Bricklayers & Allied Craftworkers Local 5, New York Welfare Fund

Active Participant Plan

Plan Document and Summary Plan Description
Effective: April 1, 2026

BRICKLAYERS & ALLIED CRAFTWORKERS LOCAL 5, NEW YORK WELFARE FUND

Active Participant Plan

66-05 Woodhaven Blvd
Rego Park, NY 11374
Telephone: (718) 459-5800

BOARD OF TRUSTEES

Employer Trustees	Union Trustees
Daniel Depew	Michael Clifford
Matthew Pepe	David Williams

Fund Administrator
Jorge Cano

Fund Counsel
Barnes, Iaccarino & Shepherd, LLP

Consultants and Actuaries
Milliman

Auditors
Teal, Becker & Chiaramonte, CPAs, P.C.

To All Participants:

The Board of Trustees of the Bricklayers & Allied Craftworkers Local 5, New York Welfare Fund (the "Fund") is pleased to provide you with this detailed description of your benefit plan coverage.

The Trustees are proud of their achievements in prudently managing the Fund and are gratified by the scope of the benefits provided to covered individuals. The Board will continue to make every effort to maintain the maximum benefits within the limits of the Fund's income for the greatest possible advantage of each covered individual.

The following pages contain a description of the principal provisions of the benefit plan. It is separated into sections as follows:

Part A: General Information About the Plan
Part B: Health Plan Coverage and Benefits
Part C: Vacation Benefit Program
Part D: Plan Administration

The Board of Trustees are obligated to collect and administer the contributions to the benefit plan which are required by agreement between your employer and the Union or between your employer and the Trustees. In addition, the Trustees are required to formulate and administer the benefit plan itself.

The Trustees are responsible for the operation of the Plan. We will be happy to assist you in every way possible to make certain that you promptly receive the benefits to which you are entitled. The Board of Trustees is assisted in these tasks by professional counselors whom the Trustees hire from time to time. These include an attorney, an accountant, and an actuary.

It is our intention to continue the successful operation of this Plan in the sound actuarial fashion that has prevailed to date.

Your contribution in this endeavor will be increased by your complete understanding of the Plan itself and of your rights under the Plan. Accordingly, it is in your interest and that of your family to familiarize yourself completely with this booklet.

Sincerely and fraternally yours,

Board of Trustees
Bricklayers & Allied Craftworkers Local 5, New York Welfare Fund

PART A – GENERAL INFORMATION ON THE PLAN

TABLE OF CONTENTS

Important Information about the Welfare Fund....A-2
Important Contact Information....A-3
Plan Interpretation and Determination....A-4
Important Notice....A-4
Required Disclosures....A-4
Persons Covered Under the Plan....A-5
Dependent Documentation....A-7
Effective Date of Benefit Coverage....A-8
Termination Date of Benefit Coverage....A-8
Changes In Personal Status....A-8
Changes In Family Status....A-8
Right of Subrogation and Lien....A-9
Coordination of Benefits Provision....A-12
Information Concerning All Coverages....A-15
Federal Continuation of Coverage Law (COBRA)....A-16
Qualified Medical Child Support Orders....A-22
Family And Medical Leave Act....A-25
Paid Family Leave....A-25
Newborns' and Mothers' Health Protection Act....A-25
Women's Health and Cancer Rights Act....A-25
Genetic Information Non-Discrimination Act ("GINA")....A-26
Patient Protection Rights of the Affordable Care Act....A-26
No Surprises Act....A-27
Health Insurance Portability and Accountability Act Of 1996 (HIPAA) Privacy Rule....A-31
Claims And Appeals Procedures....A-32
Future of the Plan and Plan Termination....A-47

IMPORTANT INFORMATION ABOUT THE WELFARE FUND

The Bricklayers & Allied Craftworkers Local 5, New York Welfare Fund (the "Fund") believes the Plan is a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status may be directed to the Fund Administrator at (718) 459-5800. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or ***.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

IMPORTANT CONTACT INFORMATION

For Information About	*Contact*
General Plan Information and Eligibility • Eligibility • Enrollment • Information about USERRA, FMLA, QMCSOs and your rights under the Plan • Request documents or other Plan related information • Replacement ID Cards • Second Level Claim Appeals • General questions about Plan coverage **COBRA Administrator** • Information About Coverage • Adding or Dropping Dependents • Cost of COBRA Continuation Coverage • Premium payment and notices. **HIPAA Privacy and Security Officer** **Death Benefit**	**Bricklayers and Allied Craftworkers Local 5, NY Welfare Fund** 66-05 Woodhaven Blvd Rego Park, NY 11374 Telephone: (718) 459-5800 Fax: (718) 459-7033
Hospital and Medical • Precertification • Claim Forms (Medical) • Medical Claims and Appeals • Plan Benefit Information • Medical PPO Providers • Additions/Deletions of Network Providers *(Always check with the Network before you visit a provider to be sure they are still contracted with the Network.)* **Dental**	**MVP Select Care, Inc.** 625 State Street Schenectady, NY 12305
Prescription Drug • Identification (ID) Cards • List of Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information • Precertification and Step Therapy • Formulary of Preferred Drugs • Specialty Drugs (Accredo Pharmacy)	**Express Scripts** P.O. Box 66773 St. Louis, MO 63166-6773 Member Services: (844) 235-4455 Pharmacist Help Desk: (800) 922-1557
Vision	**CPS Optical** 11 Hanover Square, 8th Floor New York, NY 10005 (212) 675-5745

PLAN INTERPRETATION AND DETERMINATION

As of the effective date, this Summary Plan Description supersedes and replaces all previous materials.

The Board of Trustees is responsible for interpreting the Plan and for making determinations under the Plan. In order to carry out their responsibility, the Trustees have exclusive authority and full discretion to determine whether an individual is eligible for any benefits under the Plan; to determine the amount of benefits, if any, an individual is entitled to from the Plan; to determine or find facts that are relevant to any claim for benefits from the Plan; to interpret all of the Plan's provisions; to interpret the provisions of the Trust Agreement governing the operation of the Plan; to interpret any other document or instrument involving or having impact upon the Plan; and to interpret all of the terms used in the Plan and all of the other previously mentioned agreements, documents, and instruments.

Because you submit a claim there is no guarantee that you are eligible for benefits or that you will receive benefit payment.

This booklet describes the main features of the Plan. If there is a conflict between any provisions in this Summary Plan Description and an underlying insurance contract, the relevant provisions of the insurance contract shall control and be deemed the official governing language.

All such interpretations and determinations made in good faith by the Trustees, or their designee, shall be final and binding upon any individual claiming benefits under the Plan and upon all participants, all employers, the Union, and any party who has executed any agreement with the Trustees or the Union; shall be given deference in all courts of law to the greatest extent allowed by applicable law; and not be overturned or set aside by any court of law unless the court finds that the Trustees, or their designee, abused their discretion in making such determination or interpretation.

The Trustees have had, and shall continue to have, the discretionary authority to finally determine all issues involving interpretation and application of both the Trust Agreement and the Plan Documents, including, but not limited to, participation, eligibility for benefits, extent and duration of coverage, amount and duration of benefits and all other issues which may arise with respect to the administration or operation of the Fund or Plan. The Trustees' determination may not be overruled absent a finding that it was arbitrary or capricious, or an abuse of discretion.

IMPORTANT NOTICE

This Summary Plan Description (SPD) describes the provisions and components of the Welfare Fund as it exists on the date shown on each page of the document. From time to time these provisions may be amended. To the extent the provisions described in these pages are amended, you will receive updated information in a timely manner.

REQUIRED DISCLOSURES

If at any time there is a material reduction in covered services under the Plan, you will be notified through a Summary of Material Modifications that will be issued at least 60 days prior to the date that the modification is adopted. Alternatively, the Fund Office will notify you of any changes to the Plan.

PERSONS COVERED UNDER THE PLAN

Participants

A participant is an individual who is:

1. Employed by an employer who has a collective bargaining agreement with the Union requiring the employer to contribute to the Welfare Fund on behalf of participants covered under the agreement; and
2. Eligible to participate in the Plan according to the rules of eligibility established by the Trustees.

Dependents

Under the provisions of the Plan, the term "covered Dependent" means any of the following persons who are not employed by a participating employer:

1. The Participant's lawful spouse (if not legally separated per a judgment of separation or a duly executed and acknowledged separation agreement);
2. The Participant's unmarried or married Dependent child, under 26 years of age who:
    a. Is the Participant's natural child;
    b. Is the Participant's stepchild;
    c. Is the Participant's legally adopted child;
    d. Is a child that is placed with the Participant for adoption and for whom the Participant has assumed and retained a legal obligation to support;
    e. Is a child for whom the Participant is obligated to provide support pursuant to a Qualified Medical Child Support Order as defined by federal law;
    f. Is a child for whom the Participant is the legal guardian or for whom the Participant has legal custody. The guardianship or custodianship must be permanent and established pursuant to court order and the Participant (or the Participant and spouse) is the sole support of the child unless that child is a beneficiary under a Qualified Medical Child Support Order under federal law.

    A child who satisfies foregoing qualifications a, b, c, d, e, or f will be a covered Dependent until the end of the month in which the child attains age 26.

3. The Participant's unmarried Dependent child 26 years of age or over who would otherwise qualify as a covered Dependent per paragraph 2. above who receives no government support (Medicaid, Social Security Income, etc.) and who is incapable of self-sustaining employment because of developmental disability, mental retardation or physical handicap; became so incapable before attaining age 26; is chiefly dependent upon the Participant for support and maintenance; and the Participant furnished proof of such incapacity to the Fund within 31 days of the date such child's coverage would ordinarily terminate due to attainment of age 26. Such Dependent's coverage shall be continued as long as the Participant remains eligible under the Fund.

Persons Not Covered Under the Plan

- ♣ Any other persons not defined in this SPD as eligible;
- ♣ A legally separated or divorced former spouse of the Participant;
- ♣ A child for whom guardianship has been temporarily entered into primarily for the purpose of obtaining coverage for a person under this Plan.

Extension of Dependent Coverage

In the event a Participant dies while covered hereunder, the coverage of a dependent that was in effect at their death will be continued following the Participant's death until the later of (1) the end of the sixth calendar month following the month of the participant's death; or (2) the end of the Participant's eligibility period.

Should someone become an eligible dependent of the Participant after their death and before the end of such period, that person will become covered for the appropriate benefits until the end of such period.

DEPENDENT DOCUMENTATION

The following items are to be furnished to the Fund Office as proof and verification of eligibility for Dependents:

For a Participant's Dependent Spouse

The spouse's social security number and a copy of the certificate of marriage.

For a Participant's Dependent Child Under Age 26:

1. For your natural child or stepchild:
    a. A copy of the child's birth certificate; plus
    b. The child's social security number.
2. For your adopted child or child placed with you prior to adoption:
    a. A copy of the court order of adoption or placement; plus
    b. A copy of the child's birth certificate; plus
    c. The child's social security number.
3. For a child who is under a Qualified Medical Child Support Order or who is under court-ordered permanent legal guardianship or custodianship of a Participant:
    a. A copy of the Qualified Medical Child Support Order or the court-ordered permanent guardianship or custodianship letter issued by a court in the county of residence; plus
    b. A copy of the child's birth certificate; plus
    c. The child's social security number.

Dependent claims submitted without the proper documentation will be delayed for payment until the Fund Office can determine whether Dependent coverage is valid.

EFFECTIVE DATE OF BENEFIT COVERAGE

Initial benefit coverage for a Participant will start at their effective date as determined by the rules of benefit eligibility. Initial benefit coverage for covered Dependents of a Participant will begin at the same effective date as the Participant's coverage.

TERMINATION DATE OF BENEFIT COVERAGE

The benefit coverage of a Participant or covered Dependent will terminate on the earlier of:

1. The date the eligibility of the Participant terminates; or
2. The date a spouse is no longer eligible as a covered Dependent; or
3. The date a child is no longer eligible as a covered Dependent.

In the event the Participant passes away, termination of coverage shall be subject to the "Extension of Dependent Coverage" described above.

CHANGES IN PERSONAL STATUS

It is important that you notify the Fund Office promptly if:

- ♣ You retire from Covered Employment;
- ♣ You obtain employment outside the Collective Bargaining Agreement;
- ♣ You get married, get divorced or legally separated;
- ♣ You acquire a new Dependent by marriage, birth, or adoption;
- ♣ You want to change your designated beneficiary;
- ♣ You are receiving New York State Disability benefits;
- ♣ You are receiving Workers' Compensation benefits;
- ♣ You change your address; or
- ♣ You change your telephone number.

CHANGES IN FAMILY STATUS

If a change occurs in your family status because of marriage, birth of a child, legal separation, divorce or death, you should immediately notify the Fund Office to revise your eligibility status to meet your new circumstances.

A Participant who is individually covered who marries will transfer to family coverage after the date of marriage and receive full continuity of coverage. Dependent spouse verification for eligibility requires a copy of the marriage certificate and social security number. Dependent child verification for eligibility requires at least a copy of the child's birth certificate and social security number but may also include additional documents depending on the situation. Please refer to the Dependent documentation section for specific requirements.

RIGHT OF SUBROGATION AND LIEN

For claims involving third party liability, this subrogation provision applies to all Participants and covered Dependents, with respect to the benefits provided under this Plan. For the purposes of this provision, the terms "you" and "your" refer to all Participants and covered Dependents.

General

Occasionally, a third party may be liable for your medical expenses. This may occur when a third party is responsible for causing your Illness or Injury or is otherwise responsible for your medical bills. The rules in this section govern how the Plan pays benefits in such situations.

The subrogation and lien rules have two purposes. First, the rules ensure that your benefits will be paid promptly. Often, where there is a question of third-party liability, many months pass before the third party pays. These rules permit this Plan to pay your covered expenses until your dispute with the third party is resolved.

Second, the rules protect this Plan from bearing the full expense in situations where a third party is liable. Under these rules, once it is determined that a third party is liable in any way for the Injury or Illness giving rise to these expenses, this Plan shall have a lien for and must be reimbursed for the relevant benefits it has advanced to you out of any recovery whatsoever that you receive that is in any way related to the event which caused you to incur the medical expenses.

Right of Subrogation and Lien

If you incur covered expenses for which a third party may be liable, you must contact the Fund Office and provide full details. The Fund Office will provide you with a copy of the Plan’s subrogation and lien agreement.

The Plan’s subrogation and lien agreement requires you to reimburse the Plan for any benefit payments made on your behalf if recovery is obtained as the result of action taken against a third party. The Plan will also be subrogated to the rights against the third party and may proceed directly against the third party for recovery of expenses by the Plan.

In addition to its subrogation rights, the Plan has the right to be reimbursed for payments made on your behalf under these circumstances. The Plan shall have a lien for and must be reimbursed from any settlement, judgment, or other payment that you obtain from or on behalf of the liable third party, before any other expenses, including attorney’s fees, are taken out of the payment.

You shall not settle any claim or case or sign any release in connection with the claim or case without the prior written approval of the Trustees. If you do, the Trustees have the right to deny you any further benefits and to hold you personally responsible for the reimbursement of any benefits paid in connection with the third-party claim or case.

The Trustees reserve the right, in their sole and absolute discretion, to require the execution of the Plan's subrogation and lien form by you (or your authorized representative if you are a minor or if

you cannot sign) before the Plan pays you any benefits related to such expenses. If the Trustees have required execution of the Plan's subrogation and lien form, no benefits will be provided unless you and your attorney (if any) sign the form. You must also notify the Plan before you retain another attorney or an additional attorney since that attorney must also execute the form. In no event shall the failure of the Trustees to require execution of the subrogation and lien form diminish or be considered a waiver of the Plan's rights of subrogation and reimbursement.

Repayment of Medical Benefits

By accepting benefits related to an Illness or Injury that is the result of an act or omission of another, you agree:

- that the Plan has established a lien on any recovery received by you (or your Dependent, legal representative, or agent);
- to notify and consult with the Plan and the Plan Administrator (or its duly authorized designee) before starting any legal action or administrative proceeding that may relate to or involve recovery of any payments of Plan benefits;
- to notify any third party responsible for your Illness or Injury of the Plan's right to reimbursement for any claims related to your Illness or Injury;
- to hold any reimbursement or recovery received by you (or your Dependent, legal representative, or agent) in trust on behalf of the Plan to cover all benefits paid by the Plan with respect to such Illness or Injury and to reimburse the Plan promptly for the benefits paid, even if you are not fully compensated ("made whole") for your loss and regardless of whether any proceeds received by you are characterized in the settlement or judgment as being paid on account of expenses for which Plan benefits were paid;
- that the Plan has the right of first reimbursement against any recovery or other proceeds of any claim against the other person (whether or not the Participant is made whole) and that the Plan's claim has first priority over all other claims and rights;
- to reimburse the Plan in full up to the total amount of all benefits paid by the Plan in connection with the Illness or Injury from any recovery received from a third party, regardless of whether the recovery is specifically identified as a reimbursement of medical expenses. All recoveries from a third party, whether by lawsuit, settlement, insurance, or otherwise, must be turned over to the Plan as reimbursement up to the full amount of the benefits paid;
- that the Plan's claim is not subject to reduction for attorney's fees or costs under the "common fund" doctrine or otherwise;
- that, in the event that you elect not to pursue your claim(s) against a third party, the Plan will be equitably subrogated to your right of recovery and may pursue your claims;
- to assign, upon the Plan's request, any right or cause of action to the Plan;
- not to take or omit to take any action to prejudice the Plan's ability to recover the benefits paid and to cooperate in doing what is reasonably necessary to assist the Plan in obtaining reimbursement;
- to cooperate in doing what is necessary to assist the Plan in recovering the benefits paid or in pursuing any recovery, including, without limitation, keeping the Plan and the Plan Administrator (or its duly authorized designee) apprised of all material developments with respect to any relevant claims, actions, or proceedings;

- to forward any recovery to the Plan within ten days of disbursement by the third party or to notify the Plan as to why you are unable to do so; and
- to the entry judgment against you and, if applicable, your dependent, in any court for the amount of benefits paid on your behalf with respect to the Illness or Injury to the extent of any recovery or proceeds that were not turned over as required and for the cost of collection, including but not limited to the Plan's attorneys' fees and costs.

No benefits will be payable for charges and expenses which are excluded from coverage under any other provision of the Plan.

The Plan may permit you to turn over less than the full amount of benefits paid and recovered as it determines in its sole discretion. Any reduction of the Plan's claim is subject to prior written approval by the Plan. The Plan will have the right to recover from you, your dependents (and/or any other person, entity, or trust in possession of such funds sought by the Plan) all benefits paid on your or your dependent's behalf by the Plan for Injuries or disabilities that you or your Dependents have suffered for which you or they recover money in a "third party" claim or lawsuit or settlement thereof.

If you are injured as a result of the negligence or wrongful act of a third party, you should contact your attorney for advice and counsel. However, this Plan will **not** pay for the fees your attorney might charge.

Assignment of Claim/Credit Against Future Benefits

The Trustees, in their sole discretion, may require you to assign your entire claim against the third party to the Plan. The Plan may enforce its right to reimbursement by filing a lawsuit, recouping the amount owed from a Participant's future benefit payments (regardless of whether benefits have been assigned by a Participant to the doctor, hospital or other provider), or pursuing any other remedy available to the Plan. If the Plan recovers from the third party any amount in excess of the benefits paid to you, plus the expenses incurred in making the recovery, then the excess will be paid to you.

Failure to Disclose and/or Cooperate

If you fail to tell the Plan that you have a claim against a third party or if you fail to assign your claim against the third party to the Plan when required to do so (and to cooperate with the Plan's subsequent recovery efforts); or if you fail to require any attorney you subsequently retain to sign the Plan's subrogation and lien form; or if you and/or your attorneys fail to reimburse this Plan out of any payment you obtain from the third party; and/or if you fail to fully reimburse the Plan (out of any settlement you receive, or otherwise, even if the Plan reduces the amount of its lien or otherwise limits its rights); then you are personally liable to the Plan for the reimbursement to the Plan for the benefits paid on your behalf. The Plan may offset the amount you owe from any future benefits for claims submitted on behalf of you or your covered Dependents, whether or not such other claim is related to the Injury or Illness giving rise to the third-party claim.

COORDINATION OF BENEFITS PROVISION

Some individuals have coverage in addition to the benefits provided by this Plan. When this happens, the amount of benefits payable under this Plan will take into account any coverage you or your covered Dependent(s) have under "other plans" so the combined benefits under this Plan and the "other plan" will not be more than the total expenses involved. Information necessary to the administration of this Coordination of Benefits provision will be required at the time a claim is submitted.

If you are a person with multiple benefit coverage, you must make a full disclosure when filing a claim with this Plan. If you fail to disclose "other plan" information, this may be considered a fraudulent claim with you being disqualified from receiving benefits from this Plan.

For coordinating benefits of multiple coverages, "Plan" means any of the following that provides benefits or services for, or because of, medical or dental care or treatment:

- Another group or individual non-group health care plan (including but not limited to a plan which provides the Covered Individual with COBRA Continuation Coverage); or
- Medicare; or
- Other government program, such as Medicaid, TRICARE, or a program of the U.S. Department of Veterans Affairs, motor vehicle insurance including but not limited to no-fault, uninsured motorist, or underinsured motorist coverage for medical expenses or loss of earnings that is required by law, or any coverage provided by a federal, state, or local government or agency; or
- Workers' Compensation; or
- Coverage resulting from a judgment at law or settlement; or
- Any responsible third party, its insurer, or any other source on behalf of that party; or
- Any first party insurance (e.g., medical, personal injury, no-fault, underinsured motorist or uninsured motorist coverage); or
- Any policy from any insurance company or guarantor of a third party; or
- Any other source (e.g., crime victim restitution, medical, disability, school insurance, etc.).

This Plan will pay its regular benefits in full, or in a reduced amount which, when added to the benefits provided by other plans, will equal 100% of the "allowable expenses" incurred. "Allowable expenses" means any necessary, reasonable, and customary expenses incurred while eligible under this Plan, part or all of which would be covered under any other plans. Expenses with no coverage by this Plan or any other plan are not allowable expenses.

In coordinating benefits for an individual having multiple coverages, the "primary" plan pays first and the "secondary" plan pays next. The total benefits paid by this Plan when it is “secondary”, when added to the total benefits paid by another plan which is “primary”, will not exceed 100% of the allowable expenses incurred. In addition, this Plan will not pay more benefits than it would normally provide without this special coordinating provision.

When duplicate coverage arises, and both plans contain a Coordination of Benefits provision, the plan covering the person incurring the claim as a Participant is the primary plan. If an individual is covered under two plans through two jobs, the plan which has covered them for the longer period of time pays first. When another plan does not contain a Coordination of Benefits provision, it will always be considered the primary plan. Payment under the secondary plan is made after the amount payable by the primary plan has been determined.

