefits for the Plan. Delta Dental processes claims for Dental Benefit claims, then requests and receives money from the Fund to pay the claims. This means that Dental Benefits are funded by the Trust Fund and Delta Dental does not guarantee payment of Dental Benefits.

The address for each of the organizations listed above is provided in the front pages of this Summary Plan Description.

Section 13.12 - Interpretation

The Board of Trustees shall have the sole and exclusive power and discretion to interpret this Plan and to decide all questions and issues including but not limited to questions of coverage and eligibility, the method of providing or arranging for benefits, and all other related matters. Any interpretation of the Plan by the Board of Trustees shall be final and binding on all persons and parties, including the Union, the Association, Employers, Employees, Retirees, and Beneficiaries. Additionally, the Board of Trustees shall have the sole and exclusive power and discretion to interpret and construe any policy, rule, or regulation established by the Board of Trustees. Any interpretation by the Trustees of any policy, rule, or regulation that was established by the Board shall be final and binding upon all persons and parties, including the Union, the Association, Employers, Employees, Retirees, and Beneficiaries.

The Board of Trustees' authority and power includes, for example, the administrative discretion necessary to determine whether an individual meets the Plan's written eligibility requirements, or to interpret any other term contained in this Summary Plan Description.

Any decisions or actions of the Board of Trustees shall be final, binding, and conclusive as to all persons. Any such decision or action shall be accorded the highest level of judicial deference and shall be subject to reversal by a court of competent jurisdiction only if such court determines that the decision of the Board of Trustees was arbitrary or capricious.

Section 13.13 - Non-Alienation

All the benefits, monies, and/or property of the Fund shall be free from the interference and control of any creditor. Neither the Association, Union, Employers, Employees, Retirees, nor Beneficiaries shall have any right, title, or interest in the Fund other than as specifically provided for in this Plan. No Employee, Dependent or other Beneficiary shall have the right to receive any part of the contributions made to the Fund by Employers or others (except as benefits provided for hereunder) in lieu of obtaining coverage under this Plan. No benefits under this Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, garnishment, attachment, execution, or levy of any kind, nor to seizure or to sale under any legal, equitable, or any other process except as required by ERISA, and except as specifically set forth below:

- In making a claim for benefits, a Covered Person may direct that the benefits be paid directly to the health care provider who provided the treatment or supplies that are the subject of that claim;
- The Plan may direct that benefits under this Plan be paid directly to the provider of benefits, in whole or in part, in whatever manner deemed reasonable and appropriate by the Board of Trustees;
- The Plan will honor any assignment of rights made by a Covered Person or on behalf of a Covered Person as required by Medicaid. In addition, the Plan will reimburse Medicaid for payments made by Medicaid for which the Plan has a legal liability, but only to the extent the Plan is required to do so by State statute; and
- If a person who is entitled to receive a payment under the Plan is, in the determination of the Board of Trustees or the Plan Administrator or its designee, incapable of giving a valid receipt for the payment, and if no guardian or conservator has been appointed for that person, the Plan may make the payment to a person or persons who, in the judgment of the Board of Trustees, has assumed the obligations of caring for the person on whose behalf the payment is being made. In the case of an expense incurred for the treatment of a minor child, the Plan

may make the payment to the child's custodial parent, whether or not that parent is covered under this Plan.

Section 13.14 - Exclusive Benefit

This Plan is maintained for the exclusive benefit of persons eligible for benefits under the terms of this Summary Plan Description, and it shall be impossible hereunder, at any time before the satisfaction of all liabilities, for any part of the corpus or income to be used for, or diverted to, purposes other than the exclusive benefit of such persons. However, nothing herein shall prevent the Trustees from returning Employer contributions made to the Fund due to a mistake of law or fact, provided that the contributions are returned within six months from the date on which the Plan Administrator determines that the contributions were made due to such a mistake. No Participant or Beneficiary or any person claiming by or through a Participant or Beneficiary shall have any rights, title, or interest in or to the Fund, or any part thereof, except as may be specifically determined by the Trustees for the payment of benefits specified in this Summary Plan Description.

Section 13.15 - Gender and Number

In the construction of this Plan, the masculine shall include the feminine, and the singular shall include the plural, in all cases in which those meanings would be appropriate.

Section 13.16 - Plan not in Place of Workers' Compensation

This Plan is not in place of and does not affect any requirement of coverage for Workers' Compensation insurance.