The order of payment rules used when coordinating benefits of a Dependent child who is covered by both parents' group plans are as follows:

1. Under the "birth date" coordination rule, the plan which covers the parent whose date of birth, excluding year of birth, occurs earlier in a calendar year, will be the "primary" plan for the child. The plan which covers the parent whose date of birth, excluding year of birth, occurs later in a calendar year, will be the "secondary" plan for the child.

   A plan which does not have the “birth date” coordination rule but the “gender” coordination rule will always be considered the primary plan.

2. When the parents are divorced or legally separated (per a judgment of separation or a duly executed and acknowledged separation agreement), the order of payment is:

   a. The plan of the parent with custody is "primary" for payment and the plan of the parent without custody is "secondary" for payment; and

   b. If the parent with custody is remarried, the order of payment is:
      - ♣ The plan of the parent with custody;
      - ♣ The plan of the adoptive parent; and
      - ♣ The plan of the parent without custody.

3. If there is a court decree stating that one of the parents is responsible for the child’s health care expense, the plan of that parent will pay first. That order will supersede any other given in 1 or 2.

4. If there is a court decree stating that the parents will share joint custody, without stating that one of the parents is responsible for the child’s health care expense, the “birth date” coordination rule described in 1. above applies.

If a husband and wife are both covered as Participants under this Plan, benefits will be provided for both persons and their eligible Dependent children on the same coordinated basis as if two separate plans were involved.

Whenever payments are made by another plan that were to be made by this Plan according to the coordination of benefit rules, this Plan will have the right to pay that plan to satisfy the intent of the coordination of benefits rules.

Payments made and the amounts paid are exercisable alone by this Plan and in its sole discretion. They are considered as benefits paid by this Plan and, to the extent of these payments, this Plan is fully discharged from liability.

Special "Benefits Deductible" Coordinating Provisions

1. Should a person who has primary coverage as a Participant or covered Dependent in another plan or is denied benefits under that plan because he or she elected not to comply with its rules or elect not to use the benefits available under that plan, then this Plan will apply a "benefits deductible" to such expenses incurred before any secondary benefits are paid by this Plan. The "benefits deductible" will be the equivalent of those benefits that would have been payable by the other plan.

2. Should a person who qualifies for benefit coverage as a covered Dependent spouse under this Plan:

   a. Also qualify for individual participant non-contributory primary coverage under the plan of their employer and "waive out" or "opt out" of such coverage under the employer's plan; or

   b. Also qualify for individual participant contributory primary coverage under the primary plan of their employer and "waive out" or "opt out" of such coverage under the employer's plan and for such waiver of coverage receive a financial incentive from the employer:

   Then this Plan will apply a "benefits deductible" to any expenses incurred by such person before any secondary Dependent benefits are payable by this Plan. The "benefits deductible" will be the equivalent of the individual participant benefits that would have been payable by the other plan of their employer.

Coordination of Benefits Claim Filing Information

Whether this Plan is primary or secondary, the Fund Office needs all necessary information about other coverage completed on your claim form before payment will be made for any claim involving coordination of benefits.

If this Plan is primary, send the Fund Office your original itemized bills along with your completed claim form.

If this Plan is secondary, send your bills to your primary plan first. After you receive payment or rejection of your claim from the primary plan, send the Fund Office a copy of your bills, the payment or rejection statement from the primary plan, and your completed claim form.

INFORMATION CONCERNING ALL COVERAGES

For the purposes of this provision, the terms “you” and “your” refer to all Participants, retired members, and covered Dependents.

The benefits provided by this Plan (other than the death benefit or disability benefits) are for reimbursement of incurred expenses. No payment by the Plan will be made for any expenses that you are legally liable for in the absence of Plan coverage.

These pages describe the main features of the Plan. The terms of the insured benefits are described completely in the group insurance contracts issued to the Trustees. These contracts of insurance govern all the rights of the insured benefits, including the descriptions contained herein.

Plan benefits for you are not guaranteed and may be changed by the Board of Trustees. All Plan provisions are subject to such rules and regulations adopted by the Trustees; the Trust Agreement which established and governs the Fund's operations; and the provisions of any group insurance policy purchased by the Trustees.

The Trustees reserve the right to amend, modify, or discontinue the types and amounts of benefits by the Plan; the eligibility rules, including those rules providing, extending, or accumulating eligibility even if the extended eligibility was already accumulated; or all or part of the Plan whenever, in their judgment, conditions make it necessary.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim is incurred.

The Board of Trustees is entitled to recover by any means available, including legal proceedings or the reduction of future benefits, any benefits that are obtained from the Plan through fraud or the submission of false benefit claims.

Contact the Fund Office if you have any questions about the terms of the Plan or proper payment of benefits.

These pages and the Fund office personnel are your authorized sources for Plan information. The Trustees have given no one else authority to speak for them regarding this Plan.

FEDERAL CONTINUATION OF COVERAGE LAW (COBRA)

Introduction

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of health coverage provided by the Fund. This section generally explains COBRA continuation coverage, when it may become available to you and your Dependents, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you when you would otherwise lose your coverage in the Fund. It can also become available to your eligible Dependents when they would otherwise lose their coverage in the Fund.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of the Fund's health coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse, and your Dependent children would be considered qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Participants have the right to elect COBRA continuation coverage if eligibility for benefit coverage is terminated (for reasons other than gross misconduct) according to the "Rules for Benefit Eligibility" stated in Part B of this SPD.

The covered spouse of a Participant has the right to elect COBRA continuation coverage if eligibility for benefit coverage is terminated for any of the following reasons:

- ♣ The death of the Participant; or
- ♣ The termination of the Participants' eligibility (for reasons other than gross misconduct); or
- ♣ The Participant becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- ♣ The termination of the covered spouse's eligibility by reason of divorce or legal separation from the Participant.

A covered child of a Participant has the right to elect COBRA continuation coverage if eligibility for benefit coverage is terminated for any of the following reasons:

- ♣ The death of the Participant; or
- ♣ The termination of the Participant's eligibility (for reasons other than gross misconduct); or
- ♣ The Participant becomes entitled to Medicare benefits (Part A, Part B, or both); or
- ♣ Parent's divorce or legal separation; or
- ♣ The covered child ceases to qualify as a "covered Dependent child" as defined by the Plan.

What Coverage is Available?

The Fund does not provide COBRA continuation coverage of any death benefit or disability benefit coverage provided by this Plan.

When is COBRA Coverage Available?

The Fund will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or a reduction of hours of employment, death of the Participant, or the Participant's becoming entitled to Medicare benefits (under Part A, part B, or both), the employer must notify the Fund Administrator of the qualifying event.

The employer must notify the Fund Administrator within 30 days after the date of the qualifying event or within 30 days after the loss of coverage, whichever is later. Such notice from the employer must include the name of the Fund, the identity of the Participant, the qualifying event, and the date of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events, it is the personal and direct responsibility of the Participant or covered Dependent to notify the Fund Office in writing:

- ♣ Of a divorce or legal separation which results in a covered spouse's eligibility for benefit coverage being terminated; and
- ♣ of a covered Dependent child attaining the maximum age, resulting in the covered child's eligibility for benefit coverage being terminated; or
- ♣ of a disability determination, including a determination that you are *no longer* disabled, or if you are determined to be disabled while you are on COBRA continuation coverage.

To be eligible to elect COBRA continuation coverage, the Participant or covered Dependent must provide this notice ***within 60 days*** of the later of: (a) the qualifying event, (b) the date on which eligibility for benefit coverage is lost due to the qualifying event, or (c) the date on which you are informed, by this SPD or by a general COBRA notice, of your obligation to provide this notice to the Fund Administrator and the procedures for providing this notice.

You must provide this notice in writing. Such notice must include the name of the Fund, the identity of the Participant and any other qualified beneficiaries, the qualifying event or disability determination, and the date of the qualifying event or disability determination. Failure to give notice within this 60-day period results in the loss of the affected person's right to elect continuation coverage.

How is COBRA Coverage Provided?

Once the Fund Administrator receives notice that a qualifying event has occurred, the Fund Office will notify the qualified beneficiaries in writing of their right to elect continuation coverage. Each qualified beneficiary will have an independent right to elect COBRA continuation

coverage. However, Participants may also elect COBRA continuation coverage on behalf of their covered spouses, and parents may elect COBRA continuation coverage on behalf of their covered children.

Election Period

You must elect COBRA continuation coverage within 60 days of the date you are notified of your right to elect COBRA continuation coverage or the date that your coverage ends, if later.

You must complete and return the election form provided to you by the Fund Administrator. Your coverage under the Plan will be continued under COBRA from the day that you would have lost coverage provided that:

a. The election form is completed and received by the Fund Office within 60 days of the date you were notified of your right to elect COBRA continuation coverage or 60 days from the date of your "qualifying event," whichever is later, and

b. The initial required premium is paid to the Fund within 45 days following the date of your COBRA election and is thereafter remitted to the Fund when due.

A qualified beneficiary has the right to elect continuation coverage even if they are already covered under another group health plan (or entitled to Medicare).

Paying for Your COBRA Continuation Coverage

If you elect COBRA continuation coverage, you are responsible for the payment of the required monthly premium, the amount of which will be provided to you with the election form, as follows:

a. You have 45 days from the date of your election of COBRA continuation coverage to pay to the Fund Office the required monthly premiums from the first month that you are required to self-pay for COBRA continuation coverage. **Remember, the first premium payment must cover the period of COBRA continuation coverage for all months for which you must self-pay through the date of the payment**. For example, if you lose coverage as of March 1 and elect to take COBRA coverage on April 15, you have until May 31 to make your first premium payment, but it must cover the period going back to March 1 – the date you had to begin to self-pay for COBRA coverage – which is three months.

b. Payment thereafter must be made on or before the first day of each month. You will have a grace period to pay the required monthly premium until the end of the month or 30 days, whichever is longer.

Failure to pay the required monthly premium by the end of the grace period will result in the termination of your COBRA continuation coverage back to the beginning of the month. All claims submitted for services rendered in that month will be denied. Once terminated, your COBRA continuation coverage cannot be reinstated.

Premium for COBRA Continuation Coverage

You will be notified of the amount of the monthly premium when you receive your COBRA election form. The Board of Trustees will set the amount of the monthly premium according to federal law. The Trustees may only change the COBRA premium annually.

How Long Does Coverage Last?

Qualifying Event Causing Health Care Coverage to End	Employee	Spouse	Dependent Child(ren)
Employee terminated (for other than gross misconduct).	18 months	18 months	18 months
Employee reduction in hours worked (making employee ineligible for the same health care coverage).	18 months	18 months	18 months
Employee dies.	N/A	36 months	36 months
Employee becomes entitled to Medicare.	N/A	36 months	36 months
Employee becomes divorced.	N/A	36 months	N/A
Dependent Child ceases to have Dependent status.	N/A	N/A	36 months

When a covered employee's Qualifying Event (e.g., termination of employment or reduction in hours) occurs within the 18-month period after the employee becomes entitled to Medicare (entitlement means the employee is eligible for and enrolled in Medicare), the employee's covered spouse and dependent children who are Qualified Beneficiaries (but not the employee) may become entitled to COBRA Continuation Coverage for a maximum period that ends 36 months after the Medicare entitlement.

A child who is born to or placed for adoption with the former Participant during a period of continuation coverage is eligible to become a qualified beneficiary. The Participant must give written notice to the Fund Administrator within 60 days of the birth or adoption of the child by the Participant.

There are two ways in which the 18-month period of COBRA continuation coverage can be extended. In no event can the COBRA continuation period be extended for more than 36 months.

Disability Extension of the 18-Month Period of COBRA Continuation Coverage

If the Social Security Administration determines that you are disabled and you notify the Fund Administrator in a timely fashion, you and your eligible Dependents may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months of continuation coverage. You must be determined to be disabled beginning before the 60th day of COBRA continuation coverage and your disability must last at least until the end of the 18-month period of continuation coverage.

To be eligible for this disability extension, you must provide notice to the Fund Administrator of your disability within 60 days after (a) the date of the disability determination, or (b) the date on which you are informed, by this SPD or by a general COBRA notice, of your obligation to provide

this notice to the Fund Administrator and the procedures for providing this notice, whichever is later.

Such notice **must** be provided in writing to the Fund Administrator. Such notice must include the name of the Fund, the identities of the Participant and the qualified beneficiaries, the disability determination, and the date of the determination.

Second Qualifying Event Extension of the 18-Month Period of COBRA Continuation Coverage

If you experience another qualifying event while receiving 18 months of COBRA continuation coverage, your covered spouse and Dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Fund Office is properly notified of the second qualifying event. This extension may be available to the covered spouse and any children receiving COBRA continuation coverage if the former Participant dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), gets divorced or legally separated, or if the Dependent children cease to be covered Dependent children as defined by the Plan, but only if the second event would have caused the covered spouse or children to lose coverage under the Plan had the first qualifying event not occurred.

To be eligible for this second qualifying event extension, you **must** provide this notice within 60 days after (a) the date of the second qualifying event, or (b) the date on which you are informed, by this SPD or by a general COBRA notice, of your obligation to provide this notice to the Fund Administrator and the procedures for providing this notice, whichever is later.

You **must** provide this notice in writing to the Fund Administrator. Such notice must include the name of the Fund, the identities of the former Participant and the qualified beneficiaries, the second qualifying event, and the date of the event.

If you or a covered Dependent have other group health coverage or Medicare at the time of a qualifying event, you or your covered Dependent will be eligible for COBRA continuation coverage. Coordination of Benefit rules will be applied in the same manner as before the qualifying event.

Termination of COBRA Continuation Coverage

Continuation coverage under COBRA will cease on the first of the following dates:

a. The date the Fund terminates;

b. The date the Fund ceases to provide the group health coverage;

c. The first day of the month for which you fail to pay the required monthly premium;

d. The date you become entitled to Medicare benefits following eligibility for COBRA continuation coverage;

e. The date the applicable period of COBRA continuation coverage is exhausted (18, 29, or 36 months); or

f. The date you become covered under another group health plan.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Instead of purchasing COBRA continuation coverage from this Plan, there may be alternative health insurance coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at ***.HealthCare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact identified below. 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") in your area or visit the EBSA website at ***.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

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

Bricklayers & Allied Craftworkers Local 5, New York Welfare Fund
66-05 Woodhaven Blvd
Rego Park, NY 11374
Tel: (718) 459-5800
Fax: (718) 459-7033

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Omnibus Budget Reconciliation Act of 1993 requires group health plans to recognize "qualified medical child support orders" by providing benefits for a Participant's Dependent child in accordance with the requirements of such an order.

A "Medical Child Support Order" ("MCSO") means a judgment, decree, or order (including a judicially approved settlement agreement having the effect of an order issued, and filed by a court of competent jurisdiction) which:

1. Provides child support with respect to a Dependent child of a Participant under the Bricklayers & Allied Craftworkers Local 5, New York Welfare Fund group health plan or provides for health benefit coverage to such a child, and is made pursuant to a state domestic relations law and relates to benefits provided under the Plan; or

2. Relates to benefits provided under the Plan and does not require the Plan to provide any type or form of benefit or any option not otherwise provided under the Plan except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act.

A "Qualified" Medical Child Support Order ("QMCSO") means a Medical Child Support Order that:

1. Creates or recognizes the existence of an alternative recipient's rights to, or assigns to an alternate recipient the right to receive benefits for which a Participant or beneficiary is eligible under a group health plan, and

2. Contains the information required to be included in a qualified order as described in the "Requirements for Qualification" section and otherwise satisfies the requirements of a Medical Child Support Order as defined above.

In addition, an "appropriately completed" National Medical Support Notice must be treated as a QMCSO. A National Medical Support Notice is a standardized medical child support order that is to be used by State child support enforcement agencies to enforce medical child support obligations.

Requirements for Qualification

A Medical Child Support Order does not meet the requirements for qualification unless the order clearly specifies:

A. The name and last known mailing address (if any) of the Participant and the name and mailing address of each alternate recipient covered by the order;

B. A reasonable description of the type of coverage to be provided by the Plan to each such alternate recipient, or the manner in which such type of coverage is to be determined;

C. The time period for which the order applies; and

D. Each Plan to which such order applies.

A Medical Child Support Order may not require a Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of any state laws relating to Medical Child Support Orders with which the Plan must comply.

An alternate recipient is any child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment in the Plan with respect to such Participant. An alternate recipient may be terminated from coverage under the same terms and conditions as apply to any other beneficiary, i.e., election of COBRA continuation coverage upon termination, lay-off, or death of the Participant. The Plan does not have an extended obligation to the alternate recipient after COBRA benefits have expired.

Qualification Process

The following procedure applies if the Fund Office is served with a Medical Child Support Order ("Order") claimed to be a QMCSO seeking benefit coverage under the Plan on behalf of a Participant's Dependent child:

1. The Fund Office will notify the Participant and any other named alternate recipient that such an Order has been received and forward a copy of the QMCSO determination procedure to the Participant and each other named alternate recipient specified in the Order at the address specified in such Order.

2. The Fund Office will determine whether the Order is qualified based on compliance with the requirements of applicable Federal law, including whether:

   a. The copy of the Order is certified;

   b. The Order is a medical child support order issued by a court pursuant to a state domestic relations law and relating to the provision of child support of a Dependent of a Participant;

   c. The Order specifies the name and last known mailing address (if any) of the Participant and each alternate recipient named in the Order, or if not, that the information is available from Fund records; and

   d. The Order clearly identifies the plan or plans affected.

3. If the Order is determined to be a Qualified Order, the Fund Office will notify the Participant and other alternate recipients named in the Order of such determination.

4. Any Participant, beneficiary, or alternate recipient who is dissatisfied with the determination can make a written request for review of the decision. A determination of the status of the

document as a Medical Child Support Order and/or whether any Medical Child Support Orders submitted are "qualified" shall become final in the absence of a written appeal postmarked no later than 90 days after the date reflected on the determination. Upon receipt of an appeal, the Board of Trustees shall issue a decision within 60 days.

5. Any alternate recipient who elects to designate a representative for receipt of copies of notices and determinations that are sent by the Fund to that alternate recipient can do so by filing a written notification with the Board of Trustees of the name and address of the representative. Once the designation is received by the Board of Trustees, all notices and determinations issued after the receipt date will be sent to the representative until such time as the alternate recipient provides written notice of the desire to change the designated representative or the address to which the designated representative is sent, revokes the designation of representative, or the Medical Child Support Order expires by its own terms.

6. When the Plan benefits are provided under a policy of insurance, or under a Health Maintenance Organization ("HMO"), the Board of Trustees delegates to the insurer or HMO its discretion to construe or determine whether a Medical Child Support Order is Qualified. The insurer's or HMO's decisions in all such matters shall be controlling, binding, and final. This provision does not, however, allow the insurer or HMO the right to extend coverage to persons who would not be eligible under this Plan.

7. Any payment for benefits made by a group health plan under a QMCSO for reimbursement of medical expenses incurred by the child named in the Order, and which are paid out-of-pocket by the eligible employee, custodial parent, or legal guardian, must be made to the Participant, custodial parent, or legal guardian.

8. Any determination that an Order is a QMCSO which is made more than 18 months from the date on which the first payment of group health benefits would be required to be made under the Order will apply prospectively (i.e., the Plan shall not be liable for payments of group health benefits for the period before the Order was determined to be a QMCSO). The Plan shall be discharged from any obligation or liability to any Participant or alternate recipient to the extent of any payment of group health benefits made pursuant to these procedures, provided the Trustees acted in accordance with their fiduciary responsibility.

9. The Trustees may require any Participant and any alternate recipient to furnish such releases, documents, or information as the Trustees may require for the administration of the Plan and determination whether an Order is or is not a QMCSO.

10. Neither the Plan, the Trustees, nor Fund Office employees are liable: for any loss, cost, or suffering occasioned by any delay in determining whether an Order is a QMCSO; or for any payment made or withheld as a result of such determination, provided such determination is made in accordance with ERISA's fiduciary responsibility provisions.

FAMILY AND MEDICAL LEAVE ACT

The Family and Medical Leave Act ("FMLA") is a Federal law that includes some provisions that may extend your eligibility for benefits from the Fund in situations where you take a leave of absence from employment for family or medical reasons. Only certain employers are obligated to abide by the FMLA and you should consult with your employer regarding eligibility and qualification for FMLA leave as well as any particular rules which your employer may have adopted with respect to such leave.

During the period of a qualified unpaid leave, you have the right under the Family and Medical Leave Act to continue to receive comparable benefit coverage for employer-sponsored medical, prescription drug, dental, and vision benefits. You are not eligible for any death benefit or disability benefit coverages during FMLA leave.

PAID FAMILY LEAVE

The New York State Paid Family Leave Law provides job-protected, paid time off so you can bond with your newly born, adopted, or fostered child within the first 12 months of birth or placement; take time to care for your spouse, domestic partner, child/stepchild, parent/stepparent, parent-in-law, grandparent, or grandchild, or sibling with a serious health condition; or take time to assist your spouse, domestic partner, child/stepchild, parent/stepparent or parent-in-law when they are deployed abroad on active military service. If you are taking approved Paid Family Leave, your Employer is responsible for making contributions to the Plan on your behalf, as if you are working, to maintain your eligibility. You MAY be required to submit your portion of contributions directly to the Fund Office to maintain eligibility. Check with your employer if they will make payments on your behalf.

To find out more about Paid Family Leave and the terms on which you may be entitled to it, contact your Employer or visit **********.paidfamilyleave.ny.gov/.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

This Plan may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child 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 mothers' and newborns' 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under the Women's Health and Cancer Rights Act of 1998, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain re-constructive surgery. Therefore, Participants who receive benefits under this

Plan in connection with a mastectomy, and who elect breast reconstruction, will be covered, in a manner determined in consultation with the attending Physician and the patient, for:

- Reconstruction of the breast on which the mastectomy is performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Coverage for these mastectomy-related services or benefits will be subject to the same copayment provisions that apply to other medical or surgical benefits under the Plan.

GENETIC INFORMATION NON-DISCRIMINATION ACT ("GINA")

GINA prohibits discrimination by group health plans, such as the Fund, against an individual based on the individual's genetic information. Group health plans and health insurance issuers generally may not request, require, or purchase genetic information for underwriting purposes, and may not collect genetic information about an individual before the individual is enrolled or covered. Pursuant to the applicable requirements of GINA, the Fund is also prohibited from setting premium and contribution rates for the group based on genetic information of an individual enrolled in the Fund.

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

The Fund does not require the designation of a primary care provider. However, you may wish to choose a primary care provider who participates in the network and who is available to accept you or your family members. For a list of the participating primary care providers, contact the telephone number on the back of your Identification Card or access MVP Healthcare's website at **********.mvphealthcare.com/find-care/doctor.

For Children, you may choose a pediatrician as the primary care provider.

You do not need prior authorization from the Fund or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in the Fund's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card, or access MVP Healthcare's website at **********.mvphealthcare.com/find-care/doctor.

As noted above, the Fund does not require the selection or designation of a primary care provider. You can visit any In-Network or Out-of-Network Health Care Professional; however, payment by the Plan may be less for the use of an Out-of-Network provider.

NO SURPRISES ACT

The Plan follows the requirements set forth by the No Surprises Act ("NSA"). The NSA sets forth the following requirements on how certain benefits must be covered:

Emergency Services

Emergency Services will be covered as follows:

1. Without the need for any prior authorization determination, even if the services are provided on an Out-of-Network basis;
2. Without regard to whether the Health Care Provider furnishing the Emergency Services is an In-Network Provider or an In-Network emergency facility, as applicable, with respect to the services;
3. Without imposing any administrative requirement or limitation on Out-of-Network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from In-Network Providers and In-Network emergency facilities;
4. Without imposing cost-sharing requirements on Out-of-Network Emergency Services that are greater than the requirements that would apply if the services were provided by an In-Network Provider or In-Network emergency facility;
5. By calculating the cost-sharing requirement for Out-of-Network Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and
6. By counting cost-sharing payments you make with respect to Out-of-Network Emergency Services toward your deductible and out-of-pocket maximum in the same manner as those received from an In-Network Provider.

As a result of the No Surprises Act, you will no longer be responsible for balance billing associated with the use of Out-of-Network Emergency Services.

Non-Emergency Services Performed by an Out-of-Network Provider at an In-Network Facility

Non-Emergency Services performed by an Out-of-Network Provider at an In-Network Health Care Facility will be covered as follows:

1. With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by an In-Network Provider;
2. By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such In-Network Provider were equal to the Recognized Amount for the items and services; and
3. By counting any cost-sharing payments made toward any deductible and out-of-pocket maximums applied under the Plan in the same manner as if such cost-sharing payments were made with respect to items and services furnished by an In-Network Provider.

Notice and Consent Exception: Non-emergency items or services performed by an Out-of-Network Provider at an In-Network facility will be covered based on the Out-of-Network cost-sharing if:

a. At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), you are provided with a written notice, as required by federal law, that the provider is an Out-of-Network Provider with respect to the Plan, the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, the names of any In-Network Providers at the facility who are able to treat you, and that you may elect to be referred to one of the In-Network Providers listed; and
b. You give informed consent to continued treatment by the Out-of-Network Provider, acknowledging that you understand that continued treatment by the Out-of-Network Provider may result in greater cost to you.

The notice and consent exception does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Out-of-Network Provider satisfied the notice and consent criteria.

Out-of-Network Air Ambulance Services

If you receive Air Ambulance services that are otherwise covered by the Plan from an Out-of-Network Provider, those services will be covered by the Plan as follows:

- The Air Ambulance services received from an Out-of-Network Provider will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by an In-Network Provider.
- In general, you cannot be balance billed for these items or services. Your cost-sharing will be calculated as if the total amount that would have been charged for the services by an In-Network Provider of Air Ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.
- Any cost-sharing payments you make with respect to covered Air Ambulance services will count toward your In-Network deductible and In-Network out-of-pocket maximum in the same manner as those received from an In-Network Provider.

Continuity of Care

In the event a Participant is a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Participant shall have the right to continuation of care.

The Plan shall notify the Participant in a timely manner, but in no event later than 7 calendar days after termination that the Provider's contractual relationship with the Plan has terminated, and that the Participant has rights to elect continued transitional care from the Provider. If the Participant

elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when the Participant ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

1. is undergoing a course of treatment for a serious and complex condition from a specific Provider;
2. is undergoing a course of institutional or Inpatient care from a specific Provider;
3. is scheduled to undergo non-elective Surgery from a specific Provider, including receipt of postoperative care with respect to the Surgery;
4. is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider; or
5. is or was determined to be terminally ill and is receiving treatment for such Illness from a specific Provider.

Note that during continuation, although Plan benefits will be processed as if the termination had not occurred and the law requires the Provider to continue to accept the previously-contracted amount, the contract itself will have terminated, and thus the Plan may be unable to protect the Participant if the Provider pursues a balance bill.

Incorrect In-Network Provider Information

A list of In-Network Providers is available to you without charge by visiting ***.mvphealthcare.com/find-care/doctor or by calling the phone number on your MVP Healthcare ID card. The network provider directory contains the name, address, specialty, telephone number, and digital contact information of each Health Care Provider or Health Care Facility with which the Plan has a contractual relationship for furnishing items and services.

MVP Healthcare updates its directories at least every 90 days and will respond to an inquiry about the network status of a provider or facility within one business day.

If you obtain and rely upon incorrect information about whether a provider is an In-Network Provider from the Plan, the Plan will apply In-Network cost-sharing to your claim, even if the provider was an Out-of-Network Provider at the time the service was rendered. **However, it is your responsibility to confirm that the provider or facility that you have selected is In-Network at the time you receive services.**

External Review Process of Certain Coverage Determinations

If your claim for benefits related to items and services covered under the No Surprises Act has been denied (i.e., an adverse benefit determination), and you are dissatisfied with the outcome after exhausting the Plan's internal claims and appeals process, you may be eligible for External Review of the determination if your appeal relates to whether the Plan is complying with the No Surprises Act.

Complaint Process

If you believe you have been wrongly billed or otherwise have a complaint under the No Surprises Act, you may contact the Fund Office or the Employee Benefit Security Administration ("EBSA") toll free number at 1-866-444-3272.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) PRIVACY RULE

The federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requires that health plans protect the confidentiality of your protected health information ("PHI").

This Plan will not use or disclose personal health information that is protected by HIPAA, except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all its business associates that use PHI to perform services on behalf of the Plan to observe HIPAA's privacy rules.

Under HIPAA, you have certain rights with respect to your PHI, including certain rights to review and obtain a copy of your PHI, receive an accounting of certain disclosures of your PHI, amend your PHI if it is inaccurate or incomplete, request that a covered entity restrict use or disclosure of your PHI, and request an alternative means or location for receiving communications of PHI other than those typically used. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan provides a privacy notice, which contains a complete description of your rights under HIPAA's privacy rules. A copy of this notice may be obtained by contacting the Fund Office at the following address:

Bricklayers & Allied Craftworkers Local 5, New York Welfare Fund
66-05 Woodhaven Blvd
Rego Park, NY 11374
Tel: (718) 459-5800
Fax: (718) 459-7033

CLAIMS AND APPEALS PROCEDURES

Internal Claims and Appeal Procedures

This section describes the procedures followed by the Plan in making internal claim decisions and reviewing appeals of denied claims. These procedures apply to claims for medical, mental health, substance use disorder, dental, vision, prescription drug, and death benefits.

The Plan's internal claims and appeals procedures are designed to provide you with a full, fair, and fast claim review that applies Plan provisions consistently with respect to you and other similarly situated Participants. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions. In addition, the Plan must consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary or appropriate or is Experimental and/or Investigational or Unproven).

The internal claims process pertains to determinations made by the appropriate Claims Administrator about whether a request for benefits (known as an initial "claim") is payable. If the appropriate Claims Administrator denies your initial claim for benefits (known as an "adverse benefit determination"), you have the right to appeal the denied claim under the Plan's internal appeals process.

General Information

Claims Administrator(s)

The Plan Administrator has delegated responsibility for initial claims decisions to the following companies/organizations:

Appropriate Claims Administrator	Types of Claims Processed
Hospital and Medical Claims Administrator **MVP Healthcare**	• Post-Service Medical Claims • Urgent, Concurrent and Pre-service Medical Claims
Prescription Drug Claims **Express Scripts Inc.**	• Pre-service and Post-Service Prescription Drug Claims
Dental Claims Administrator **MVP Healthcare**	• Pre-Service Dental Claims • Post-Service Dental Claims
Vision Claims Administrators **CPS Optical**	• Post-Service Vision Claims
Death Benefit Claims **Bricklayers & Allied Craftworkers Local 5, New York Welfare Fund**	• Death Benefit Claims

When Claims Must Be Filed (Timely Filing)

The Plan will provide benefits for claims submitted only within the following guidelines: (1) if the claim is submitted by a Network Provider, then 180 days from the date services were provided or as otherwise stipulated in the fee agreement between the In-Network Provider and MVP, except when coordination of benefits applies and this Plan is the secondary payer; or (2) if the claim is submitted directly by the Participant, the Participant's non-physician designee, or a Non-Network Provider, then 180 days from the date services were provided. If a claim is subject to coordination of benefits, as described in the "Coordination of Benefits" section of this SPD, and this Plan is the Participant's secondary plan, the Participant must submit the claim to MVP within 180 days of the date of the final statement from the Participant's primary plan.

Submission of Claims

Claims should be submitted to the appropriate Claims Administrator as follows:

Hospital, Medical, & Dental Claims	MVP Select Care, Inc. PO Box 2207 Schenectady, NY 12301 Phone: East: 800-229-5851 West: 800-767-1678 Website: ***.mvphealthcare.com
***Prescription Drug* Claims**	Express Scripts 225 Summit Avenue Montvale, NJ 07645 866-713-8004
Vision Claims	CPS Optical 11 Hanover Square, 8th Floor New York, NY 10005 212-675-5745 **********.cpsoptical.com/
Death Benefit Claims	Bricklayers and Allied Craftworkers Local 5, NY Welfare Fund 66-05 Woodhaven Blvd Rego Park, NY 11374 Telephone: (718) 459-5800 Fax: (718) 459-7033

Health Claims

Full and final authority to adjudicate claims and make determinations as to their payability by and under the Plan belongs to and resides solely with the Plan Administrator. The Plan Administrator shall make claims adjudication determinations after full and fair review and in accordance with

the terms of this Plan, applicable law, and with ERISA. To receive due consideration, claims for benefits and questions regarding said claims should be directed to the appropriate Claims Administrator. The Plan Administrator may delegate to the Claims Administrator responsibility to process claims in accordance with the terms of the Plan and the Plan Administrator's directive(s).

Written proof that expenses eligible for Plan reimbursement and/or payment were Incurred, as well as proof of their eligibility for payment by the Plan, must be provided to the Plan Administrator via the Claims Administrator. Although a provider of medical services and/or supplies may submit such claims directly to the Plan by virtue of an assignment of benefits, ultimate responsibility for supplying such written proof remains with the Claimant. The Plan Administrator may determine the time and fashion by which such proof must be submitted. No benefits shall be payable under the Plan if the Plan Administrator so determines that the claims are not eligible for Plan payment, or, if inadequate proof is provided by the Claimant or entities submitting claims to the Plan on the Claimant's behalf.

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim", since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations, and Exclusions. Once treatment is rendered, a claim must be filed with the Plan (which will be a "Post-service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

There are four types of claims: Pre-Service (Urgent and Non-urgent), Concurrent Care, and Post-Service. However, because of this Plan's design Pre-Service Urgent Care claims will not be filed with the Plan; Post-Service claims will instead be filed after the urgent care is provided.

1. Pre-Service Claims. A "Pre-Service Claim" occurs when issuance of payment by the Plan is dependent upon determination of payability prior to the receipt of the applicable medical care; however, if the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-Service Claim".

   Urgent care or Emergency medical services or admissions will not require notice to the Plan prior to the receipt of care. Furthermore, if in the opinion of a Physician with knowledge of the Claimant's medical condition, pre-determination of payability by the Plan prior to the receipt of medical care (a Pre-Service Claim) would result in a delay adequate to jeopardize the life or health of the Claimant, hinder the Claimant's ability to regain maximum function (compared to treatment without delay), or subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, said claim may be deemed to be a "Pre-Service Urgent Care Claim". In such circumstances, the Claimant is urged to obtain the applicable care without delay, and communicate with the Plan regarding their claim(s) as soon as reasonably possible.

   If, due to Emergency or urgency as defined above, a Pre-Service claim is not possible, the Claimant must comply with the Plan's requirements with respect to notice required after receipt of treatment and must file the claim as a Post-service Claim, as herein described.

Prior authorization of a non-Emergency Hospital admission is a "claim" only to the extent of the determination made – that the type of procedure or condition warrants Inpatient confinement for a certain number of days. The rules regarding Pre-Service Claims will apply to that determination only. Once a Claimant has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-Service Claim.

2. Concurrent Claims. If a Claimant requires an on-going course of treatment over a period of time or via a number of treatments, the Plan may approve of a "Concurrent Claim." In such circumstances, the Claimant must notify the Plan of such necessary ongoing or routine medical care, and the Plan will assess the Concurrent Claim as well as determine whether the course of treatment should be reduced or terminated. The Claimant, in turn, may request an extension of the course of treatment beyond that which the Plan has approved. If the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment, and the Claimant must simply comply with the Plan's requirements with respect to notice required after receipt of treatment, as herein described.

3. Post-Service Claims. A "Post-Service Claim" is a claim for benefits from the Plan after the medical services and/or supplies have already been provided.

A Pre-Service Claim (including a Concurrent Claim that also is a Pre-Service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Claims Administrator in accordance with the Plan's procedures.

Death Benefit Claims

A Death Benefit Claim is a request by a designated beneficiary for benefit payment following the death of the Participant.

Claim Elements

An initial claim must include the following elements (as applicable) to trigger the Plan's internal claims process:

1. The date of service.
2. The name, address, telephone number and tax identification number of the Provider of the services or supplies.
3. The place where the services were rendered.
4. The Diagnosis and procedure codes.
5. The amount of charges or any applicable pre-negotiated rate.
6. The name of the Plan.
7. The name of the covered Employee.
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be initiated with the Plan.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Claims Administrator within 45 days (48 hours in the case of urgent care claims) from receipt by the Claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions

Health Benefit Claims

The Claims Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of Pre-Service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-Service Non-Urgent Care Claims:
    a. If the Claimant has provided all the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
    b. If the Claimant has not provided all the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible. The Claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Claims Administrator and the Claimant (if additional information was requested during the extension period).

2. Concurrent Claims:
    a. Plan Notice of Reduction or Termination. If the Claims Administrator is notifying the Claimant of a reduction or termination of a course of treatment (other than by plan amendment or termination), notification will occur before the end of such period of time or number of treatments. The Claimant will be notified sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination.
    b. Request by Claimant Involving Urgent Care. If the Claims Administrator receives a request from a Claimant to extend the course of treatment beyond the period of time or number of treatments involving urgent care, notification will occur as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Claimant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.

c. Request by Claimant Involving Non-Urgent Care. If the Claims Administrator receives a request from the Claimant for a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-Service Non-Urgent Claim or a Post-Service Claim).

3. Post-Service Claims:
   a. If the Claimant has provided all the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
   b. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.
   c. If the Claimant has not provided all the information needed to process the claim and additional information is requested during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Claims Administrator and the Claimant.

4. Extensions:
   a. Pre-Service Non-Urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
   b. Post Service Claims. This period may be extended by the Plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Death Benefit Claim

Generally, your designated beneficiary will receive written (or electronic, as applicable) notice of a decision on the initial claim within 90 days of receipt of the claim by the Claims Administrator. If additional time or information is required to make a determination on the claim (for reasons beyond the control of the Claims Administrator, the designated beneficiary will be notified in writing (or electronically, as applicable) within the initial 90-day determination period. The 90-day period may be extended up to an additional 90 days.

Notification of an Adverse Benefit Determination

The Claims Administrator shall provide a Claimant with a notice, either in writing or electronically (or, in the case of Pre-Service Urgent Care Claims, by telephone, facsimile or similar method, with written or electronic notice following within three days), containing the following information:

1. A reference to the specific portion(s) of the Plan Document upon which a denial is based.
2. Specific reason(s) for a denial.
3. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.
4. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review.
5. A statement that the Claimant is entitled to receive, upon request, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits.
6. Upon request, the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Claimant, upon request).
8. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided to the Claimant, upon request.
9. In a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determinations

Where to Send Initial Appeals

Appeals for Medical Benefits Administered by MVP Healthcare

The Claimant must file an appeal regarding a Post-Service Claim and applicable Adverse Benefit Determination, in writing within 180 days following receipt of the notice of an Adverse Benefit Determination.

For Pre-Service Claims. Oral appeals should be submitted in writing as soon as possible after they have been initiated. To file any appeal in writing, the Claimant's appeal must be addressed as follows:

MVP Select Care
P.O. Box 2207
Schenectady, NY 12301

Attn: Member Appeals
Fax: 1-518-386-7600
Phone: **Please see ID Card**
Website: ***.mvphealthcare.com

The Plan maintains a two-level review for Post-Service Medical Claims. If you are dissatisfied with the first level appeal determination for a Post-Service Claim, you may submit a second level appeal to the Board of Trustees at the address below.

Appeals for Prescription Drug, Dental, Vision, Death Benefits, and Second Level Appeals for Medical Claims administered by MVP Healthcare:

This Plan requires two levels of appeal by a Claimant before the Plan's internal appeals are exhausted. For each level of appeal, the Claimant and the Plan are subject to the same procedures, rights, and responsibilities as stated within this Plan.

Once a Claimant receives an Adverse Benefit Determination in response to an initial claim for benefits, the Claimant may appeal that Adverse Benefit Determination, which will constitute the initial appeal. If the Claimant receives an Adverse Benefit Determination in response to that initial appeal, the Claimant may appeal that Adverse Benefit Determination to the Board of Trustees, which will constitute the final internal appeal. If the Claimant receives an Adverse Benefit Determination in response to the Claimant's second appeal, such Adverse Benefit Determination will constitute the final Adverse Benefit Determination, and the Plan's internal appeals procedures will have been exhausted.

All appeals for these benefits should be sent to the Board of Trustees at:

Board of Trustees
Bricklayers & Allied Craftworkers Local 5, New York Welfare Fund
66-05 Woodhaven Blvd
Rego Park, NY 11374
Tel: (718) 459-5800
Fax: (718) 459-7033

External Appeal Process

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with applicable law, applies only to an Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Claimant believes the claim has been denied wrongly, the Claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Claimant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

1. A 180-day timeframe following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination. The Plan will not accept appeals filed after a 180-day timeframe.
2. The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
3. A review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
4. A review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination.
5. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
6. Upon request, the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice.
7. If applicable, a discussion of the basis for disagreeing with the disability determination made by either (a) the Social Security Administration; or (b) an independent medical expert that has conducted a full medical review of the Claimant if presented by the Claimant in support of the claim.
8. That a Claimant will be provided, upon request: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits in possession of the Plan Administrator or the Claims Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and (d) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.

Timing of Notification of Benefit Determination on Review

<u>Health Benefit Claims</u>

The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within the following timeframes:

1. Pre-Service Non-Urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.
2. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim: Pre-Service Non-Urgent or Post-Service.
3. Post-Service Claims: Within a reasonable period of time, but not later than 30 days per internal appeal.

For Vision and Dental Appeals. The Plan will make an appeal determination no later than the date of the Board of Trustees' meeting immediately following the Plan's receipt of your written request for an internal appeal, unless the request for an internal appeal review is filed within 30 calendar days preceding the date of such meeting. In such case, an appeal determination will be made no later than the date of the second meeting following the Plan's receipt of your written request for an appeal. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, an appeal determination will be rendered not later than the third meeting following the Plan's receipt of your written request for review. If such an extension is necessary, the Plan will provide you with a written (or electronic, as applicable) notice of extension describing the special circumstances and date the appeal determination will be made. You will be notified in writing (or electronically, as applicable) of the benefit determination no later than five calendar days after the benefit determination is made.

Death Benefit

A written (or electronic, as applicable) notice regarding a determination of the appeal will be sent to your designated beneficiary within 60 days from the date the written request for an appeal is received by the Plan.

Calculating Time Periods

The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review

The Plan Administrator shall provide a Claimant with notification, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

1. Information sufficient to allow the Claimant to identify the claim involved (including date of service, the health care Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. Specific reason(s) for a denial.
3. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice.

4. A statement that the Claimant is entitled to receive, upon request, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits.
5. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided.
6. A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review.
7. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Claimant, upon request.
8. Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist Participants with the internal claims and appeals processes.
9. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the provision relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review to be Final

The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding, and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.

Requirements for Second Level Appeal

The Claimant must file an appeal regarding a Pre-service or Post-service claim and applicable Adverse Benefit Determination, in writing within 60 days following receipt of the notice of the first level Adverse Benefit Determination.

Appointment of Authorized Representative

A Claimant may designate another individual to be an authorized representative and act on their behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be in writing, signed and dated by the Claimant.

The Plan will permit, in a medically urgent situation, such as a claim involving Urgent Care, a Claimant's treating health care practitioner to act as the Claimant's authorized representative.

Should a Claimant designate an authorized representative, all future communications from the Plan will be conducted with the authorized representative instead of the Claimant, unless the Plan Administrator is otherwise notified in writing by the Claimant. A Claimant can revoke the authorized representative at any time. A Claimant may authorize only one person as an authorized representative at a time.

Recognition as an authorized representative is completely separate from a Provider accepting an assignment of benefits or requiring a release of information. An assignment of benefits by a Claimant shall not be recognized as a designation of the Provider as an authorized representative. Assignment and its limitations under this Plan are described below.

Payment of Benefits

Where benefit payments are allowable in accordance with the terms of this Plan, payment shall be made in U.S. Dollars (unless otherwise agreed upon by the Plan Administrator). Payment shall be made, in the Plan Administrator's discretion, to an assignee of an assignment of benefits, but in any instance may alternatively be made to the Claimant, on whose behalf payment is made and who is the recipient of the services for which payment is made. Should the Claimant be deceased, payment shall be made to the Claimant's heir, assign, agent, or estate (in accordance with written instructions), or, if there is no such arrangement and in the Plan Administrator's discretion, the institute and/or Provider who provided the care and/or supplies for which payment is to be made – regardless of whether an assignment of benefits occurred.

Anti-Assignment Provision

The benefits contained in this Plan, and any right to reimbursement or payment arising out of such benefits, are not assignable or transferrable, in whole or in part, in any manner or to any extent, to any person or entity. Any payment by the Plan directly to a provider pursuant to a written election or purported assignments submitted by a Participant is provided at the discretion of the Board of Trustees as a convenience to the Participant and does not imply an enforceable assignment of any benefits or the right to pursue a claim or cause of action by the provider.

No Participant shall at any time, either during the time in which they are a Participant in the Plan, or following their termination as a Participant, in any manner, have any right to assign their right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which they may have against the Plan or its fiduciaries. A medical Provider which accepts

an Assignment of Benefits does so as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations, or Exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Claimant or Dependent on whose behalf such payment was made.