Section 13.17 - Governing Law

The Plan is established in the State of Missouri. To the extent that Federal law does not apply, any questions arising under the Plan shall be determined under the laws of the State of Missouri.

Section 13.18 - Recovery of Overpayments

No person is entitled to any benefit under the Plan except as expressly provided under the Plan. The fact that payments have been made from the Plan in connection with any claim for benefits under the Plan does not establish the validity of the claim, or provide the right to have such benefits continue for any period of time, or prevent the Plan from recovering the benefits paid to the extent the Trustees ultimately determine that in fact there was no right to payment of the benefits under the Plan.

The Plan shall have the right to recover, by all legal and equitable means, any amounts paid that the recipient was not rightfully entitled to under the terms of this Plan (i.e., overpayments). This right to recovery shall include, but not be limited to, the right to recoup such amounts from future benefits to be paid to or on behalf of the Participant and his/her Dependents and the right to recoup such amounts from any benefits to be paid to or on behalf of any survivors of the Participant or Dependent. This right to recovery shall further include the right to collect additional costs incurred by the Plan to recover the overpayment (for example, attorney's fees and costs). For purposes of this Section 13.18, the term "overpayment" shall include payments made on behalf of an individual who was not eligible for coverage from the Plan (for example, if a Participant gets divorced and the Participant did not notify the Fund Office of the divorce, payments made for claims incurred by the Participant's ex-spouse are considered overpayments).

The Plan's right to recovery shall include but not be limited to the following:

(a) In the event of an overpayment of benefits to or on behalf of a Participant (including an individual who ceased to meet the Plan's definition of Participant), the Plan may recover the overpayment by:

(1) A direct recovery from the Participant;

(2) A direct recovery from the medical provider who received the overpayment;

(3) Reducing future benefits to or on behalf of the Participant; or

(4) Reducing future benefits to or on behalf of the Participant's Dependents.

(b) In the event of an overpayment of benefits to or on behalf of a Dependent (including an individual who ceased to meet the Plan's definition of Dependent), the Plan may recover the overpayment by:

(1) A direct recovery from the Dependent;

(2) A direct recovery from the Participant whose participation in the Plan was the basis for the Dependent's eligibility in the Plan;

(3) A direct recovery from the medical provider who received the overpayment;

(4) Reducing future benefits to or on behalf of the Dependent;

(5) Reducing future benefits to or on behalf of the Participant whose participation in the Plan was the basis for the Dependent's eligibility in the Plan; or

(6) Reducing future benefits to any additional Dependent of the Participant whose participation in the Plan was the basis for the Dependent's eligibility in the Plan.

ARTICLE XIV - STATEMENT OF ERISA RIGHTS

As a Participant in the Pipe Fitters Local No. 533 Health and Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of 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 that is denied or ignored, in

whole or in part, you may file suit in a state or Federal court once you have exhausted the appeals process described in Article IX - Claims and Appeals Procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ARTICLE XV - DEFINITIONS

THE FOLLOWING WORDS HAVE SPECIFIC MEANINIGS WHEN USED IN THE PLAN. IT IS IMPORTANT TO UNDERSTAND THE MEANINGS OF THESE DEFINED TERMS WHILE USING THIS BOOKLET.

15.01 Allowable Charge
15.02 Annual Out-of-Pocket Maximum
15.03 Association
15.04 Beneficiary
15.05 Board of Trustees or Trustees
15.06 Claimant
15.07 Coinsurance
15.08 Collective Bargaining Agreement
15.09 Contribution Rate
15.10 Covered Employment
15.11 Covered Person
15.12 Deductible
15.13 Dentist
15.14 Dependent
15.15 Designated Beneficiary
15.16 Eligible Employee
15.17 Employee
15.18 Employer
15.19 Fund
15.20 Fund Office
15.21 Hospital
15.22 Injury
15.23 Medically Necessary
15.24 Medicare
15.25 Nurse Practitioner
15.26 Participant
15.27 Pension Plan
15.28 Physician
15.29 Physician Assistant
15.30 Plan
15.31 Plan Administrator
15.32 Plan Sponsor
15.33 Plan Year
15.34 Reasonable, Usual, and Customary
15.35 Rescission and Coverage
15.36 Retiree
15.37 Sickness
15.38 Summary Plan Description
15.39 Trust Agreement
15.40 Union
15.41 United Association

Section 15.01 - Allowable Charge

"Allowable Charge" means:

(1) For treatment received from in-network providers, the reasonable charge for the services, not exceeding the lesser of the billed charge or the Reasonable, Usual, and Customary charge for the particular service, product, or procedure that is the subject of the claim;