A Claimant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expenses for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Claimant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Claimant and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Claimant, Provider, or other person or entity to enforce the provisions of this section, then that Claimant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Claimant and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Claimants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Claimant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made for any of the following circumstances:

1. In error.
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act.
3. Pursuant to a misstatement made to obtain coverage under this Plan.
4. With respect to an ineligible person.
5. In anticipation of obtaining a recovery if a Claimant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions as described in the "Right of Subrogation and Lien" section.
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Claimant or by any of their covered Dependents if such payment is made with respect to the Claimant or any person covered or asserting coverage as a Dependent of the Claimant.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Claimant for any outstanding amount(s).

Limitation on When A Lawsuit May Be Started

You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before administrative agencies, until after all administrative procedures have been exhausted (including this Plan's internal claims and appeal procedures described in this section) for every issue deemed relevant by the claimant, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision. The law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act of 1974 without exhausting these appeal procedures if the Plan has failed to follow them properly.

No lawsuit may be started more than 90 days after the Plan's denial of the Participant's appeal. Any legal action related to the Plan may only be brought in the United States District Court for the Southern District of New York.

Failure by the Participant to request an appeal of a denial within the prescribed time period will constitute a waiver of the right to review of the denial and any claim will be considered barred and no action may be brought against the Fund and/or the Board of Trustees.

Failure to file a lawsuit, appear, and participate at a scheduled hearing or failure to take any other action with respect to the denial will bar the claim and no action may be brought.

FUTURE OF THE PLAN AND PLAN TERMINATION

This Summary Plan Description includes information concerning the circumstances that may result in disqualification, ineligibility, or denial of benefits that a Participant or beneficiary might otherwise reasonably expect the Plan to provide. This Summary Plan Description details the eligibility rules, benefits, limitations and exclusions from coverage.

It is anticipated that the Plan will remain in effect indefinitely. However, the right to amend or modify the Plan is reserved by the Board of Trustees, in accordance with the Trust Agreement. In addition, the continuance of the Plan is subject to the maintenance of the Collective Bargaining Agreements that provide for employer contributions to the Plan.

If it ever becomes necessary to terminate the Plan, the Trust Agreement provides that assets then held by the Trustees must be used exclusively on behalf of Plan Participants. In no event will any of the assets revert to any employer or to the Union. In the event of termination of the Plan, the assets are to be used exclusively to continue the payment of benefits provided to Participants, their covered Dependents, beneficiaries, or their estates, to defray reasonable administration and termination expenses and to otherwise effectuate the purposes of the Trust Agreement. Upon the necessity of termination, the Trustees would establish a plan to be applied to the balance of assets so that the assets would be applied solely for these purposes.

Upon final liquidation of the Plan, Participants and beneficiaries would have no further rights under the Plan.

PART B – HEALTH PLAN COVERAGE AND BENEFITS

TABLE OF CONTENTS

Determination of Plan Rules B-2
General Eligibility Rule Provisions B-3
Rules For Benefit Eligibility B-4
Schedule of Benefits for Participants B-8
Schedule of Benefits – Active Members and Dependents B-9
How the PPO Plan Works B-18
Utilization Management B-21
MVP PPO Plan Benefits B-24
Schedule of Non-PPO Plan Benefits for Participants and their Covered Dependents B-35
Vision Benefits B-36
Dental Benefit B-37
Schedule of Dental Benefits for Participants B-40
Prescription Drug Benefit B-50
Death Benefit B-56
Effect of Medicare B-57
Benefit Plan Exclusions B-59
Benefit Plan Definitions B-64

DETERMINATION OF PLAN RULES

Because you receive or submit a claim form there is no guarantee that you are eligible for benefits or that you will receive benefit payment.

The Board of Trustees has exclusive authority and discretion to make all determinations concerning eligibility and the amount of any benefits payable by this Plan.

The Trustees' determinations will be based solely on clearly defined and ascertainable criteria contained in the Plan at the time a claim occurs. Their decisions are final and binding.

GENERAL ELIGIBILITY RULE PROVISIONS

1. All questions with respect to eligibility shall be determined by the Trustees, whose decisions shall be final.

2. The "Rules for Benefit Eligibility" in Part B are subject to change by vote of the Trustees, including any temporary waiver or modification that the Trustees may determine to be in the best interest of the Fund and the Participants and their covered dependents.

3. Participating employers are those employers who enter into a contractual agreement with the Union to make contributions to this Fund in accordance with said agreement.

4. Covered Employment means work in a classification for which the Union is the collective bargaining representative and for which contributions are required to be made to the Fund by the employer. The term includes other employment with an employer provided such employment is defined as "Covered Employment," for purposes of this program, in an agreement between the Trustees and the employer. The term also includes work outside the jurisdiction of the Union for which contributions are made to the Fund by another Fund to which such contributions were required, by agreement, to be made and with which this Fund has a reciprocal agreement.

RULES FOR BENEFIT ELIGIBILITY

Participants

1. Initial and Continuing Eligibility

Initial Eligibility

An individual who has not before qualified for coverage or who was formerly covered but whose coverage has terminated will be eligible for coverage under the Plan if the following condition is met:

- They must have worked at least 1,000 hours in Covered Employment in a consecutive twelve-month period.

Eligibility for coverage begins on the 1st day of the calendar month immediately following the month in which the participant worked the 1,000th hour in Covered Employment, provided they are available for work at such time.

Once initial eligibility for coverage is established, continuing eligibility will be based on the work periods and insurance periods as stated in the "Continuing Eligibility" rules.

Continuing Eligibility

a. A participant who is currently qualified for benefit coverage must have at least 1,000 hours of reported Covered Employment in a work period (January 1st - December 31st) to be eligible for benefit coverage in the corresponding twelve (12) month insurance period (January 1st - December 31st of the following year).

These rules are illustrated below:

Work Period	Insurance Period
A Participant Must Work at Least 1,000 Hours in Covered Employment During January 1st through December 31st	To be Eligible for Benefits During the Following January 1st through December 31st

Termination of Benefit Coverage – Participant

The coverage of a participant will terminate upon the earliest of:

1. The December 31st on which they did not work at least 1,000 hours in Covered Employment during the year ending on such date.
2. Immediately upon becoming unavailable for Covered Employment.
3. The date they enter the armed forces of any country.
4. The date of their death.

5. The last day of employment with the Fund for a Fund employee.
6. The date they become employed by a non-contributing employer in the Masonry Industry.
7. The date they accept fringe benefits in cash.
8. The date an individual who is physically able to work refuses an opportunity to work in Covered Employment.

However, if a participant has been reinstated to coverage, in accordance with the Uniformed Services Employment and Reemployment Rights Act ("USERRA") (see Section 3 below) during the second half of a calendar year and was unable to secure 1,000 hours in Covered Employment during such year because there was lack of such Covered Employment, then subsection (a) above will not apply to them until the next succeeding December 31st at the earliest.

2. Special Eligibility Continuation Provision

a. Disability Bank

In the event a participant, who was covered for a period of 2 years prior to disability, becomes totally disabled so as to be unable to earn any compensation and notifies the Fund Administrator by certified mail, they will be eligible to draw on their disability bank, if they wish, in order to be credited with a minimum of 1,000 hours of Covered Employment for the year in which they are disabled.

A participant's disability bank will consist of the sum of hours credited on the following basis: for each day of reported disability, the participant will receive 7 hours of credited service up to a maximum of 288 days of disability in a two-year period and a maximum of 2,014 hours in their lifetime.

b. Direct Pay

If a participant's eligibility for benefit coverage is to terminate in accordance with the current continuing eligibility rules, they may be entitled to extend eligibility if the following applies:

- They are reported for less than 1,000 hours of Covered Employment in a Work Period; and
- They were continuously eligible for benefit coverage in the two insurance years preceding the insurance year in which their eligibility for benefit coverage is to terminate.

A participant with 700 to 999 hours of Covered Employment reported in a Work Period may continue eligibility for benefit coverage in the following insurance year provided they make direct payment of an amount determined by multiplying the direct-pay factor of 1.25 by the current hourly contribution rate and then multiplying the resulting factor by the difference between 1,000 hours and their hours reported in the Work Period.

With respect to this direct pay provision, while the Fund Administrator will notify the participant by separate letter as to the amount of direct payment due for coverage continuation, it will be the participant's personal responsibility to make full payment in advance of the applicable insurance year.

Direct payment can be made in full or in installments by certified check, bank check, money order, or personal check. Failure to pay the required amount by the date specified in the notification letter will result in termination of eligibility for benefit coverage effective December 31st of the applicable Work Period.

The direct payment provision is limited to a maximum of three consecutive insurance years (within any period of five consecutive insurance years) and is available only if the participant is working in Covered Employment or is registered with Bricklayers & Allied Craftworkers Local 1 as being ready, willing, able, and available for Covered Employment at the start of the insurance year for which the direct payment is to be made.

3. Military Service: Uniformed Services Employment and Reemployment Rights Act (USERRA)

In the event a Participant enters active duty for military service with the United States Armed Forces, their eligibility (including covered Dependents) will terminate immediately upon induction. Upon honorable discharge from such military service, the Participant's eligibility will be reinstated on the date they return to Covered Employment (provided they return within 60 days from the date of honorable discharge) and be continued for the number of months of continued eligibility they were entitled to upon leaving for military service or to the end of the current insurance year, whichever is greater.

A Participant who has hours of Covered Employment reported on their behalf and who leaves for military service (excluding voluntary enlistment) before becoming eligible for benefit coverage, shall have their prior employment time counted in satisfaction of the initial eligibility waiting period provided that they resume active work with a participating employer within the time limits set by law for reinstatement of employment rights.

An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if such a period would not have been imposed had coverage not been terminated because of service. However, an exclusion or waiting period may be imposed for coverage of any Illness or Injury determined by the Veterans Administration to have been incurred in, or aggravated during, the performance of service in the uniformed service.

Under USERRA, a Participant (and their covered Dependents) has the right to continue their existing health benefits while absent from employment because of service in the uniformed service.

This right applies only to Participants and their covered Dependents who were covered under the Plan immediately prior to the uniformed leave of absence.

The maximum length of continuation coverage required under USERRA is the lesser of:

a. 24 months beginning on the day that the uniformed service leave commences; or

b. a period beginning on the day that the uniformed service leave began and ending on the day after the Participant fails to return to employment within the time allowed by USERRA.

A Participant who elects to continue existing health plan coverage may be required to pay no more than 102% of the full premium under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Participant's share, if any, for the coverage.

SCHEDULE OF BENEFITS FOR PARTICIPANTS

SELF-INSURED BENEFIT	Amount of Coverage
Active Participant Death Benefit	$5,000

SCHEDULE OF BENEFITS – ACTIVE MEMBERS AND DEPENDENTS

Benefit Category	In-Network	Out of Network	Comments
General Benefit Information			
Annual Deductible - Medical Only Embedded	$250 Individual $500 Family* *Once 2 members have each satisfied their deductible, any remaining individual deductibles will be waived for the year.	$500 Individual $1000 Family* *Once 2 members have each satisfied their deductible, any remaining individual deductibles will be waived for the year.	In-Network deductible does not accumulate towards OON deductible. Out of Network deductible will accumulate towards In Network deductible Rx is Carved out
Communicable Diseases - Medical Only Embedded	$250 Individual	$500 Individual	Does not accumulate towards Annual Deductible. Rx is Carved out
Member Coinsurance	20%	50%	
Last Quarter Carryover	No	No	
Out of Pocket Maximum - Medical Only Embedded.	$2,500 Individual included Deductible	$5,000 Individual includes Deductible	In-Network Out of Pocket does not accumulate towards OON Out of Pocket. Out of Network Out of Pocket does not accumulate towards INN Out of Pocket. Rx is Carved out
Inpatient Facility			
Hospital Inpatient Services Includes inpatient admissions: Medical, Surgical, ICU, NICU	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	If member termination takes place during an Inpatient stay, covered will be to the end of confinement.
Hospital Observation Stay	Covered in Full No Deductible	50% Coins After Out-of-Network Deductible	
Skilled Nursing Facility	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	No Limits
Hospital Inpatient Physical Rehab Facility	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	No Limits
Physician Inpatient Visits	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Medical Services & Therapies Outpatient & Office			
Cardiac and Pulmonary Rehab Outpatient	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	No Limits

Cardiac and Pulmonary Rehab Specialist Office	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	No Limits
Chemo Therapy Outpatient Hospital	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Chemo Therapy PCP Office	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Chemo Therapy Specialist Office	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Radiation Therapy Outpatient Hospital	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Radiation Therapy PCP Office	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Radiation Therapy Specialist Office	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Dialysis Outpatient Hospital	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Dialysis PCP Office	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Dialysis Specialist Office	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Infusion Therapy Outpatient Hospital	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Infusion Therapy PCP Office	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Infusion Therapy Specialist Office	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Infusion Therapy Home	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
PT/OT/ST Office	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	No Limits
PT/OT/ST Outpatient	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	No Limits
Surgical			
Facility Outpatient Hospital	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Ambulatory Surgical Facility	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Physician Inpatient	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Physician Outpatient/ Ambulatory Surgery	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Surgery PCP Office	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	

Surgery Specialist Office	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Bariatric Surgery	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	Members must use an MVP Center of Excellence, for Bariatric Surgery.
Autologous Blood & Blood Transfusions	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Anesthesia (To Include Any Place of Service)	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Diagnostic Services			
Lab Outpatient Hospital	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Lab Independent	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Lab PCP Office	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Lab Specialist Office	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Radiology Outpatient Hospital	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Radiology Independent Center	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Radiology PCP Office	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Radiology Specialist Office	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Advances Imaging Outpatient (CAT Scans, PET Scans, MRI's and Nuclear Medicine Scans)	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Advanced Imaging Independent Center (CAT Scans, PET Scans, MRI's and Nuclear Medicine Scans)	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Advanced Imaging Office (CAT Scans, PET Scans, MRI's and Nuclear Medicine Scans)	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Diagnostic Testing Outpatient Hospital	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Diagnostic Testing PCP Office	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	

Diagnostic Testing Specialist Office	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Emergency Care (Facility and Professional Charges)			
Ambulance (Includes Land & Air)	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Emergency Room In and Out of Area	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	Copay waived if Admitted as Inpatient.
Emergency Room Physician	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	If a participant receives emergency room services at a participating hospital but is treated by a non-participating physician, the physician services will be adjudicated as in-network benefits.
Hospital Observation Stay	Covered in Full No Deductible	50% Coins After Out-of-Network Deductible	
Urgent Visit Center In and Out of Area	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Physician Services Outpatient Office (Non Preventive)			
Office Visit Nurse	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Office Visit PCP (includes clinic, home, nursing facility)	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Office Visit Specialist (includes clinic, home, nursing facility)	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Outpatient Hospital Physician Consult PCP	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Outpatient Hospital Physician Consult Specialist	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Physician Second Surgical Opinion	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Gia Virtual Care	Covered in Full No Deductible	*Not Covered*	
Telehealth Services through traditional providers via phone or computer	Cost share determined by Provider of Service	Cost share determined by Provider of Service	
Administration of Injectable Drug by PCP in Office	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Administration of injectable Drug by Specialist in Office	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Drugs Injected in Office Setting	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	

Allergy Testing	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Allergy Injections/Serum	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Preventive Care			
Well Child Visit	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	Testing, Labs, X-rays, and other services associated with routine visit are
Well Child Immunizations	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Well Adult Visits	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Well Adult Immunizations	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	Immunizations for travel, school, work are not covered.
Routine Gynecological Services	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Mammo Screenings	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Sterilization Procedures for Women (Vasectomy Follows Surgical Benefit)	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Norplant & IUD Insertion & Removal	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	IUD devices not covered under medical
Bone Density Screening	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Prostate Screening	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Preventive Colonoscopy	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Flu Shots/Mist	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Breast Pumps	Covered in Full No Deductible	50% Coins After Out-of-Network Deductible	
Breast Pump Supplies	Covered in Full No Deductible	50% Coins After Out-of-Network Deductible	
Lactation Classes			
Maternity Care (Facility & Professional Charges)			
Maternity Pre-Natal Visits	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	No Maternity Coverage for dependent children.
Maternity Ultrasounds	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	No Maternity Coverage for dependent children.

Maternity Lab Work	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	No Maternity Coverage for dependent children.
Physician & Midwife Delivery Only	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	No Maternity Coverage for dependent children.
Maternity Postnatal Care	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	No Maternity Coverage for dependent children.
Hospital Inpatient or Birthing Center	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	No Maternity Coverage for dependent children.
Hospital Inpatient New Born Nursery (Standard 96 Hrs.)	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	No Maternity Coverage for dependent children.
Physician Newborn Routine Visit	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	No Maternity Coverage for dependent children.
Other Professional Services			
Acupuncture	*Not Covered*	*Not Covered*	
Chiropractic Care	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Osteopathic Manipulation	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Diabetic Education	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Nutritional Counseling	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	Letter of medical necessity
Podiatry Care (routine foot care is not covered, except for diabetics)	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Vision - Routine Eye Exam	*Not Covered*	*Not Covered*	Carved Out to Vendor -
Vision Hardware Coverage (frames, lenses, contact lenses)	*Not Covered*	*Not Covered*	Carved Out to Vendor -
Diagnostic Hearing Testing (Non-Routine)	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Hearing Aid Evaluation	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Hearing Aids No Par Network TruHearing provides discounts to MVP Members	20% Coins No Deductible	50% Coins No Deductible	$650 lifetime maximum, does not apply to deductible or out of pocket maximum
Communicable Diseases (All Places of Service)	20% Coins After Communicable Diseases In-Network Deductible	50% Coins After Communicable Diseases Out-of-Network Deductible	
Infertility Services			

Basic Infertility Services	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Advanced Infertility Services	*Not Covered*	*Not Covered*	
Family Planning			
Abortion	*Not Covered*	*Not Covered*	
Vasectomy	*Not Covered*	*Not Covered*	
Special Services			
Dental (*Only Services for Accidental Injury are Covered under the Medical Plan*)	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	Accidental Dental Only
Home Health Care	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	No Limits
Hospice Bereavement Counseling	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	No Limits
Hospice Care Inpatient	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	Limited to 210 days combined Inpatient and Outpatient per Lifetime
Hospice Care Outpatient	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	Limited to 210 days combined Inpatient and Outpatient per Lifetime
Modified Food Solids	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	No Limits
Enteral Formula	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	Covered through Medical benefit.
Oral Surgery	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Private Duty Nursing	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
TMJ Treatment	If medially necessary and approved, paid based on the service rendered.	If medially necessary and approved, paid based on the service rendered.	TMJ coverage based on medical necessity
Transplants	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	Donor organ procurement is not covered. Transplants must be at an MVP Credentialed, or Optum Center of Excellence Facility. All Requests must come to Case Management.
Travel or Lodging for Transplant.	*Not Covered*	*Not Covered*	
Gender Dysphoria	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
DME, Prosthetics, Orthotics, Supplies			

Durable Medical Equipment (DME) *Example: walkers, canes, hospital beds, oxygen equipment, wheelchairs, speech generating devices, etc.*	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Small item DME obtained through pharmacy *Example: nebulizer, peak flow meters, AeroChamber*	Pharmacy Carved Out		
Diabetic DME *Example: Insulin pumps/pump supplies, continuous glucose monitor systems and sensors*	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Diabetic Pharmacy Items *Example: blood glucose monitor, test strips, lancets*			
Disposable Medical Supplies Covered *Example: ostomy, oxygen supplies*	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Disposable Medical Supplies obtained through pharmacy *Example: ostomy*	Pharmacy Carved Out		
Medical Supplies Plan Specific Details Example: *wound care supplies, catheters, compression stockings*	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Diabetic Shoes/Diabetic Molded Shoe Inserts	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Foot Orthotics - non-diabetic shoes and shoe inserts	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	Letter of medical necessity
Orthotics *Example: A brace or device that provides stability, or correction of the knee, arm, back, etc.*	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Prosthetics - External *Example: Replaces a missing external body part such as arm or leg*	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Prosthetics - Internal *Replaces an internal body part during surgery such as a joint*	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	

Wigs	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Mental Health			
Inpatient Hospital	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Inpatient Physician Visits	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Residential Treatment	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Partial Hospitalization Program	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Outpatient Visits - Office	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Outpatient Visits - Facility	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Intensive Outpatient Program	20% Coins After In-Network Deductible	50% Coins After Out-of-Network Deductible	
Substance Abuse			
Inpatient Detox	20% Coins No Deductible	50% Coins No Deductible	
Inpatient Physician Visits	20% Coins No Deductible	50% Coins No Deductible	
Inpatient SA Rehab	20% Coins No Deductible	50% Coins No Deductible	
Residential Treatment	20% Coins No Deductible	50% Coins No Deductible	
Partial Hospitalization Program	20% Coins No Deductible	50% Coins No Deductible	
Outpatient Visits - Office	20% Coins No Deductible	50% Coins No Deductible	
Outpatient Visits - Facility	20% Coins No Deductible	50% Coins No Deductible	
Intensive Outpatient Program	20% Coins No Deductible	50% Coins No Deductible	

HOW THE PPO PLAN WORKS

As a Participant in the Bricklayers and Allied Craftworkers Local 5, New York Welfare Fund, you have access to a comprehensive medical benefit program. The following information will help you make the best use of the Plan.

1. The Preferred Provider Organization Plan Design ("PPO"). The PPO plan design provides two levels of Benefits for Covered Services depending on whether you obtain Covered Services from a Participating Provider ("In-Network Services") or a Non-Participating Provider ("Out-of-Network Services"). Depending on your choice, costs will vary as shown in the "Schedule of Benefits." You can reduce your out-of-pocket costs by following the requirements for In-Network Benefits.

   A. The Provider Network:

      You have access to a comprehensive national network of participating physicians, hospitals, labs, and other facilities, as well as other Providers through the MVP Participating Provider Network. You can search for Participating Providers at MVP's website at ***.mvphealthcare.com or contact MVP's Customer Care Center for assistance.

2. In-Network Services. To receive In-Network Benefits, you must receive services from an MVP Participating Provider. Benefits for some Covered Services are available only when provided by a Participating Provider. These services are marked as "Not Covered" in the Out-of-Network column of the "Schedule of Benefits."