(2) For treatment received from out-of-network providers:

(a) If the treatment is received in an air ambulance, then Allowable Charge means the lesser of the amount that the air ambulance billed or the qualifying payment amount;

(b) If the treatment is received in an out-of-network emergency room for an Emergency Medical Condition, then Allowable Charge means the amount that is in the applicable state's All-Payer Model Agreement unless the applicable state does not have an All-Payer Model Agreement, in which case Allowable Charge means the qualifying payment amount;

(c) If treatment is received from an out-of-network provider at an in-network Hospital or Facility, then Allowable Charge means the amount that is in the applicable state's All-Payer Model Agreement unless the applicable state does not have an All-Payer Model Agreement, in which case Allowable Charges means the qualifying payment amount; and

(d) If treatment is received from any other out-of-network provider (i.e., an out-of-network provider that is not described in (a), (b), or (c) above), then Allowable Charge means a reasonable charge for the services, not exceeding the lesser of the billed charge or the Reasonable, Usual, and Customary charge for the particular service, product, or procedure that is the subject of the claim.

For purposes of the definition of Allowable Charges, the qualifying payment amount should be calculated in accordance with the No Surprises Act, which generally means that it is the median of the Plan's contracted rates in effect as of January 31, 2019 for the same or similar services that were provided in the same geographic region, increased for inflation.

Section 15.02 - Annual Out-of-Pocket Maximum

"Annual Out-of-Pocket Maximum means the dollar amount of eligible Allowable Charges a Covered Person must incur in a single calendar year before the Plan begins to pay 100% for services and supplies provided by an in-network provider. Once a Covered Person meets his/her Annual Out-of-Pocket Maximum (or the Covered Person's family has met their Annual Out-of-Pocket Maximum), the Plan will begin to pay 100% of the Allowable Charges for services and supplies provided by in-network providers. Unless the Plan provides otherwise, Allowable Charges paid for services and supplies provided by out-of-network providers do not count towards a Covered Person's Annual Out-of-Pocket Maximum. Additionally, unless the Plan provides otherwise, there is no Annual Out-of-Pocket Maximum for out-of-network provider services and supplies.

Section 15.03 - Association

"Association" means the Mechanical Contractors Association of Greater Kansas City.

Section 15.04 - Beneficiary

"Beneficiary" means any person who is eligible to receive benefits under this Plan based on a Participant's (i.e., an Eligible Employee's or a Retiree's) participation in this Plan. Beneficiaries under this Plan include Dependents of Eligible Employees, designated covered Dependents of Retirees, and Designated Beneficiaries of Eligible Employees or Retirees under the Death Benefit and Accidental Death and Dismemberment Benefit Programs of this Plan.

Section 15.05 - Board of Trustees or Trustees

"Board of Trustees" or "Trustees" means the persons designated as members of the Board of Trustees of the Pipe Fitters Local No. 533 Health and Welfare Plan, in accordance with the Trust Agreement.

Section 15.06 - Claimant

"Claimant" means the individual who received the treatment that is the subject of a claim for benefits submitted to the Plan. Claimant also means an authorized representative or personal representative who acts on the primary Claimant's behalf with respect to a particular claim in accordance with Section 9.02.

Section 15.07 - Coinsurance

"Coinsurance" means the percentage of the total Allowable Charge that a Covered Person (and not the Plan) is responsible for paying once the Covered Person has paid his/her Deductible (or the Covered Person's family has paid their family Deductible).

Section 15.08 - Collective Bargaining Agreement

"Collective Bargaining Agreement" means the Agreement and Contract By and Between Members of Mechanical Contractors Association of Kansas City and Pipefitters Association Local Union No. 533 of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada, in effect as of the effective date of this Restated Plan Document or any successor agreement thereto.

Section 15.09 - Contribution Rate

"Contribution Rate" means the hourly rate established under the Collective Bargaining Agreement.

Section 15.10 - Covered Employment

"Covered Employment" means employment of an Employee by an Employer which requires the Employer to submit Contributions to the Plan on behalf of the Employee in accordance with the terms of the Collective Bargaining Agreement, a Participation Agreement, or the Reciprocity Agreement.

Section 15.11 - Covered Person

"Covered Person" means any person who is eligible to receive benefits from this Plan, including Participants (i.e., an Eligible Employee or a Retiree), Dependents, and Designated Beneficiaries.

Section 15.12 - Deductible

"Deductible" means the amount of Allowable Charges that a Covered Person (or the Covered Person's family) must pay each calendar year before benefits are payable from the Plan.

Section 15.13 - Dentist

"Dentist" means a health care provider licensed to practice dentistry by the State in which (s)he practices.

Section 15.14 - Dependent

"Dependent" means a child or spouse of a Participant who has met the requirements to obtain eligibility and coverage from the Plan in accordance with Section 1.11 and Section 1.12, as applicable.

Section 15.15 - Designated Beneficiary

"Designated Beneficiary" means the person designated by the Participant, or by the terms of this Plan, to receive such Participant's benefits under the Death Benefit and Accidental Death and Dismemberment Benefit articles of this Plan.

Section 15.16 - Eligible Employee

"Eligible Employee" means any Employee who has met the requirements to obtain coverage under this Plan as set forth in Article I.

Section 15.17 - Employee

"Employee" means a person who is employed by an Employer to perform work for which the Employer is obligated to submit contributions to the Plan pursuant to the terms of the Collective Bargaining Agreement, a Participation Agreement, or the United Association Health & Welfare Fund Reciprocal Agreement.

Section 15.18 - Employer

"Employer" means any of the following:

- An entity that is signatory to the Collective Bargaining Agreement or a Participation Agreement, and who is obligated to make Contributions to the Plan pursuant to the Collective Bargaining Agreement or a Participation Agreement;
- An entity that is obligated to make Contributions to the Plan pursuant to the United Association Health & Welfare Fund Reciprocal Agreement;
- The Union;
- The Association; or
- The Pipe Fitters Local No. 533 Training Center.

Section 15.19 - Fund

"Fund" means the Pipe Fitters Local No. 533 Health and Welfare Fund. (*See also* Plan.)

Section 15.20 - Fund Office

"Fund Office" means any office or other physical location out of which the Fund is administered.

Section 15.21 - Hospital

"Hospital" means:

(1) An institution constituted, licensed, and operated in accordance with the laws pertaining to hospitals, which maintains on its premises all facilities necessary to provide for the diagnosis and medical and surgical treatment of Injury or Sickness and which provides such treatment for compensation, by or under the supervision of Physicians on an inpatient basis with continuous 24-hour nursing service by Registered Nurses; or

(2) An institution which qualifies as a hospital, a psychiatric hospital, a tuberculosis hospital, or a provider of services under Medicare, and which is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations.

NOTE: Residential or nonresidential treatment facilities, health resorts, nursing homes, Christian Science sanatoria, institutions for exceptional children, skilled nursing facilities, places that are primarily for the care of convalescents, clinics, Physicians' offices, private homes, ambulatory surgical centers and hospice centers are not Hospitals.

Section 15.22 - Injury

"Injury" means physical harm sustained as the direct result of an accident and all related symptoms and recurrent conditions resulting from the same accident.

Section 15.23 - Medically Necessary

"Medically Necessary" means:

(1) A treatment, service, or supply that is:

- Furnished by a Physician or other licensed provider to identify or treat a diagnosed or reasonably suspected Sickness or Injury;
- Appropriate and necessary for the symptoms, diagnosis, or treatment of the Sickness or Injury;
- In accordance with standards of good medical practice within the organized medical community;
- Not primarily for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any Physician or other licensed provider, or any Hospital or Facility. The fact that a Physician may provide, order, recommend or approve a treatment, service, prescription drug, or supply does not mean that it will be considered Medically Necessary for the medical coverage provided by the Plan; and
- The most appropriate level of treatment that can be provided safely for the patient. For Hospital - Inpatient Services, this means that acute care as an inpatient is needed due to the kind of treatment the patient is receiving or the severity of the patient's condition, and that safe and adequate care cannot be received on an outpatient basis or in a less intensified medical setting.

(2) A prescription drug that meets all of the following criteria (i.e., a prescription drug that is considered Medically Necessary if it meets all of the following criteria):

- It is required to treat a Sickness or Injury and the absence of the drug could cause adverse consequences for the person in need of the prescription drug;
- It is appropriate and necessary for the treatment of the Sickness or Injury;
- It is in accordance with standards of good medical practice within the organized medical community; and
- It is the most appropriate level of treatment that can be provided safely for the patient.

Section 15.24 - Medicare

"Medicare" means the program of benefits provided under Title XVIII of the Social Security Act of 1965, as amended.