3. Out-of-Network Services. If you choose to receive Medically Necessary Covered Services outside of MVP's Network of Participating Providers, you can still receive Benefits, but at a reduced level of coverage and at higher out-of-pocket costs to you. Most covered Out-of-Network Services are reimbursed at a percentage of the Allowable Charge after you have met your annual Deductible. **If the Non-Participating Provider's charge is more than the Allowable Charge under the Plan, you will be responsible for paying one hundred (100%) percent of the difference between MVP's Allowable Charges and the Non-Participating Provider's Charges in addition to any Deductible or Coinsurance**. Charges that are in excess MVP's Allowable Charges are not applied to your annual out-of- pocket maximum. Some services, such as routine and preventive care are only covered In- Network and not covered Out-of-Network. Please refer to the "Schedule of Benefits."

   Where day and visit limitations are indicated with regard to Covered Services, these contractual limitations apply whether the Covered Service is accessed In-Network or Out-of- Network.

4. Understanding the Plan's Benefits for Covered Services. Below are key terms and provisions that will help you understand how the Plan provides Benefits and your responsibility for Charges submitted to the Plan for Covered Services.

Choice of Providers

The Plan is not intended to disturb the Physician-patient relationship. Each Participant has a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. Physicians and other health care Providers are not agents or delegates of the Plan. The delivery of medical and other health care services on behalf of any Participant remains the sole prerogative and responsibility of the attending Physician or other health care Provider. The Participant, together with their Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

Your Payments

Annual Deductibles. **This Plan has an Out-of-Network Deductible provision**. Deductibles are listed on the "Schedule of Benefits," and must be satisfied before the Plan will provide Benefits under this Plan. Amounts in excess of the Allowable Charge do not count towards the Annual Deductible for Out-of-Network services.

The **Individual Deductible** applies to each covered Participant for each Calendar Year. Once the Individual Deductible has been satisfied, the Plan provides Benefits for Covered Services for that Participant according to the "Schedule of Benefits."

The **Family Deductible** applies to you and all your covered Dependents for each Calendar Year. If you and your Dependents have met the Family Deductible, you and your Dependents do not have to pay any further Deductible for the rest of the Calendar Year. Although no one family member needs to pay more than the individual deductible, you and your Dependents cannot apply more than the amount of each person's Individual Deductible toward the Family Deductible.

Coinsurance/Copayments. Coinsurance and Copayments are listed on the "Schedule of Benefits." When you access Covered Services from a Provider you must pay any applicable Copayment and Coinsurance directly to the Provider.

Annual Out-of-Pocket Maximums. This Plan contains an Out-of-Pocket Maximum provision for Out-of-Network Services only. An Out-of-Pocket Maximum limits your payments for Covered Services during the Calendar Year. Please see the "Schedule of Benefits" for the Plan's Out-of-Pocket Maximums.

The **Individual Out-of-Pocket Maximum** applies to each covered Participant for each Calendar Year. Once the annual Deductible, Copayments, and Coinsurance payments for Covered Services for a covered Participant satisfy the Individual Out-of-Pocket Maximum, the Plan will pay one hundred (100%) percent of the Allowable Charge for those Covered Services that count toward the Individual Out-of-Pocket Maximum for the remainder of that Calendar Year.

The Plan's Payments

Allowable Amount or Allowable Charge. This is the maximum Benefit available under this Plan. Except as outlined in "No Surprises Act" below, if the charge billed by a Non-Network Provider for any covered service is higher than the Allowable Charge determined by the Plan, Participants are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously-given assignment of benefits or to proactively prohibit assignment of benefits to anyone, including any Provider, at its discretion.

To receive benefit consideration, Participants may need to submit claims for services provided by Non-Network Providers to the Claims and Appeals Administrator. Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit claims themselves.

5. Medical Necessity.

The Plan will only provide Benefits if a Covered Service is Medically Necessary. Medically Necessary or Medical Necessity means that a Covered Service is:

- Recommended by your treating physician; and
- Determined by MVP's Medical Director or physician designee to meet the following criteria:
    1. The service is appropriate and consistent with the diagnosis and treatment of your medical condition;
    2. The service is not primarily for your convenience, the convenience of your family, or your provider;
    3. The service is required for the direct care and treatment or management of that condition;
    4. The service is provided in accordance with general standards of good medical practice, as evidenced by, reports in peer reviewed medical literature; reports and guidelines as published by nationally recognized health care organizations that include supporting scientific data; and any other relevant information brought to our attention; and
    5. The service is rendered in the most efficient and economical way and at the most economical level of care that can safely be provided to the Participant.

MVP maintains protocols to aid in the determination of whether a service is Medically Necessary.

UTILIZATION MANAGEMENT

"Utilization Management" consists of several components to assist Participants in staying well: providing optimal management of chronic conditions, support, and service coordination during times of acute or new onset of a medical condition. The scope of the program includes Hospital admission prior authorization, continued stay review, length of stay determination, discharge planning, and case management. These programs are designed to ensure that Medically Necessary, high quality patient care is provided and enables maximum benefits under the Plan. To maximize Plan reimbursements, please read the following provisions carefully.

This Plan requires Prior Authorization and/or Concurrent Review by or to MVP before you receive certain Covered Services. All services are subject to Retrospective Review. Approval of services through Prior Authorization or Concurrent Review is not a guarantee of Benefits. MVP may deny Benefits if there is material misrepresentation or fraud by a Covered individual, and as otherwise permitted by law. **Failure to comply with these requirements may result in a denial or reduction of Benefits.**

Prior Authorization. Prior Authorization means the required approval that must be obtained from MVP before you receive certain Covered Services. MVP reviews information about your medical condition and the proposed services to determine whether such services are Medically Necessary Covered Services.

A. When Prior Authorization is Required. Some services requiring prior authorization for Covered Expenses are noted below and are for illustrative purposes only and not intended to be inclusive. For a complete listing of prior authorization requirements, please contact the number on the back of the Participant ID card:
    1. Non-Emergency Land and Air Ambulance Services;
    2. Bariatric Surgery *(must use Bariatric Network)*;
    3. Skilled Nursing Facility Services;
    4. Home Health Care Services (Out-of-Network);
    5. Transplant Services *(must use MVP's network);*
    6. Durable Medical Equipment, External Prosthetic Devices, Orthotic Devices (prior authorization may be required for select DME items);
    7. High Tech Imaging Services, including CT Scans, MRAs, MRIs, PET Scans, MRCPs, CTAs, and Nuclear Cardiology;
    8. Genetic Testing;
    9. Oral Surgery for TMJ (covered only for Medically Necessary conditions);
    10. Inpatient Admissions;
    11. Facility Based Sleep Studies;
    12. Hospice Services; and
    13. In-Office Procedures being done in an Ambulatory Surgery Setting.

    Remember that although the Plan will automatically pre-authorize a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery, it is important that the Participant has their Physician call to obtain prior authorization in case there is a need to have a longer stay.

The prior authorization process is limited to determining the Medical Necessity of the procedure. **It does not verify eligibility for benefits nor guarantee benefit payments under the Plan.** It is the Participant's responsibility to verify that certain services have been pre-authorized.

B. How to Obtain Prior Authorization.

1. Generally. To request Prior Authorization, you or your Provider must contact MVP's Utilization Management Department at 1-800-568-0458. You or your Provider must provide MVP with your name, MVP ID number, your Provider's name and address, the date that services are requested, and your diagnosis. You or your Provider must contact MVP at least five (5) days before your proposed admission or service date. You or your Provider must notify MVP if your admission or service date changes. It is your responsibility to make sure that Prior Authorization is given when using an Out-of-Network Provider.

2. Urgent Care or Emergency Admissions. If a Participant needs medical care for a condition which could seriously jeopardize their life, obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

   If a Participant must be admitted on an Emergency basis, the Participant, or an individual acting on behalf of the Participant, should follow the Physician's instructions carefully and contact member services (please see ID card for phone number) as follows:

   - ♣ For Emergency admissions after business hours on Friday, on a weekend, or over a holiday weekend, a call to member services must be made within 72 hours after the admission date, but no later than the first business day following the Emergency admission, by or on behalf of the covered patient.

   - ♣ For Emergency admissions on a weekday, a call to member services must be made within 48 hours after the admission date, by or on behalf of the covered patient.

   If a medical service is provided in response to an Emergency situation or urgent care scenario, prior approval from the Plan is not required. The Plan will require notice within 72 hours after the admission date, but no later than the first business day following the Emergency admission, by or on behalf of the Participant. Such a claim shall then be deemed to be a Post-service Claim.

3. Non-Emergency Admissions. For Hospital stays that are scheduled in advance, a call to member services should be completed as soon as possible before actual services are rendered. Once the prior authorization call is received, it will be routed to an appropriate review specialist who will create an online patient file. The review specialist will contact the Participant's attending Physician to obtain

information and to discuss the specifics of the admission request. If appropriate, alternative care will be explored with the Physician.

If, after assessing procedure necessity, the need for an Inpatient confinement is confirmed, the review specialist will determine the intensity of management required and will remain in contact with the Physician or Hospital during the confinement.

If, at any time during the review process, Medical Necessity cannot be validated, the review specialist will refer the episode to a board-certified Physician advisor who will immediately contact the attending Physician to negotiate an appropriate treatment plan. At the end of the Hospital confinement, the review specialist is also available to assist with discharge planning and will work closely with the attending Physician and Hospital to ensure that medically appropriate arrangements are made.

4. Outpatient Services. A Participant is required to contact the prior authorization department when the Physician requests certain outpatient procedures and services.

Case Management. Case management is a preemptive coordination of a Participant's care in cases where the medical condition is, or is expected to be serious, chronic, or when the cost of treatment is expected to be significant. This program provides for a case manager who monitors Participants and explores, discusses, and recommends coordinated and/or alternate types of appropriate Medically Necessary care. Case management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate. Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

Second Surgical Opinion. If a Physician recommends Surgery for a Participant, the Participant may request a second opinion as to whether or not the Surgery is Medically Necessary.

A Participant is not required to have a second surgical opinion. The second opinion must be given by a board-certified specialist who examines the Participant and who, by reason of their specialty, is competent to consider the proposed Surgery.

Coverage is also available for a second medical opinion from a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or recurrence of cancer or for a recommended course of treatment for cancer.

Pre-Surgical Approval. The Plan recommends that a pre-determination of benefits be obtained prior to certain Surgical Procedures. Generally, if the Participant is considering any Surgery, please contact member services at least 48 hours prior to the scheduled Surgery at the number on the ID card for more information. Pre-surgical approval is not a guarantee of coverage.

MVP PPO PLAN BENEFITS

Medical Benefits

These medical benefits will be payable as shown in the "Summary of Benefits" or as otherwise described in this Plan. Subject to the Plan's provisions, limitations, and Exclusions, the following are covered major medical benefits:

Advanced Imaging. Charges for advanced imaging including: Computed Tomographic ("CT") studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine, and PET scans. Covered Expenses include the readings of these medical tests/scans.

Air Ambulance (Emergency Only). Air medical transport/ambulance is a service performed by either a helicopter or fixed wing aircraft to rapidly transfer those who are critically ill to a facility capable of caring for them. Transfer can be between two facilities or from an Emergency scene. The determination of whether air ambulance transport for a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors and is subject to the Claims Administrator's policies, procedures, and guidelines.

Allergy Services. Charges related to the treatment of allergies.

Ambulance (Emergency Only). Covered Expenses for professional ambulance, including approved available water and rail transportation to a local Hospital, or transfer to the nearest facility having the capability to treat the condition if the transportation is connected with an Inpatient confinement.

Ambulatory Surgical Center. Services of an Ambulatory Surgical Center for Medically Necessary care provided.

Anesthesia. Anesthesia, anesthesia supplies, and administration of anesthesia by facility staff.

Birthing Center. Services of a birthing center for Medically Necessary care provided within the scope of its license.

Blood/Blood Derivatives. Charges for blood and blood plasma (if not replaced by or for the patient), including blood processing and administration services. Blood storage and blood destruction are not covered.

Chemotherapy. Charges for chemotherapy, including materials and services of technicians.

Chiropractic Care. Spinal adjustment and manipulation x-rays for manipulation and adjustment and other modalities performed by a Physician or other licensed practitioner, as limited in the "Summary of Benefits."

Cochlear Implants. Charges for cochlear implants for Participants who are certified as deaf or hearing impaired by a Provider.

Delivery of Services Using Telehealth. If a Network Provider offers covered services using Telehealth, the Plan will not deny the covered services because they are delivered using Telehealth. Covered services delivered using Telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the Plan that are at least as favorable as those requirements for the same service when not delivered using Telehealth.

Dental Services—Accident Only. Charges made for a continuous course of dental treatment started within 12 months from the date of the Injury to sound natural teeth. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support, and are functional in the arch.

> ***NOTE:*** *No charge will be covered under the medical Plan for dental and oral Surgical Procedures involving orthodontic care of teeth, periodontal disease, and preparing the mouth for fitting of or continued use of dentures.*

Diabetic Education. Services and supplies used in Outpatient diabetes self-management programs are covered under this Plan when they are provided by a Physician.

Dialysis. Charges for dialysis.

Durable Medical Equipment. Charges for rental, up to the purchase price, of Durable Medical Equipment, including glucose home monitors for insulin dependent diabetics. At its option, and with its advanced written approval, the Plan may cover the purchase of such items when it is less costly and more practical than rental. The Plan does not pay for any of the following:

1. Any purchases without the Plan's advanced written approval.
2. Replacements or repairs.

   > ***NOTE:*** *The Plan covers repair and replacement of Durable Medical Equipment when Medically Necessary due to a physiological change to the patient, due to normal wear and tear of an item, or if the existing equipment is damaged and cannot be made serviceable.*

3. The rental or purchase of items which do not fully meet the definition of "Durable Medical Equipment."

Foot Disorders. Surgical treatment of foot disorders, including associated services, performed by a licensed Physician (excluding routine foot care).

Gender-Affirming Care. The Plan covers the following gender-affirming services when ordered by a Provider or Physician:

- Psychotherapy.

- Pre- and post-surgical hormone therapy.
- Gender-affirming surgery/ies. Surgery must be performed by a qualified Provider.

Glaucoma. Treatment of glaucoma.

Hearing Aids. Charges for hearing aids, which includes examinations for the prescription, fitting, and/or repair of hearing aids.

Home Health Care. Charges for Home Health Care services and supplies are covered only for care and treatment of an Illness or Injury when Hospital or Skilled Nursing Facility confinement would otherwise be required. The Diagnosis, care, and treatment must be certified by the attending Physician and be contained in a home health care plan. Charges by a Home Health Care Agency for any of the following are covered:

1. Registered Nurses or Licensed Practical Nurses.
2. Certified home health aides under the direct supervision of a Registered Nurse.
3. Registered therapist performing physical, occupational, or speech therapy.
4. Physician calls in the office, home, clinic, or outpatient department.
5. Services, Drugs, and medical supplies which are Medically Necessary for the treatment of the Participant that would have been provided in the Hospital, but not including Custodial Care.
6. Rental of Durable Medical Equipment or the purchase of this equipment if economically justified, whichever is less.

   NOTE: *Transportation services are not covered under this benefit.*

Hospice Care. Charges relating to Hospice Care, provided the Participant has a life expectancy of six months or less, subject to the maximums, if any, stated in the "Summary of Benefits." Covered Hospice expenses are limited to:

1. Room and Board for confinement in a Hospice.
2. Ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Illness.
3. Medical supplies, Drugs, and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition.
4. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse, or a Licensed Vocational Nurse (L.V.N.).
5. Home health aide services.
6. Home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse, or a home health aide.
7. Medical social services by licensed or trained social workers, psychologists, or counselors.
8. Nutrition services provided by a licensed dietitian.
9. Respite care.

10. Bereavement counseling, which is a supportive service provided by the Hospice team to Participants in the deceased's family after the death of the terminally ill person, to assist the Participants in adjusting to the death. Benefits will be payable up to 5 visits per Participant if the following requirements are met:
    1. On the date immediately before their death, the terminally ill person was in a Hospice Care Program and a Participant under the Plan.
    2. Charges for such services are Incurred by the Participants within six months of the terminally ill person's death.

The Hospice Care program must be renewed in writing by the attending Physician every 30 days. Hospice Care ceases if the terminal Illness enters remission.

Hospital. Charges made by a Hospital for:

1. Inpatient Treatment:
    1. Daily semi private Room and Board charges.
    2. Intensive Care Unit ("ICU") and Cardiac Care Unit ("CCU") Room and Board charges.
    3. General nursing services.
    4. Medically Necessary services and supplies furnished by the Hospital, other than Room and Board.
2. Outpatient Treatment:
    1. Emergency room.
    2. Treatment for chronic conditions.
    3. Physical therapy treatments.
    4. Hemodialysis.
    5. X-ray, laboratory, and linear therapy.

Impregnation and Infertility Treatment. Charges for Infertility services include the initial evaluation and testing for infertility including history and physical exam of female and male partner, education of both partners regarding fertility, semen analysis, endometrial biopsy, post-coital examination, laboratory screenings, and laparoscopy and/or hysteroscopy as clinically indicated. For specific benefit information please contact member services directly at the phone number located on the back of the member ID card.

The following services are covered:

- Artificial insemination or intrauterine insemination (IUI).

Laboratory and Pathology Services. Charges for x-rays, diagnostic tests, labs, and pathology services.

Mastectomy. Coverage for Mastectomy, reconstruction of the breast on which the Mastectomy has been performed, surgery and reconstruction of the other breast, and prostheses and physical complications from all stages of Mastectomy, including lymphedemas as required by the Women's Health and Cancer Rights Act.

Medical Foods (Enteral formulas). Medical foods are considered a Covered Expense if intravenous therapy ("IV") or tube feedings are Medically Necessary. Medical foods taken orally are not covered under the Plan, except for PKU formula when Medically Necessary.

Disposable Medical Supplies. Supplies obtained in a medical setting that are primarily and customarily used only for a medical purpose, including but not limited to sterile bandages, cleansing solution, and catheter supplies. These supplies will be appropriate for use in the home and are meant to be discarded after use.

Mental Health and Substance Use Disorder Benefits. Benefits are available for Inpatient or Outpatient care for mental health and Substance Use Disorder conditions, including individual and group psychotherapy, psychiatric tests, and expenses related to the Diagnosis when rendered by a covered Provider. Benefits are also available for, but not limited to, Residential Treatment Facility, Partial Hospitalization, and Intensive Outpatient Services.

Midwife Services. Benefits for midwife services performed by a certified nurse midwife ("CNM") who is licensed as such and acting within the scope of their license. This Plan will not provide benefits for lay midwives or other individuals who become midwives by virtue of their experience in performing deliveries.

Newborn Care. Hospital or other approved Facility and Physician nursery care for newborns who are children of the employee or spouse and properly enrolled in the Plan, as set forth below. Benefits will be provided under the child's coverage, and the child's own Deductible and Coinsurance provisions will apply:

1. Hospital routine care for a newborn during the child's initial Hospital confinement at birth.
2. The following Physician services for well-baby care during the newborn's initial Hospital confinement at birth:
    1. The initial newborn examination and a second examination performed prior to discharge from the Hospital.
    2. Circumcision.

NOTE: *The Plan will cover Hospital or other approved Facility and Physician nursery care for an ill newborn as any other medical condition, provided the newborn is properly enrolled in the Plan. These benefits are provided under the baby's coverage.*

Nursing Services. Services of a Registered Nurse or Licensed Practical Nurse.

Nutritional Counseling. Charges for nutritional counseling for the management of a medical condition (including both physical and mental health conditions such as anorexia and bulimia).

Oral Surgery. Oral surgery in relation to the bone, including tumors, cysts and growths not related to the teeth, and extraction of soft tissue impacted teeth by a Physician or Dentist.

Physician Services. Services of a Physician for Medically Necessary care, including office visits, home visits, Hospital Inpatient care, Hospital Outpatient visits and exams, clinic care, and surgical opinion consultations.

Pregnancy Expenses. Expenses attributable to a Pregnancy, including as required under the Newborns' and Mothers' Health Protection Act of 1996. Pregnancy expenses of Dependent Children are not covered. Coverage may be available for expenses related to certain complications of Pregnancy. Benefits for Pregnancy expenses are paid the same as any other Illness.

Preventive Care. Charges for Preventive Care services.

Private Duty Nursing. Private duty nursing (Outpatient only).

Prosthetics, Orthotics, Supplies, and Surgical Dressings. Prosthetic devices (other than dental) to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, but not including charges for repair or maintenance. Orthotic devices but excluding orthopedic shoes and other supportive devices for the feet.

Rehabilitative Services and Therapies. Services for individual therapy are covered on an Inpatient or Outpatient basis. They are services or supplies used for the treatment of an Illness or Injury and include:

1. **Cardiac Therapy.** Charges for cardiac therapy.
2. **Cognitive Therapy.** Charges for cognitive therapy.
3. **Occupational Therapy.** Rehabilitation treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free standing outpatient facility.
4. **Physical Therapy.** Rehabilitation treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free standing duly licensed outpatient therapy facility.
5. **Respiration Therapy.** Respiration therapy services.
6. **Speech Therapy.** Charges for speech therapy.
7. **Vision Therapy.** For patients with eye movement disorders, designed to modify different aspects of visual function.

See the “Summary of Benefits” for treatment and/or frequency limitations, as applicable.

Radiation Therapy. Charges for radiation therapy and treatment.

Second Surgical Opinions. Charges for second surgical opinions.

Skilled Nursing Facility. Charges made by a Skilled Nursing Facility or a convalescent care facility, as defined in the Plan, up to the limits set forth in the “Summary of Benefits,” in connection with convalescence from an Illness or Injury for which the Participant is confined. For

information on Inpatient medical benefits for mental health or Substance Use Disorders, please refer to the "Mental Health and Substance Use Disorder Benefits" described above.

Surgery. Surgical operations and procedures, unless otherwise specifically excluded under the Plan, and limited as follows:

1. Multiple procedures adding significant time or complexity will be allowed at:
    a. One hundred percent (100%) of the Maximum Allowable Charge for the first or major procedure.
    b. Fifty percent (50%) of the Maximum Allowable Charge for the secondary and subsequent procedures.
    c. Bilateral procedures which add significant time or complexity, which are provided at the same operative session, will be allowed at one hundred percent (100%) of the Maximum Allowable Charge for the major procedure, and fifty percent (50%) of the Maximum Allowable Charge for the secondary or lesser procedure.
2. The Maximum Allowable Charge for services rendered by an assistant surgeon will be limited to twenty percent (20%) of the Maximum Allowable Charge identified for the surgeon's service.
3. No benefit will be payable for incidental procedures, such as an appendectomy during an abdominal Surgery, performed during a single operative session.

Surgical Treatment of Jaw. Surgical treatment of Diseases, Injuries, fractures and dislocations of the jaw by a Physician or Dentist.

Telehealth. Charges for any Medically Necessary services, for which benefits are otherwise provided by the Plan, when those services are provided via audio or video communications.

Telemedicine Program. In addition to providing Covered Services via telehealth, the Plan will cover online internet consultations between you and Providers who participate in the telemedicine program for a medical condition. Visit ***.StartwithGia.com for more information on Telemedicine services. Some of these services may include 24/7 virtual urgent/emergency care and mental health.

Temporomandibular Joint Disorder. Charges for the Diagnosis and treatment of, or in connection with, temporomandibular joint disorders, myofascial pain dysfunction, or orthognathic treatment.

Tobacco Use Disorder and/or Nicotine Dependency. Tobacco and nicotine dependence screening, counseling, nicotine withdrawal programs, facilities, Drugs, or supplies.

Transplants. Organ or tissue transplants are covered for the following human to human organ or tissue transplant procedures:

1. Bone marrow.
2. Heart.
3. Lung.

4. Heart and lung.
5. Liver.
6. Pancreas.
7. Kidney.
8. Cornea.

In addition, the Plan will cover any other transplant that is not Experimental.

Wigs. Charges associated with the initial purchase of a wig after chemotherapy or radiation therapy; however, the Plan will not cover wigs made from human hair unless the Participant is allergic to all synthetic wig materials.

Medical Exclusions

Some health care services are not covered by the Plan. In addition to the General Exclusions set forth in the "Benefit Plan Exclusions" section, these include, **but are not limited to**, any charge for care, supplies, or services, which are:

Abortion. For or related to an abortion.

Acupuncture. Relating directly or indirectly to acupuncture, including acupuncture provided in lieu of anesthetic.

Alternative Medicine. For holistic or homeopathic treatment, naturopathic services, and thermography, including drugs.

Biofeedback. For biofeedback.

Communication Aids. For the purchase, rental, repair, or replacement of communication aides. Communication aides that do not generate synthesized or digital speech are not covered. Examples of non-covered communication aides include the following: telecommunication devices for the deaf (TDDs), teletype machines (TTYs), Braille typewriters, flash cards, or devices that allow the patient to communicate written/typed (rather than synthesized) messages to others.

Conversion Therapy. The Plan will not cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Participant under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

Dietician Services. Except as specifically provided in this document, the Plan will not provide benefits for dietician services, homemaker services, home delivered meals, or other food or food-related services

Disposable Medical Supplies. Except as specifically provided in this document, the Plan will not provide benefits for disposable medical supplies including, but not limited to diapers, chux, sponges, syringes, needles, incontinence pads, reagent strips, catheters, elastic support stockings, compressive garments, dressings, and bandages.

Doula. This Plan does not cover benefits provided by a Doula.

Education or Training Program. Performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein.

Educational and Vocational Services. Except as specifically provided in this document, the Plan will not provide benefits for services required to determine appropriate educational or vocational placements or services or for other educational or vocational testing. The Plan will also not provide benefits for special education and related services, and assistive technology devices and assistive technology services determined to be needed as a result of such educational or vocational evaluations, including, but not limited to therapy services, cognitive retraining and rehabilitation, behavioral modification, services for remedial education, evaluation and treatment of learning disabilities, interpreter services and lessons in sign language.

Employer Services. Services furnished by a medical department or clinic provided by the Employer as part of employment.

Examinations. Any health examination required by any law of a government to secure insurance or school admissions or professional or other licenses, except as required under applicable federal law.

Experimental or Investigational Services. Except as specifically provided in this paragraph, the Plan will not provide benefits for services which the Claims Administrator determines are Experimental or Investigational services. However, the Plan will provide benefits for Experimental or Investigational services if the Claims Administrator determines: (a) that the proposed service has demonstrated promise in treating the underlying condition through a clinical trial sanctioned by the United States Food and Drug Administration; and (b) that an expert panel with quality assurance and technology assessment expertise has reviewed the proposed service and deemed it appropriate.

Hair Pieces. For wigs, artificial hair pieces, human or artificial hair transplants, or any Drug, prescription or otherwise, used to eliminate baldness. ***NOTE:*** *This Exclusion does not apply to hair pieces and wigs that are covered under the Plan for patients who are undergoing chemotherapy or radiation.*

Home Modifications and Fixtures and Home Appliances. Purchase, rental, repair, replacement, or maintenance of home modifications and fixtures including but not limited to installation of electrical power, water supply, or sanitary waste disposal, elevators, escalators, ramps, seat lift chairs, stair glides, handrails, swimming pools, whirlpool baths, home tracking systems, exercise or physical fitness equipment, air or water purifiers, central or unit air conditioners, humidifiers, dehumidifiers, and emergency alert systems and equipment, and business or vehicle modifications, or for services for evaluation, fitting, or modification of such modifications and fixtures.

Hypnosis. Related to the use of hypnosis.

Non-Standard Allergy Services. Non-standard allergy services, including, but not limited to skin titration, cytotoxicity testing, and urine auto injections.

Nutritional Supplements. For nutritional supplements.

Personal Convenience Items. For equipment that does not meet the definition of Durable Medical Equipment, including air conditioners, humidifiers, and exercise equipment, whether or not recommended by a Physician.

Pregnancy of a Dependent Child. Charges related to pregnancy incurred by an eligible Dependent Child, including, but not limited to, pre-natal, delivery and post-natal care, treatment of miscarriage and complications due to pregnancy, unless specifically provided as a covered benefit elsewhere in this Plan.

Repair of Purchased Equipment. For maintenance and repairs needed due to misuse or abuse of purchased equipment.

Replacement Braces. For replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Participant's physical condition to make the original device no longer functional.

Self-Help Education and Training. Except as specifically provided in this document, the Plan will not provide benefits for self-diagnosis, self-treatment, or self-help training.

Support Therapies. Except as specifically provided in this document, the Plan will not provide benefits for support therapies including, but not limited to, marriage counseling, pastoral or religious counseling, sex counseling, or other social counseling, assertiveness training, dream therapy, music or art therapy, recreational therapy, and play therapy.

Travel. For travel, whether or not recommended by a Physician, except as specifically provided herein.

Utilization Management Compliance. Services that exceed the number of visits authorized in a referral, by prior authorization or concurrent review, or for services that exceed a day or visit limit described in this document.

Vitamins. For vitamins.

Weight Loss Services. Except as specifically provided in this document, services or programs in connection with weight reduction, dietary control, dietary supplements, and exercise classes, or for surgical weight loss procedures, unless it is in connection with benefits for Medically Necessary covered services for the treatment of Class III Obesity (BMI is equal to or greater than 40.0 kg/m^2).

SCHEDULE OF NON-PPO PLAN BENEFITS FOR PARTICIPANTS AND THEIR COVERED DEPENDENTS

SERVICE CATEGORY	BENEFITS		
Vision Benefits[1] Annual Maximum	$75		
Dental Care Benefits[2] Annual Deductible[3] Per Individual[4] Annual Maximum Per Individual Per Family Orthodontia[5] – Lifetime Maximum	80% of Submitted Charges $50 $2,000 $4,000 $1,000		
Prescription Drug Benefits	**Participating**		**Non-Participating**
	Retail Pharmacy	Home Delivery	Pharmacy
Generic Copay	$10	$20	Not Covered
Brand Copay	$30	$60	Not Covered
PPI/NSA* Generic Copay	$50	$60	Not Covered
PPI/NSA* Brand Copay	$70	$100	Not Covered

Please refer to the following pages for a more detailed description of your benefit plan.

[1] This benefit is not covered under the PPO plan of benefits. Therefore, the annual medical deductibles and coinsurance do not apply.
[2] This benefit is not covered under the PPO plan of benefits. Therefore, the annual medical deductibles and coinsurance do not apply.
[3] Separate from the annual medical deductible.
[4] The annual dental deductible is waived for the remainder of the calendar year after three individuals have each met their deductible.
[5] Not subject to the annual dental deductible.
* PPI/NSA = Proton Pump Inhibitor and Non-Sedating Antihistamine.

VISION BENEFITS

Vision benefits are treated as a stand-alone (or excepted) benefit under the Health Insurance Portability and Accountability Act ("HIPAA") and the Patient Protection and Affordable Care Act ("ACA") as they are separately administered.

This benefit is a Non-PPO benefit and is not subject to the annual medical deductibles, coinsurance, and out-of-pocket maximums required under the MVP PPO plan benefits. Refer to the "Schedule of Non-PPO Plan Benefits" for the level of coverage provided by this benefit.

When a covered person incurs an expense for any of the following vision care services and such expenses are incurred for services rendered or supplies furnished by an Optician, Optometrist, or Ophthalmologist acting within the scope of their license, the Plan will pay up to the maximum amount shown in the "Schedule of Non-PPO Plan Benefits" for any one or more of the following vision care services:

- ♣ An eye examination performed by a licensed optometrist or ophthalmologist to determine if vision correction is necessary.
- ♣ Lenses if warranted by prescription.
- ♣ Contact lenses (excluding tinted contact lenses) if warranted by prescription.
- ♣ Frames if warranted by prescription.

Vision Care Expenses Not Covered

Payment by the Plan will not be made for the following vision care expenses:

1. Expenses for which benefits are payable under the MVP PPO Plan benefits or any governmental plan or law.
2. Any medical or surgical treatment or supplies furnished for treatment of any eye injury or eye disease.
3. Non-prescription sunglasses.
4. Orthoptics, vision training, or aniseikonia.
5. Expenses incurred for services performed or supplies furnished by other than a licensed Optician, Optometrist, or Ophthalmologist.
6. Expenses that the covered person is not required to pay.
7. Vision care expenses for which benefits are payable under Worker's Compensation legislation or for services provided by hospitals or facilities operated by federal, state, or municipal agencies for which no charge would have been made in the absence of insurance.

Vision benefits are not covered under the medical plan. Contact your Plan Administrator for more information or call CPS Optical at 212-675-5745.

DENTAL BENEFIT

Dental benefits are treated as a stand-alone (or excepted) benefit under the Health Insurance Portability and Accountability Act ("HIPAA") and the Patient Protection and Affordable Care Act ("ACA") as they are separately administered.

This benefit is a Non-PPO benefit and is not subject to the annual medical deductibles, coinsurance, and out-of-pocket maximums required under the MVP PPO plan benefits. Refer to the "Schedule of Non-PPO Plan Benefits" for the level of coverage provided by this benefit.

Amount of Benefits

When an individual has incurred covered dental charges for services, supplies, or treatment furnished (other than orthodontia), the Plan will pay an amount of benefits up to 80% of submitted charges after satisfaction of the deductible, up to the annual maximum benefits.

Deductibles:

Annual Deductible
Per Individual……..……..……..$50

The deductible is waived for the remainder of the calendar year after three individuals have each met their deductible.

Maximum Benefits
Annual Maximum Benefit
Per Individual……..……...…….$1,200
Per Family…….……..$2,500

Covered Dental Services

The Plan covers services and supplies for which a charge is made by a dentist or physician that are required in connection with the dental care and treatment of any diseases, defects, or accidental bodily injuries.

Benefit Determination

The Plan covers treatment performed while covered. Treatment will be considered to have been performed for the listed procedure as follows:

1. Dentures, full or partial – when the impression is taken for the appliance.
2. Fixed bridgework, crowns, and gold restorations – when the tooth is first prepared.
3. Root canal therapy – when the tooth is first prepared.
4. Orthodontics – when the first appliance is installed.

Orthodontia Benefits

Initial diagnosis and Appliances……..…...……$150

Maximum per person per course of treatment……..$1,000*

* The initial diagnosis and appliances maximum of $150 is included in the $1,000 maximum. The maximum monthly payment will be for expenses incurred for that month calculated by dividing the total charge for the course of treatment (not covered by the allowance for initial diagnosis and appliances) by the number of months scheduled for the course of treatment.

Exceptions and Limitations

The Plan does not cover:

1. Treatment on or to the teeth or gums for cosmetic purposes, including charges for personalization or characterizations of dentures.
2. Prosthetic services or devices (including bridge and crowns) started or underway prior to the date the Participant became eligible.
3. Dental conditions for which the person for whom the claim is presented has received, or is entitled to receive, compensation for that particular dental condition under any Worker's Compensation or occupational disease law.
4. Dental treatment provided by or paid for by the United States Government or any instrumentality thereof.
5. Replacement of lost or stolen prosthetics.
6. Replacement of prosthetics less than five (5) years after a preceding placement, except a denture replacement made necessary by the initial placement or an opposing full denture which necessitates the replacement of an existing denture.

The Deductible amount listed above is the amount each Participant must pay each toward Covered Expenses. Once the Deductible is satisfied, additional Covered Expenses will be reimbursed according to the percentages set forth above, subject to the limitations and Exclusions set forth in this section. Dental and Orthodontic expense benefits are separate from and in addition to the Medical Benefits of this Plan. These benefits are available only if elected by an Employee for themself and eligible Dependents.

<u>Alternate Treatment</u>

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a Participant chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the Participant and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Maximum Allowable Charge for an amalgam filling. The patient will pay the difference in cost.

Pre-Determination of Dental Benefits

If a planned dental service or Participant's proposed course of treatment can be reasonably expected to involve dental charges of $200 or more, a Participant may submit a description of the procedures to be performed and an estimate of the charges to the Fund Administrator or Claims Administrator prior to the commencement of the course of treatment. However, approval is not required prior to treatment. Any pre-determination of dental benefits is provided only as a convenience to the Participant.

If requested, the Fund Administrator or Claims Administrator will notify the Participant and the Dentist or Physician of the pre-determination based upon such proposed course of treatment. In determining the amount of benefits available, consideration will be given to alternate procedures, services, supplies and courses of treatment which may be performed to accomplish the required result.

The pre-determination is not a guarantee of payment or approval of a benefit. After treatment is received, a claim must be filed as a post service claim, which will be subject to all applicable Plan provisions.

SCHEDULE OF DENTAL BENEFITS FOR PARTICIPANTS

Benefit Category		Comments
General Benefit Information		
Annual Deductible	$50 per individual/$150 per family	
Last Quarter Carryover	No	
Annual Maximum Benefit	$2000.00 individual $4000.00 family	
Lifetime Maximum Benefit	$1000.00 applies to orthodontic related services	
Plan Benefit - Type 1 Expenses	80% of submitted charges, subject to the annual deductible	
Plan Benefit - Type 2 Expenses	80% of submitted charges, subject to the annual deductible	
Plan Benefit - Type 3 Expenses	80% of submitted charges, subject to the annual deductible	
Plan Benefit - Type 4 Expenses (Orthodontics)	50% of submitted charges	No age limitation applied to payable Orthodontic charges
Pre-Determination Required for Services:	N/A	
Penalty due to lack of Pre-Determination	N/A	
Clinical Oral Evaluations		
Routine Exams	80% of submitted charges, subject to the annual deductible	
Non-Routine Exams (Problem Focused)	80% of submitted charges, subject to the annual deductible	
Pre-Diagnostic Services	80% of submitted charges, subject to the annual deductible	
Radiographs/Diagnostic Imaging (Including Interpretation)		
Intraoral - Complete series (Including Bitewings)	80% of submitted charges, subject to the annual deductible	
Intraoral - Periapical/Occlusal Films	80% of submitted charges, subject to the annual deductible	
Extraoral Film(s)	80% of submitted charges, subject to the annual deductible	
Bitewings	80% of submitted charges, subject to the annual deductible	
Posterior-Anterior or Lateral skill and facial bone survey film	50% of submitted charges	Related to Orthodontic treatment
Sialography	50% of submitted charges	Related to Orthodontic treatment
TMJ arthrogram/Films	80% of submitted charges, subject to the annual deductible	
Tomographic survey	80% of submitted charges, subject to the annual deductible	

Panoramic Film	80% of submitted charges, subject to the annual deductible	
Cephalometric Film	50% of submitted charges	Related to Orthodontic treatment
Oral/facial photographic images	50% of submitted charges	Related to Orthodontic treatment
Cone Beam	80% of submitted charges, subject to the annual deductible	
Maxillofacial MRI	80% of submitted charges, subject to the annual deductible	
Maxillofacial ultrasound	80% of submitted charges, subject to the annual deductible	
Sialoendoscopy	80% of submitted charges, subject to the annual deductible	
Interpretation and Report Only	80% of submitted charges, subject to the annual deductible	
Test and Examinations		
Cultures	80% of submitted charges, subject to the annual deductible	
Genetic test	80% of submitted charges, subject to the annual deductible	
Caries susceptibility tests	80% of submitted charges, subject to the annual deductible	
Adjunctive pre-diagnostic tests	80% of submitted charges, subject to the annual deductible	
Pulp Vitality tests	80% of submitted charges, subject to the annual deductible	
Diagnostic casts	80% of submitted charges, subject to the annual deductible	
Oral Pathology Laboratory		
Accession of tissue	80% of submitted charges, subject to the annual deductible	
Decalcification procedure	80% of submitted charges, subject to the annual deductible	
Special Stains	80% of submitted charges, subject to the annual deductible	
Tissue in-situ hybridization	80% of submitted charges, subject to the annual deductible	
Exfoliative cytologic smears	80% of submitted charges, subject to the annual deductible	
Electron Microscopy-diagnostic	80% of submitted charges, subject to the annual deductible	
Immunofluorescence	80% of submitted charges, subject to the annual deductible	
Consultation on slides	80% of submitted charges, subject to the annual deductible	
Accession of brush biopsy	80% of submitted charges, subject to the annual deductible	

Other oral pathology procedures, by report	80% of submitted charges, subject to the annual deductible	
Dental Prophylaxis		
Adult	80% of submitted charges, subject to the annual deductible	
Child	80% of submitted charges, subject to the annual deductible	
Topical Fluoride Treatment (Office Procedure)		
Topical application of fluoride	80% of submitted charges, subject to the annual deductible	
Other Preventive Services		
Nutritional Counseling	80% of submitted charges, subject to the annual deductible	
Tobacco Counseling	80% of submitted charges, subject to the annual deductible	
Oral Hygiene Instructions	80% of submitted charges, subject to the annual deductible	
Sealants	80% of submitted charges, subject to the annual deductible	
Preventive Resin restoration	*Not Covered*	
Space Maintainers	80% of submitted charges, subject to the annual deductible	
Restorative Services		
Amalgam Restorations	80% of submitted charges, subject to the annual deductible	
Resin-Based composite Restorations - Direct	80% of submitted charges, subject to the annual deductible	
Gold Foil Restorations	80% of submitted charges, subject to the annual deductible	
Inlay/Onlay - Metallic	80% of submitted charges, subject to the annual deductible	
Inlay/Onlay - Porcelain/ceramic	80% of submitted charges, subject to the annual deductible	
Inlay/Onlay - Resin-based composite	80% of submitted charges, subject to the annual deductible	
Crowns - Single Restorations Only	80% of submitted charges, subject to the annual deductible	
Recement inlay, onlay or partial coverage restoration	80% of submitted charges, subject to the annual deductible	
Recement cast or prefabricated post and core	80% of submitted charges, subject to the annual deductible	
Recement crown	80% of submitted charges, subject to the annual deductible	
Prefabricated porcelain/ceramic crown	80% of submitted charges, subject to the annual deductible	
Prefabricated stainless steel crown	80% of submitted charges, subject to the annual deductible	

Prefabricated resin crown	80% of submitted charges, subject to the annual deductible	
Sedative filling	80% of submitted charges, subject to the annual deductible	
Core buildup, including pins	80% of submitted charges, subject to the annual deductible	
Pin retention	80% of submitted charges, subject to the annual deductible	
Cast post and core/post removal	80% of submitted charges, subject to the annual deductible	
Labial Veneer	*Not Covered*	
Temporary crown (fractured tooth)	80% of submitted charges, subject to the annual deductible	
Additional procedures to construct new crown under existing partial denture framework	80% of submitted charges, subject to the annual deductible	
Coping	80% of submitted charges, subject to the annual deductible	
Crown Repair, by report	80% of submitted charges, subject to the annual deductible	
Inlay repair necessitated by restorative material failure	80% of submitted charges, subject to the annual deductible	
Onlay repair necessitated by restorative material failure	80% of submitted charges, subject to the annual deductible	
Veneer repair necessitated by restorative material failure	80% of submitted charges, subject to the annual deductible	
Resin infiltration of incipient smooth surface lesions	80% of submitted charges, subject to the annual deductible	
Endodontics		
Pulp Capping	80% of submitted charges, subject to the annual deductible	
Pulpotomy	80% of submitted charges, subject to the annual deductible	
Pulpal therapy on primary teeth	80% of submitted charges, subject to the annual deductible	
Endodontic therapy (Including treatment plan, clinical procedures and follow-up care)	80% of submitted charges, subject to the annual deductible	
Endodontic retreatment	80% of submitted charges, subject to the annual deductible	
Apexification/Recalcification procedures	80% of submitted charges, subject to the annual deductible	
Pulpal regeneration	*Not Covered*	
Apicoectomy/Periradicular Services	80% of submitted charges, subject to the annual deductible	
Surgical procedure for isolation of tooth with rubber dam	80% of submitted charges, subject to the annual deductible	
Hemisection, not including root canal therapy	80% of submitted charges, subject to the annual deductible	

Canal preparation and fitting of preformed dowel or post	80% of submitted charges, subject to the annual deductible	
Periodontics - Surgical Services		
Ginivectomy or gingivoplasty	80% of submitted charges, subject to the annual deductible	
Anatomical crown exposure	80% of submitted charges, subject to the annual deductible	
Gingival flap procedure, including root planing	80% of submitted charges, subject to the annual deductible	
Apically position flap	80% of submitted charges, subject to the annual deductible	
Crown lengthening	80% of submitted charges, subject to the annual deductible	
Osseous surgery	80% of submitted charges, subject to the annual deductible	
Bone replacement graft	80% of submitted charges, subject to the annual deductible	
Biologic materials to aid in tissue regeneration	80% of submitted charges, subject to the annual deductible	
Guided tissue regeneration	80% of submitted charges, subject to the annual deductible	
Surgical revision procedure	80% of submitted charges, subject to the annual deductible	
Tissue graft procedures	80% of submitted charges, subject to the annual deductible	
Periodontics - Non-Surgical Services		
Provisional splinting	80% of submitted charges, subject to the annual deductible	
Periodontal scaling/root planing	80% of submitted charges, subject to the annual deductible	
Full mouth debridement	80% of submitted charges, subject to the annual deductible	
Localized delivery of antimicrobial agents	80% of submitted charges, subject to the annual deductible	
Periodontics - Other Services		
Periodontal maintenance	80% of submitted charges, subject to the annual deductible	
Unscheduled dressing change	80% of submitted charges, subject to the annual deductible	
Prosthodontics (Removable)		
Complete Dentures	80% of submitted charges, subject to the annual deductible	5 year replacement rule applies
Partial Dentures	80% of submitted charges, subject to the annual deductible	5 year replacement rule applies
Adjustments to Dentures	80% of submitted charges, subject to the annual deductible	
Repairs to Complete Dentures	80% of submitted charges, subject to the annual deductible	