Section 15.25 - Nurse Practitioner

"Nurse Practitioner" means a primary treating health care provider who is both of the following:

(1) A registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner in accordance with state law, if any is applicable; and

(2) Certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners.

Section 15.26 - Participant

"Participant" means any Eligible Employee or a Retiree who has met all prerequisites to obtain coverage under this Plan and who is enrolled for coverage under this Plan.

Section 15.27 - Pension Plan

"Pension Plan" means the "Pipe Fitters Local No. 533 Pension Plan".

Section 15.28 - Physician

"Physician" means a person who is either of the following and operating within the scope of his/her license:

(1) An individual, other than a Dentist, who is licensed to prescribe and administer drugs or to perform surgery; or

(2) An individual who is an ophthalmologist, chiropractor, osteopath, psychologist, master of social work or certified registered nurse assistant.

Section 15.29 - Physician Assistant

"Physician Assistant" means a person who is both of the following:

(1) A physician assistant who is authorized by the state in which the services are furnished to practice as a physician assistant in accordance with state law, if any is applicable; and

(2) Certified as a physician assistant by a recognized national certifying body that has established standards for physician assistants.

Section 15.30 - Plan

"Plan" means the Pipe Fitters Local No. 533 Health and Welfare Plan, as herein set forth, and as from time to time amended (that is, the plan of benefits offered under the terms of the Restated Agreement and Declaration of Trust of the Pipe Fitters Local No. 533 Health & Welfare Fund).

Section 15.31 - Plan Administrator

"Plan Administrator" means the Board of Trustees of the Pipe Fitters Local No. 533 Health and Welfare Fund. The Board of Trustees retains ultimate authority as the Plan Administrator for this Plan, but may delegate the responsibility for carrying out regular Plan administration functions and activities, along with the authority to carry out such functions and activities, to a third-party administrator or other person or entity. The specific duties, responsibilities, and authority to be delegated to any third-party administrator shall be set forth in a written contract between the Board of Trustees and any such third-party administrator. As used in this Plan document, the term Plan Administrator refers to any person or entity responsible for carrying out the regular administrative functions and activities on behalf of the Plan.

Section 15.32 - Plan Sponsor

"Plan Sponsor" means the Board of Trustees of the Pipe Fitters Local No. 533 Health & Welfare Fund.

Section 15.33 - Plan Year

"Plan Year" means the 12-month period that begins on June 1 and ends on May 31.

Section 15.34 - Reasonable, Usual, and Customary

"Reasonable, Usual, and Customary" means the amount normally charged by the provider for similar services or supplies, and does not exceed the amount ordinarily charged by most providers of comparable services or supplies in the locality where the services or supplies are received. In determining whether charges are reasonable, usual,

and customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which require additional time, skill, or experience. The Plan Administrator may adopt standard protocols or other criteria to be used in determining whether a particular covered charge is reasonable, usual, and customary.

Section 15.35 - Rescission of Coverage

"Rescission of Coverage" means a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to failure to timely pay required premiums or contributions.

Section 15.36 - Retiree

"Retiree" means a former employee who is eligible to receive benefits under this Plan, as fully set forth in Section 1.06.

Section 15.37 - Sickness

"Sickness" means any abnormal physical or mental condition, including physical sickness, mental illness, or functional nervous disorder, which affects the person's ability to function normally. A recurrent sickness will be considered to be one sickness. Concurrent sicknesses will be considered one sickness unless the concurrent sicknesses are totally unrelated. The term "Sickness," as used in this Plan document, shall also include pregnancy, childbirth, or resulting complications, but not in connection with a Dependent child's pregnancy or childbirth by a Dependent child.

Section 15.38 - Summary Plan Description

"Summary Plan Description" means this combination Plan document and Summary Plan Description, and any amendments to this Plan document and Summary Plan Description.

Section 15.39 - Trust Agreement

"Trust Agreement" means the Agreement and Declaration of Trust made as of June 1, 1954, by and among the Union, the Association, and the Board of Trustees, as amended and restated on September 1, 2003, as the Restated Agreement and Declaration of Trust of the Pipe Fitters Local No. 533 Health and Welfare Fund, and as may be amended or restated from time to time in the future.

Section 15.40 - Union

"Union" means the Pipe Fitters Association Local No. 533 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States, Canada, and Australia.

Section 15.41 - United Association

"United Association" means the United Association of Journeymen and Apprentices of the Plumbing, Pipefitting, and Sprinkler Fitting Industry of the United States and Canada.