Repairs to Partial Dentures	80% of submitted charges, subject to the annual deductible	
Denture Rebase Procedures	80% of submitted charges, subject to the annual deductible	
Denture Reline Procedures	80% of submitted charges, subject to the annual deductible	
Interim Prosthesis	80% of submitted charges, subject to the annual deductible	
Tissue Conditioning	80% of submitted charges, subject to the annual deductible	
Overdenture	80% of submitted charges, subject to the annual deductible	
Precision attachment, by report	*Not Covered*	
Modification of removable prosthesis following implant surgery	80% of submitted charges, subject to the annual deductible	
Maxillofacial Prosthetics		
Maxillofacial Prosthetics	80% of submitted charges, subject to the annual deductible	D5992,D5993 - Not Covered
Implant Services		
Surgical Implant	80% of submitted charges, subject to the annual deductible	
Implant Supported Prosthesis	80% of submitted charges, subject to the annual deductible	
Implant removal/repair	80% of submitted charges, subject to the annual deductible	
Radiographic/surgical implant index	80% of submitted charges, subject to the annual deductible	
Prosthodontics - Fixed		
Fixed Partial Denture Pontics	80% of submitted charges, subject to the annual deductible	5 year replacement rule applies
Interm pontic	*Not Covered*	
Fixed Partial Denture Retainers	80% of submitted charges, subject to the annual deductible	5 year replacement rule applies
Fixed Partial Denture Inlays	80% of submitted charges, subject to the annual deductible	
Fixed Partial Denture Onlays	80% of submitted charges, subject to the annual deductible	
Fixed Partial Denture Retainers - Crowns	80% of submitted charges, subject to the annual deductible	
Interim retainer crown	*Not Covered*	
Connector Bar	80% of submitted charges, subject to the annual deductible	
Recement fixed partial denture	80% of submitted charges, subject to the annual deductible	
Stress breaker	80% of submitted charges, subject to the annual deductible	

Precision Attachment	*Not Covered*	
Cast post/core services related to fixed partial	80% of submitted charges, subject to the annual deductible	
Coping	80% of submitted charges, subject to the annual deductible	
Fixed partial denture repair	80% of submitted charges, subject to the annual deductible	
Pediatric partial denture, fixed	80% of submitted charges, subject to the annual deductible	
Oral and Maxillofacial Surgery		
Extractions (Includes local anesthesia, suturing, if needed and routine postoperative care)	80% of submitted charges, subject to the annual deductible	
Surgical Extractions (Includes local anesthesia, suturing, if needed and routine postoperative care)	80% of submitted charges, subject to the annual deductible	
Coronectomy - intentional partial tooth removal	*Not Covered*	
Oroantral fistula closure	80% of submitted charges, subject to the annual deductible	
Closure of sinus perforation	80% of submitted charges, subject to the annual deductible	
Tooth reimplantation,transplantation	80% of submitted charges, subject to the annual deductible	
Surgical access of unerupted tooth	80% of submitted charges, subject to the annual deductible	
Mobilization of tooth	80% of submitted charges, subject to the annual deductible	
Placement of device to facilitate eruption of tooth	50% of submitted charges	Related to Orthodontics
Biopsy of oral tissue	80% of submitted charges, subject to the annual deductible	
Exfolative cytological sample	80% of submitted charges, subject to the annual deductible	
Brush biopsy	80% of submitted charges, subject to the annual deductible	
Surgical repositioning of tooth	80% of submitted charges, subject to the annual deductible	
Fiberotomy	80% of submitted charges, subject to the annual deductible	
Surgical placement: temporary anchorage device	80% of submitted charges, subject to the annual deductible	
Harvest of bone for autogenous grafting procedure	*Not Covered*	
Alveoloplasty	80% of submitted charges, subject to the annual deductible	
Excision of soft tissue lesions	80% of submitted charges, subject to the annual deductible	

Excision of intra-osseous lesions	80% of submitted charges, subject to the annual deductible	
Excision of bone tissue	80% of submitted charges, subject to the annual deductible	
Incision and drainage of abscess	80% of submitted charges, subject to the annual deductible	
Removal of foreign body	80% of submitted charges, subject to the annual deductible	
Partial Ostectomy/Sequestrectomy	80% of submitted charges, subject to the annual deductible	
Maxillary sinusotomy	80% of submitted charges, subject to the annual deductible	
Simple fracture treatment	80% of submitted charges, subject to the annual deductible	
Compound fracture treatment	80% of submitted charges, subject to the annual deductible	
Reduction of dislocation and management of other TMJ dysfunctions	80% of submitted charges, subject to the annual deductible	
Repair of traumatic wounds	80% of submitted charges, subject to the annual deductible	
Complicated suturing	80% of submitted charges, subject to the annual deductible	
Skin graft	80% of submitted charges, subject to the annual deductible	
Collection and application of autologous blood concentrate product	*Not Covered*	
Osteoplasty for orthognathic deformities	80% of submitted charges, subject to the annual deductible	
Osteotomy	80% of submitted charges, subject to the annual deductible	
LeFort I/II/III	80% of submitted charges, subject to the annual deductible	
Osseous, osteoperiosteal or cartilage graft	80% of submitted charges, subject to the annual deductible	
Sinus augmentation	80% of submitted charges, subject to the annual deductible	
Bone replacement graft for ridge preservation	80% of submitted charges, subject to the annual deductible	
Repair of maxillofacial tissue defect	80% of submitted charges, subject to the annual deductible	
Frenulectomy/Frenuloplasty	80% of submitted charges, subject to the annual deductible	
Excision of hyperplastic tissue	80% of submitted charges, subject to the annual deductible	
Excision of pericoronal gingival	80% of submitted charges, subject to the annual deductible	

Surgical reduction of fibrous tuberosity	80% of submitted charges, subject to the annual deductible	
Sialolithotomy	80% of submitted charges, subject to the annual deductible	
Excision of salivary gland	80% of submitted charges, subject to the annual deductible	
Sialodochoplasty	80% of submitted charges, subject to the annual deductible	
Closure of salivary fistula	80% of submitted charges, subject to the annual deductible	
Emergency tracheotomy	80% of submitted charges, subject to the annual deductible	
Coronoidectomy	80% of submitted charges, subject to the annual deductible	
Synthetic graft	80% of submitted charges, subject to the annual deductible	
Implant-mandible for augmentation	80% of submitted charges, subject to the annual deductible	
Appliance removal	80% of submitted charges, subject to the annual deductible	
Intraoral placement of a fixation device not in conjunction with a fracture	80% of submitted charges, subject to the annual deductible	
Orthodontic Services		
Limited Orthodontic treatment	50% of submitted charges	No age limitation applied to payable Orthodontic charges
Interceptive Orthodontic treatment	50% of submitted charges	No age limitation applied to payable Orthodontic charges
Comprehensive Orthodontic treatment	50% of submitted charges	No age limitation applied to payable Orthodontic charges
Treatment to control harmful habits	50% of submitted charges	No age limitation applied to payable Orthodontic charges
Pre-orthodontic treatment visit	50% of submitted charges	No age limitation applied to payable Orthodontic charges
Periodic orthodontic treatment visit	50% of submitted charges	No age limitation applied to payable Orthodontic charges
Orthodontic Retention	50% of submitted charges	No age limitation applied to payable Orthodontic charges
Orthodontic treatment (alternative billing to a contract fee)	50% of submitted charges	No age limitation applied to payable Orthodontic charges

Repair of Orthodontic appliance	50% of submitted charges	No age limitation applied to payable Orthodontic charges
Replacement of lost or broken retainer	50% of submitted charges	No age limitation applied to payable Orthodontic charges
Rebond/cement/repair retainer	50% of submitted charges	No age limitation applied to payable Orthodontic charges
Other General Services		
Palliative (Emergency) treatment of dental pain	80% of submitted charges, subject to the annual deductible	
Fix partial denture section	80% of submitted charges, subject to the annual deductible	
Local Anesthesia	80% of submitted charges, subject to the annual deductible	
General Anesthesia	80% of submitted charges, subject to the annual deductible	
Analgesia	80% of submitted charges, subject to the annual deductible	
Professional Consultation	80% of submitted charges, subject to the annual deductible	
Professional Visits	80% of submitted charges, subject to the annual deductible	
Therapeutic drug injection	80% of submitted charges, subject to the annual deductible	
Other drugs and/or medicaments, by report	80% of submitted charges, subject to the annual deductible	
Application of desensitizing medicament/resin	80% of submitted charges, subject to the annual deductible	
Behavior management	80% of submitted charges, subject to the annual deductible	
Treatment of complications (Post-Surgical)	80% of submitted charges, subject to the annual deductible	
Occlusal Guard	80% of submitted charges, subject to the annual deductible	
Fabrication of athletic mouthguard	80% of submitted charges, subject to the annual deductible	
Repair/Reline of occlusal guard	80% of submitted charges, subject to the annual deductible	
Occlusion analysis	80% of submitted charges, subject to the annual deductible	
Occlusal adjustment	80% of submitted charges, subject to the annual deductible	
Enamel Microabrasion	80% of submitted charges, subject to the annual deductible	
Odontoplasty	80% of submitted charges, subject to the annual deductible	
External/Internal bleaching	*Not Covered*	

PRESCRIPTION DRUG BENEFIT

This benefit is a non-PPO benefit and is not subject to the annual medical deductibles, coinsurance, out-of-pocket maximums, and lifetime maximum required under the MVP PPO plan benefits.

The following is a general summary of the key features of this program.

	Participating Retail Pharmacy Service	Home Delivery Pharmacy Service
When to Use	When you need a prescription on a short-term basis *(for example, an antibiotic to treat strep throat)*	For prescriptions you use on a regular basis *(for example, medication to reduce blood pressure)*
Supply per Prescription/Refill	Up to 30 days	Up to 90 days
Your Copay Per Prescription/Refill		
Generic	$10	$20
Brand	$30	$60
PPI/NSA* Generic	$50	$60
PPI/NSA* Brand	$70	$100
Member Services	1 (866) 544-2926 24 hours a day	

PPIs/NSAs

Certain PPIs and NSAs are available over the counter ("OTC"). Purchasing OTC drugs instead of prescription drugs can save you money. You should contact Express Scripts Member Services to find out which PPIs and NSAs are available OTC.

Participants seeking PPI/NSA Brand medications are required to receive prior authorization through a Formulary Coverage Review (FCR) by calling 1-800-753-2851.

Member Services

Most doctors' offices submit prescriptions electronically, but if you want to request home delivery, you can call Express Scripts at 1 (866) 544-2926 to:

1. Request Home Delivery Pharmacy Service order forms or envelopes.
2. Find a participating pharmacy.
3. Speak with an Express Scripts Member Services representative.
4. Speak with a registered pharmacist

* PPI/NSA = Proton Pump Inhibitor and Non-Sedating Antihistamine. Examples of PPIs are Nexium, Prevacid, Aciphex, Protonix, and Omeprazole. Examples of NLSAs are Zyrtec, Allegra, and Clarinex.

* PPI/NSA = Proton Pump Inhibitor and Non-Sedating Antihistamine. Examples of PPIs are Nexium, Prevacid, Aciphex, Protonix, and Omeprazole. Examples of NSAs are Zyrtec, Allegra, and Clarinex.

Or go online at ***.express-scripts.com or use the Express Scripts Mobile App to:

- ♣ Order and track the status of your home delivery prescriptions.
- ♣ Check prescription coverage and pricing.
- ♣ Request Home Delivery Pharmacy Service order forms and envelopes.
- ♣ Locate a participating retail network pharmacy and download claim forms.

Retail Pharmacy Service

The retail network pharmacy is most convenient when filling your short-term prescription needs.

Ordering new prescriptions or refills at a participating retail pharmacy:

1. Show your prescription I.D. card at the pharmacy.
2. Pay your coinsurance (the pharmacist will tell you the amount).

Home Delivery Pharmacy Service

1. The home delivery network pharmacy is most convenient and cost-saving when filling your long-term prescription needs.
2. Your medications are dispensed by one of the pharmacists in Express Script's network of home delivery pharmacies.
3. Medications are shipped to you by standard delivery at no additional cost (express shipping is available for an added charge).
4. You can track your prescriptions at ***.express-scripts.com, by calling **1 (866) 544-2926**, or on the Express Scripts Mobile App.

Registered pharmacists are available around the clock for medication consultations.

Ordering New Prescriptions

Ask your doctor to write a new prescription for up to the number of days permitted by the plan (90 days) plus refills (if appropriate) for up to one (1) year. Prescriptions may be submitted as follows:

1. **Electronically**
   Ask your doctor to submit the new prescription(s) electronically to ESI.

2. **Mail**
   Send the new prescription(s), along with the enclosed "Express Scripts Home Delivery Pharmacy Service Order Form" and the appropriate copay to Express Scripts in the return envelope.

   Express Scripts
   Mail your prescriptions using a self-stamped envelope to:

   Express Scripts
   P.O. Box 66577
   Saint Louis, MO 63166-6577

EnGuide Pharmacy / CHD
Mail your GLP-1 prescriptions (e.g., Monjarno or Ozempic) using a self-stamped envelope to:

EnGuide Pharmacy / CHD
P.O. Box 66500
St. Louis, MO 63166-6500

3. **Fax**
   Ask your doctor to call the fax information line: **1 (888) 327-9791** for faxing instructions. Only your doctor may fax a prescription. Please be sure to give your doctor your member I.D. number, which is on your prescription I.D. card. You will be billed later.

4. **Online**
   Visit ***.express-scripts.com. Once you are registered and logged in, scroll to the bottom of the "order center", click on the "request a new prescription from your doctor" link, and follow the on-screen instructions.

   Your medication will be delivered to you within 7 to 11 days after you mail your order. Orders placed via the Internet or fax may be received even faster. Standard shipping is free. When placing your order, you should have at least a 14-day supply of that medication on hand to hold you over. If you do not have enough medication, you may need to ask your doctor for another prescription for a 14-day supply to be filled at your local retail network pharmacy.

Refilling your Prescription
You can easily refill your home delivery prescriptions online, by telephone, or by mail. You must have your member I.D. number (which is on your prescription I.D. card) and your prescription number for the medication available.

1. **Online**
   Each time registered users log on to ***.express-scripts.com, available prescription refills will be displayed in the personalized "order center", as well as within your prescription history. From the order center, simply check the box next to the items you want to order and follow the on-screen instructions to check out.

2. **Telephone**
   Call 1 (866) 544-2926 to use the automated refill system.

3. **Mail**
   Use the refill order form that will accompany your prescription. Mail them with your copay to Express Scripts in the return envelope.

Special Services
To access TTY service for hearing-impaired members call **1 (800) 759-1089.**

To request Braille labels for Express Scripts Home Delivery Pharmacy Service prescriptions, call **1 (866) 544-2926.**

Medical Necessity
The following are covered benefits only if medically necessary unless listed as an exclusion below:

1. Erythroid Stimulants (i.e. Epogen/Procrit)

Prior Authorization
This program provides coverage for some drugs only if they are prescribed for certain uses. For this reason, some medications must receive prior authorization before they can be covered. If the prescribed medication requires prior authorization, please contact the Fund Administrator. If your medication is not approved for coverage under this Plan, you will be responsible for paying the full cost of the drug.

Prior authorization is required for the following prescription drugs:

1. Injectable medications (except those listed under covered drugs, medical necessity, or exclusions)
2. Ostomy supplies
3. Retin-A
4. Anabolic steroids
5. Drugs to treat impotency:
   - Retail: limited to 30 days or 6 units, whichever is less per claim
   - Express Scripts Home Delivery Pharmacy Service: limited to 90 days or 18 units, whichever is less per claim.

Generic Drugs
The brand name is the product name under which a drug is advertised and sold. Generic medications contain the same active ingredients and are subject to the same rigid U.S. Food and Drug Administration ("FDA") standards for quality, strength, and purity as their brand name counterparts. Generally, generic drugs cost less than a brand name drug. Please ask your doctor to prescribe generic drugs whenever appropriate.

Frequently Asked Questions

1. **Are my prescriptions covered at any pharmacy?**
   No, prescriptions are covered only if they are filled at participating pharmacies.

2. **Will my pharmacy know how to process my prescriptions with Express Scripts?**
   You will need to tell your pharmacy that your pharmacy benefit administrator is Express Scripts. Present your Express Scripts card to the participating retail pharmacy so your member information can be entered.

3. **Will my pharmacy know the correct copays to charge me?**
   Express Scripts electronically sends the correct copay amount when your pharmacy processes your prescription online.

4. **What should** I **do if my pharmacy has problems using my card?**
   First, make sure your pharmacy has entered your Express Scripts card information in their system. Participating pharmacies have been supplied with the Express Scripts pharmacy helpline telephone number to call for help. You may also call the Member Services number on the back of your card (**1 (866) 544-2926)** if there is any problem using your card. Please contact the Fund Administrator if you have questions regarding eligibility or if you believe your prescription is not being processed correctly.

5. **Do I need to fill out the Health, Allergy** & **Medication Questionnaire?**
   You will need to complete this if you wish to use Express Scripts Home Delivery Pharmacy Service. This allows Express Scripts' system to send warning messages to the pharmacist if you are using medicines that may be a problem for you based on your health conditions. Please send the questionnaire to Express Scripts.

6. **What do I need to do if I am using the Home Delivery Pharmacy for the first time?**
   Have your doctor complete two prescriptions. The first should be for up to a 30-day supply that you can fill at your local pharmacy. The second prescription should be for up to a 90-day supply to send to Express Scripts Home Delivery Pharmacy Service. Covered drugs may be subject to limit on quantity, dosage, or treatment duration.

7. **How do I tell Express Scripts Home Delivery Pharmacy Service that I want to use only brand name medicines?**
   You will need to contact Member Services using the telephone number on the back of your ID card. Otherwise, they will fill your prescription with a generic equivalent, if available.

8. **How can** I **check on the status of my mail order?**
   You may call the Member Services number on the back of your card or log onto the Express Scripts website shown on the front of your card.

Prescription Drug Exclusions

The following are excluded from coverage unless specifically listed as a benefit under "Covered Drugs":

1. Non-Federal Legend Drugs
2. Federal Legend Non-Drugs
3. Non Federal Legend Non-Drugs
4. Investigational Drugs
5. Prescription Digital Therapeutics Exclusion Drug List
6. VARIZIG (STD)

7. Oral Vaccines (Std)
8. Home Delivery: ACA Merged Offering Vaccines
9. Smoking Deterrents (Std, Legend)
10. Bricklayers Local 5 Custom Misc. Exclusion
11. Abortifacients (Std) Mifeprex
12. Hydroquinone, Skin Bleaching Agent
13. STD Cosmetic Drugs -ALL(Photo Aged, Depig, Hair Growth, Inj)
14. Biologicals - Human Regenerative Tissue
15. Immuno-supressants, Systemic (Stdl)
16. Antigenic Skin Test - Tuberculosis Intradermal
17. Home Delivery: Antigenic Skin Tests
18. Home Delivery: RABIES VACCINE/IMMUN AGNT
19. Biologicals, Immunizations/Vaccines, Allergy Sera, Blood Prd
20. Takhzyro (Std)
21. Crysvita (burosumab)
22. Colony Stimulating Factors
23. CNS Stimulants (Std, Legend)
24. Amphetamines (Std)
25. Methadone/Dolophine (Std)
26. Substance Abuse Treatment Agents (Std, All)
27. Anti-Obesity Preparations (Std, OTC and Legend)
28. Hematinics (Std, Legend)
29. Vitamins (Std, Legend)
30. RX Fluoride Prep - Std
31. Static INJ00529: EPINEPHRINE GPI 12
32. Clarinex (Std)
33. First-Lansoprazole
34. FIRST OMEPRAZOLE (STD)
35. Fasenra (Std)
36. Zinplava (Std)
37. Nascobal SS/ MS
38. Fertility Agents (Std, All)
39. Depo-Provera/Depo-SubQProvera (Std)
40. Contraceptives Except oral/injectable (Std)
41. SUB-Q Infusion Pump, STD

DEATH BENEFIT

A death benefit will be paid to your named beneficiary in the event of your death from any cause. Be sure to fill out a "Designation of Beneficiary" card. The Designation of Beneficiary cards are always available from the Fund Office. You may change your beneficiary at any time you desire by filling out a new card.

If you fail to name a beneficiary or if the person you designated as your beneficiary dies before you, your death benefit will be paid to your estate.

The Fund Administrator will notify your beneficiary of your death benefit. A minimum of three letters of notification will be sent to your beneficiary. If there is no response to these notifications within six months from the date of the first letter, your death benefit will be forfeited to the Welfare Fund. Your forfeited death benefit will be used to pay the administrative expenses of operating the Welfare Fund.

Any attempted assignment by the beneficiary will be considered null and void. In such case, the money will be held by the Trustees for such purposes, as they, in their sole discretion, deem proper.

Refer to the "Schedule of Benefits" for the death benefit.

EFFECT OF MEDICARE

If you are 65 years or over, or if you qualify under any of the special provisions of the Medicare law (such as Social Security Disability), you are eligible for Social Security health benefits – Medicare. The same rules apply to your spouse.

- ♣ Medicare Part "A" helps pay for hospitalization services and is provided without a premium charge by the Federal Government.
- ♣ Medicare Part "B" helps pay for doctor's services and many other health care services and is provided at a monthly premium charge by the Federal Government.

To be sure that you are eligible for Medicare benefits – Part A and Part B – you should register for Medicare within three months before your 65th birthday, whether or not you expect to continue to work after age 65.

Once you are retired and eligible for Medicare benefits, the Plan will not pay benefits that you could receive from Medicare. Once your covered Dependent spouse becomes eligible for Medicare, the Plan will not pay benefits your Dependent spouse could receive from Medicare.

Evidence of participation in Medicare must be submitted to the Fund Office upon the date you and/or your spouse start participation.

There are special rules for coverage of working retired members (and covered Dependent spouses of working retired members) who are:

a. Age 65 or over;

b. Eligible for Medicare benefits; and

c. Eligible for Fund coverage.

If you are a person meeting these conditions:

1. This Fund's benefit plan is your "primary" health insurance plan for hospital and doctor services. This means you continue to submit all your claims to the Fund Office and receive the same benefits as any younger eligible retired member or Dependent spouse.

2. Medicare is your "secondary" health insurance plan for hospital and doctor services. After this Plan pays "primary" benefits, you should submit a claim to Medicare for any remaining expenses.

This Plan ceases to be "primary" health insurance plan on the earlier of:

a. The date a Participant aged 65 and over retires; or

b. For a covered Dependent spouse aged 65 or over, the date their spouse retires.

At the date of a. or b. above, Medicare becomes the "primary" health insurance plan for hospital services covered under Medicare Part A and for doctor's services covered under Medicare Part B. You should submit your hospital and doctor claims to Medicare for payment of any "primary" benefits.

Those receiving monthly Social Security Disability benefits will become eligible for Medicare benefits 24 months after the date of entitlement of their Social Security award.

BENEFIT PLAN EXCLUSIONS

In addition to any exclusions and limitations described in other sections of this Plan, the Plan will not provide benefits arising from care, supplies, treatment, and/or services for:

Administrative Costs. Expenses that are solely for and/or applicable to administrative costs of completing claim forms or reports or for providing records wherever allowed by applicable law and/or regulation.

After the Termination Date. Expenses that are incurred by the Participant on or after the date coverage terminates, unless termination occurs while receiving inpatient services, even if payments have been predetermined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the Plan or applicable law and/or regulation.

Alcohol. Expenses involving a Participant who has taken part in any activity made illegal either due to the use of alcohol or a state of intoxication. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an activity made illegal due to the use of alcohol or a state of intoxication. Expenses will be covered for Injured Participants other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for Substance Use Disorder treatment as specified in this Plan, if applicable. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical, mental health, or substance use disorder condition), even if the condition is not diagnosed before the Injury.

Broken/Missed Appointments. Expenses that are charged solely due to the Participant's having failed to honor an appointment.

Complications of Non-Covered Services. Expenses that are required as a result of complications from a service not covered under the Plan, unless expressly stated otherwise.

Cosmetic Surgery. Expenses that are incurred in connection with the care and/or treatment of Surgical Procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or supply which are primarily used to improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, except to the extent where it is needed for: (a) repair or alleviation of damage resulting from an accident; (b) because of infection or Illness; (c) because of congenital disease, developmental condition or anomaly of a covered Dependent child which has resulted in a functional defect; or (d) as required under the Women's Health and Cancer Rights Act of 1998. A treatment will be considered cosmetic for either of the following reasons: (a) its primary purpose is to beautify; or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to Injury, Illness, or congenital abnormality. The term "cosmetic services" includes those services which are described in IRS Code Section 213(d)(9).

Custodial Care. Expenses that do not restore health, unless specifically mentioned otherwise.

Excess. Expenses that exceed Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.

Experimental. Expenses that are Experimental or Investigational.

Family Member. Expenses for treatment or services that are performed by a person who is related to the Participant as a spouse, parent, child, brother or sister, whether the relationship exists by virtue of "blood" or "in law".

Foreign Services. Except for Emergency, the Plan will not provide benefits for services accessed outside the United States. Services that are received outside of the United States if travel is for the purpose of obtaining medical services will not be covered, unless otherwise approved by the Plan Administrator or Claims Administrator.

Government. Expenses for treatment or services that the Participant obtains, but which is paid, may be paid, is provided or could be provided for at no cost to the Participant through any program or agency, in accordance with the laws or regulations of any government, or where care is provided at government expense, unless there is a legal obligation for the Participant to pay for such treatment or service in the absence of coverage. This Exclusion does not apply when otherwise prohibited by law, including laws applicable to Medicaid and Medicare.

Government-Operated Facilities. That meet the following requirements:

1. That are services furnished to the Participant in any veteran's Hospital, military Hospital, Institution or facility operated by the United States Government or by any State government or any agency or instrumentality of such governments.
2. That are services or supplies which can be paid for by any government agency, even if the patient waives their rights to those services or supplies.

This Exclusion does not apply where otherwise prohibited by law.

Hazardous Pursuit, Hobby or Activity. That are of an Injury or Illness that results from engaging in a hazardous pursuit, hobby, or activity for the purpose of financial gain including but not limited to jet skiing, motorcycling, snowmobiling, sky diving, bungee jumping, race car driving, cliff climbing, riding ATVs, etc.

Illegal Acts. Expenses that arise from or are caused during the commission of any illegal act. It is not necessary for an arrest to occur, charges to be filed, incarceration to occur, or a conviction to be had for this Exclusion to apply. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical, mental health, or substance use disorder conditions), even if the condition is not diagnosed before the Injury.

Illegal Drugs or Medications. Expenses that are for services, supplies, care, or treatment to a Participant for Injury or Illness incurred while the Participant was voluntarily taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. This Exclusion will apply even if the Participant has a prescription for the drug and the drug is legal in the state where the Participant lives. Expenses will be covered for Injured Participants other than the person using controlled substances and expenses will be covered for Substance Use Disorder treatment as specified in this Plan. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical, mental health, or substance use disorder conditions), even if the condition is not diagnosed before the Injury.

Incurred by Other Persons. Expenses that are expenses actually incurred by other persons.

Long Term Care. Expenses that are related to long-term care.

Medical Necessity. Expenses that are not Medically Necessary and/or arise from services and/or supplies that are not Medically Necessary.

Military Service. That are related to conditions determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

Negligence. Expenses that are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, institution, or Provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator.

No Coverage. Expenses that are Incurred at a time when no coverage is in force for the applicable Participant and/or Dependent.

No Legal Obligation. Expenses that are for services provided to a Participant for which the Provider of a service does not and/or would not customarily render a direct charge, or charges incurred for which the Participant or Plan has no legal obligation to pay, or for which no charges would be made in the absence of this coverage, including but not limited to charges for services not actually rendered, fees, care, supplies, or services for which a person, company, or any other entity except the Participant or the Plan, may be liable for necessitating the fees, care, supplies, or services.

Non-Covered Services. Services not listed in this Plan as a Covered Expense or any service that is related to services not covered under this Plan, even if such service is prescribed by the Participant's Provider. This includes services in excess of any limitations or maximums described in this Plan.

Non-Prescription Drugs. Expenses that are for drugs for use outside of a Hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician's written prescription. Drugs for which there is a non-prescription equivalent available.

Not Acceptable. Expenses for services and treatment that are not accepted as standard practice by the American Medical Association ("AMA"), American Dental Association ("ADA"), or the Food and Drug Administration ("FDA").

Not Covered Provider. Expenses that are performed by Providers that do not satisfy all the requirements per the Provider definition as defined within this Plan.

Not Specified As Covered. Expenses that are not specified as covered under any provision of this Plan.

Occupational. Expenses that are for any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit where Workers' Compensation or another form of occupational injury medical coverage is available.

Other than Attending Physician. Expenses that are other than those certified by a Physician who is attending the Participant as being required for the treatment of Injury or Illness and performed by an appropriate Provider.

Personal Injury Insurance. Expenses that are in connection with an automobile accident for which benefits payable hereunder are, or would be otherwise covered by, mandatory no-fault automobile insurance or any other similar type of personal injury insurance required by state or federal law, without regard to whether the Participant actually had such mandatory coverage. Benefits will be excluded to the amount of first party medical coverage required under the applicable state law, regardless of a Participant's election of lesser coverage. This Exclusion does not apply if the Injured person is a passenger in a non-family owned vehicle or a pedestrian.

Postage, Shipping, Handling Charges, Etc. Expenses that are for any postage, shipping, or handling charges which may occur in the transmittal of information to the Claims Administrator; including interest or financing charges.

Prior to Coverage. Expenses for treatment or services that are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

Professional (and Semi-Professional) Athletics (Injury/Illness). Expenses that are in connection with any Injury or Illness arising out of or in the course of any employment for wage or profit; or related to professional or semi-professional athletics, including practice.

Prohibited by Law. Expenses that are themselves prohibited by applicable law, in general or within the context of the course of treatment, or to the extent that payment under this Plan is prohibited by law.

Provider Error. Expenses that are required as a result of unreasonable Provider error.

Subrogation, Reimbursement, and/or Third Party Responsibility. Expenses that are for an Illness or Injury not payable by virtue of the Plan's subrogation, reimbursement, and/or third-party responsibility provisions.

Unreasonable. Expenses that are not reasonable in nature or in charge (see definition of Maximum Allowable Charge) or are required to treat Illnesses or Injuries arising from and due to a Provider's error, wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This Exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es).

Vehicle Accident. Expenses that are for treatment of any Injury where it is determined that a Participant was involved in a motorcycle accident while not wearing a helmet or in an automobile accident while not wearing a seatbelt (or car seat), even if the cause of the Illness or Injury is not related to the failure of the Participant to wear a helmet or seatbelt (or car seat). This Exclusion does not apply: (a) to Participants who were passengers on public transportation, ride for hire or livery services; or (b) when a seatbelt or helmet is not required by law.

War/Riot. Expenses incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot, when the Participant is a member of the armed forces of any country, or during service by a Participant in the armed forces of any country, or voluntary participation in a riot. This Exclusion does not apply to any Participant who is not a member of the armed forces and does not apply to victims of any act of war or aggression.

With respect to any Illness or Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Illness or Injury if the Illness or Injury results from being the victim of an act of domestic violence or a documented medical condition, even if the condition is not diagnosed before the Illness or Injury. To the extent consistent with applicable law, this exception will not require this Plan to provide particular benefits other than those provided under the terms of the Plan.

BENEFIT PLAN DEFINITIONS

The following words and phrases shall have the following meanings when used in this Summary Plan Description. Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in this Definitions section, but some terms are defined within the provision the term is used. Becoming familiar with the terms defined in the Definitions section will help to better understand the provisions of this Plan.

The following definitions are not an indication that charges for particular care, supplies, or services are eligible for payment under the Plan; they may be used to identify ineligible expenses. Please refer to the appropriate sections of this document for that information.

"Ambulatory Surgical Center" shall mean any permanent public or private State licensed and approved (whenever required by law) establishment that operates exclusively for the purpose of providing Surgical Procedures to patients not requiring hospitalization with an organized medical staff of Physicians, with continuous Physician and nursing care by Registered Nurses ("RNs"). The patient is admitted to and discharged from the facility within the same working day as the facility does not provide service or other accommodations for patients to stay overnight.

"Calendar Year" shall mean the 12-month period from January 1 through December 31 of each year.

"Cardiac Care Unit" shall mean a separate, clearly designated service area which is maintained within a Hospital and which meets all the following requirements:

1. It is solely for the care and treatment of critically ill patients who require special medical attention because of their critical condition.
2. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital.
3. It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area.
4. It contains at least two beds for the accommodation of critically ill patients.
5. It provides at least one professional Registered Nurse, in continuous and constant attendance of the patient confined in such area on a 24 hour a day basis.

"CDC" shall mean Centers for Disease Control and Prevention.

"Certified IDR Entity" shall mean an entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the United States Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

"Chiropractic Care" shall mean the detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

"Claimant" shall mean a Participant of the Plan, or entity acting on their behalf, authorized to submit claims to the Plan for processing, and/or appeal an Adverse Benefit Determination.

"COBRA" shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Coinsurance" shall mean the predetermined percentage of the Maximum Allowable Charge for covered services that applies after the Deductible is satisfied.

"Copayment" or "Copay" shall mean a dollar amount the Participant pays for health care expenses.

"Cosmetic Surgery" shall mean any expenses incurred in connection with the care and treatment of, or operations which are performed for plastic, reconstructive, or cosmetic purposes or any other service or supply which are primarily used to improve, alter, or enhance appearance of a physical characteristic which is within the broad spectrum of normal but which may be considered displeasing or unattractive, except when required by an Injury. This does not include surgery covered under the Women's Health and Cancer Rights Act of 1998.

"Covered Expense(s)" shall mean a service or supply provided in accordance with the terms of this document, whose applicable charge amount does not exceed the Maximum Allowable Charge for an eligible Medically Necessary service, treatment, or supply, meant to improve a condition or Participant's health, which is eligible for coverage in accordance with this Plan. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option. All treatment is subject to benefit payment maximums shown in the "Schedule of Benefits" and as set forth elsewhere in this document.

"Custodial Care" shall mean care or confinement designated principally for the assistance and maintenance of the Participant, in engaging in the activities of daily living, whether or not totally disabled. This care or confinement could be rendered at home or by persons without professional skills or training. This care may relieve symptoms or pain but is not reasonably expected to improve the underlying medical condition. Custodial Care includes, but is not limited to, assistance in eating, dressing, bathing and using the toilet, preparation of special diets, supervision of medication which can normally be self-administered, assistance in walking or getting in and out of bed, and all domestic activities.

"Deductible" shall mean an aggregate amount for certain expenses for covered services that is the responsibility of the Participant to pay for themself each Calendar Year before the Plan will begin its payments.

> **Annual Deductibles.** Deductibles are listed in the "Schedule of Benefits" section and must be satisfied before the Plan will provide benefits. Amounts in excess of the Maximum Allowable Charge do not count toward the Annual Deductible.

The Individual Deductible applies to each covered Participant for each Calendar Year. Once the Individual Deductible has been satisfied, the Plan provides benefits for covered services for that Participant according to the "Schedule of Benefits."

The Family Deductible applies to the Participant and their covered Dependents for each Calendar Year. If the Participant and their Dependents have met the Family Deductible, the Participant and their Dependents do not have to pay any further Deductible for the rest of the Calendar Year. Although no one family member needs to pay more than the individual deductible, the Participant and their Dependents cannot apply more than the amount of each person's Individual Deductible toward the Family Deductible.

"Diagnosis" shall mean the act or process of identifying or determining the nature and cause of a disease or Injury through evaluation of patient history, examination, and review of laboratory data.

"Drug" shall mean a Food and Drug Administration ("FDA") approved Drug or medicine that is listed with approval in the *United States Pharmacopeia*, *National Formulary* or *AMA Drug Evaluations* published by the American Medical Association ("AMA"), that is prescribed for human consumption, and that is required by law to bear the legend: "Caution—Federal Law prohibits dispensing without prescription", or a State restricted drug (any medicinal substance which may be dispensed only by prescription, according to State law), legally obtained and dispensed by a licensed drug dispenser only, according to a written prescription given by a Physician and/or duly licensed Provider. "Drug" shall also mean insulin for purposes of injection.

"Durable Medical Equipment" shall mean equipment and/or supplies ordered by a health care Provider for everyday or extended use which meets all the following requirements:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of an Illness or Injury; and
4. Is appropriate for use in the home.

"Emergency Medical Condition" shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (a) serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the woman's unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part..

"Emergency Services" shall mean, with respect to an Emergency Medical Condition, the following:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Network Provider or Non-Participating Health Care Facility (regardless of the department of the Hospital in which items or services are furnished) after the Participant is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the Provider determines that the Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Participant is in a condition to, and in fact does, give informed consent to the Provider to be treated as a Non-Network Provider.

"ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended.

"Exclusion" shall mean conditions or services that this Plan does not cover.

"Experimental" and/or "Investigational" shall mean a service that has been applied primarily in the laboratory setting.

Investigational services mean a service that has been applied to human subjects because it has theoretic rationality or has shown promise in preliminary human study.

In either case, no final conclusions have been reached concerning the efficacy/effectiveness of the service, nor has a specific role in clinical evaluation, management, or treatment for the service been defined. Further study, such as controlled clinical trials comparing two treatment alternatives, are usually required to resolve these issues. The results of such studies are published and available for critical review in peer-reviewed medical literature.

The Claims Administrator evaluates each service or item to determine if it is Experimental or Investigational. The criterion that is considered when making this determination is based upon one or all the Claims Administrator's policies, procedures, and guidelines.

If benefits for a service/drug are denied on the basis that the service/drug is Experimental or Investigational, no benefits will be available for services/drugs provided in connection with the Experimental or Investigational services/drugs. The fact that a service/drug may be the only available treatment for a particular condition does not mean that the service/drug will be approved for benefits or that the service/drug is not Experimental or Investigational.

All phases of clinical trials shall be considered Experimental.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

"Gene Therapy" shall mean replacing a gene that causes a medical problem with one that does not; adding genes to help the body fight or treat disease; or inactivating genes that cause medical problems.

"Habilitation/Habilitative Services" shall mean health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

"HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

"Home Health Care" shall mean the continual care and treatment of an individual if all the requirements are met:

1. The institutionalization of the individual would otherwise have been required if Home Health Care was not provided.
2. The Home Health Care is the result of an Illness or Injury.

"Home Health Care Agency" shall mean an agency or organization which provides a program of Home Health Care and which meets one of the following requirements:

1. Is a Federally certified Home Health Care Agency and approved as such under Medicare.
2. Meets the established standards and is operated pursuant to applicable laws in the jurisdiction in which it is located and is licensed and approved by the regulatory authority having the responsibility for licensing, where licensing is required.
3. Meets all the following requirements:
    a. It is an agency which holds itself forth to the public as having the primary purpose of providing a Home Health Care delivery system bringing supportive services to the home;
    b. It has a full time administrator;
    c. It maintains written records of services provided to the patient;
    d. Its staff includes at least one Registered Nurse (R.N.) or it has nursing care by a Registered Nurse (R.N.) available; and
    e. Its employees are bonded and it provides malpractice insurance.

"Hospital" shall mean an Institution, accredited by the Joint Commission on Accreditation of Hospitals (sponsored by the AMA and the AHA), under the supervision of a staff of Physicians that maintains diagnostic and therapeutic facilities on premises, for the provision of medical (including Surgical facilities for all Institutions other than those specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA), diagnosis, treatment, and care to Injured or sick persons, on an Inpatient basis, with 24 hour a day nursing service by Registered Nurses.

To be deemed a "Hospital", the facility must be duly licensed if it is not a State tax supported Institution, and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution; or an Institution which is supported in whole or in part by a Federal government fund.

Institutions and/or facilities not deemed to be a "Hospital" in accordance with Medicare, shall not be deemed to be Hospitals for this Plan's purposes.

"Hospital" shall also have the same meaning, where appropriate in context, set forth in the definition of "Ambulatory Surgical Center".

"Illness" shall mean any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Physician and as compared to the person's previous condition.

"Impregnation and Infertility Treatment" shall mean any services, supplies or Drugs related to the Diagnosis or treatment of infertility.

"Incurred" shall refer to the date the covered service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

"Independent Freestanding Emergency Department" means a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services.

"Injury" shall mean an accidental bodily injury, which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit.

"Inpatient" shall mean a Participant who receives care as a registered and assigned bed patient while confined in a Hospital, other than in its outpatient department, where a room and board is charged by the Hospital.

"Institution" shall mean a facility created and/or maintained for the purpose of practicing medicine and providing organized health care and treatment to individuals, operating within the scope of its license, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, Residential Treatment Facility, psychiatric treatment facility, Substance Use Disorder Treatment Center, alternative birthing center, or any other such facility that the Plan approves.

"Intensive Outpatient Services" shall mean programs that have the capacity for planned, structured, service provision of at least two hours per day and three days per week. The range of services offered could include group, individual, family or multi-family group psychotherapy,

psychoeducational services, and medical monitoring. These services would include multiple or extended treatment/rehabilitation/counseling visits or professional supervision and support. Program models include structured "crisis intervention programs", "psychiatric or psychosocial rehabilitation", and some "day treatment".

"Leave of Absence" shall mean a period of time during which the Employee must be away from their primary job with their employer, while maintaining the status of employee during said time away from work, generally requested by an employee and having been approved by their employer, and as provided for in the employer's rules, policies, procedures and practices where applicable.

"Mastectomy" shall mean the Surgery to remove all or part of breast tissue to treat or prevent breast cancer.

"Maximum Allowable Charge" or "Allowable Charge" shall mean the amount payable for a specific covered item under the Plan. The Maximum Allowable Charge will be a negotiated rate, if one exists.

For claims subject to the No Surprises Act, if no negotiated rate exists, the Allowable Amount or Allowable Charge will be the Qualifying Payment Amount, or an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable.

If neither of these factors is applicable, the Plan Administrator will exercise its discretion to determine the Allowable Amount or Allowable Charge based on the FAIR Health rate for the geographic area where the items or services are rendered. The FAIR Health rate will be the rate in the FAIR Health Database, which was developed to bring transparency to healthcare costs and health insurance information through comprehensive data products, consumer resources and to support health services data research. For further information visit ***.fairhealth consumer.org.

In the event that there is no FAIR Health Database rate for a specific service, supply or equipment covered under this Plan, the claim will be processed at either actual Provider charges, a discount from a third-party network partner, or a negotiated discount if possible.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. The Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

"Medically Necessary" or "Medical Necessity" shall refer to health care services ordered by a Physician exercising prudent clinical judgment provided to a Participant for the purposes of evaluation, diagnosis, or treatment of that Participant's Illness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent,

site and duration for the diagnosis or treatment of the Participant's Illness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Participant's Illness or Injury without adversely affecting the Participant's medical condition. The service must meet all the following requirements:

1. Its purpose must be to restore health;
2. It must not be primarily custodial in nature; and
3. It is ordered by a Physician for the diagnosis or treatment of an Illness or Injury.

The Plan reserves the right to incorporate CMS guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or a Covered Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition and that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed, or approved by a Physician does not necessarily mean that it is "Medically Necessary". In addition, the fact that certain services are specifically excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that all other services are "Medically Necessary".

To be Medically Necessary, all the above criteria must be met. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary based on recommendations of the Plan Administrator's own medical advisors, the findings of the American Medical Association or similar organization, or any other sources that the Plan Administrator deems appropriate.

"Medicare" shall mean the Federal program by which health care is provided to individuals who are 65 or older, certain younger individuals with disabilities, and individuals with End-Stage Renal Disease, administered in accordance with parameters set forth by the Centers for Medicare and Medicaid Services ("CMS") and Title XVIII of the Social Security Act of 1965, as amended, by whose terms it was established.

"Mental Disorder," "Behavioral Disorder," or "Neurodevelopmental Disorder" shall mean any disease or condition, regardless of whether the cause is organic, that is classified as a "Mental Disorder," "Behavioral Disorder," or "Neurodevelopmental Disorder" in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources.

"Network" or "In-Network" shall mean the facilities, Providers, and suppliers who have by contract via a medical Provider Network agreed to allow the Plan access to discounted fees for

service(s) provided to Participants, and by whose terms the Network's Providers have agreed to accept assignment of benefits and the discounted fees thereby paid to them by the Plan as payment in full for Covered Expenses. The applicable Provider Network will be identified on the Participant's identification card.

"Non-Network" or "Out-of-Network" shall mean the facilities, Providers and suppliers that do not have an agreement with a designated Network to provide care to Participants.

"Outpatient" shall mean treatment including services, supplies, and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory, or x-ray facility, an Ambulatory Surgical Center, or the patient's home.

"Partial Hospitalization" shall mean medically directed intensive, or intermediate short-term mental health and Substance Use Disorder treatment, for a period of less than twenty-four (24) hours but more than four (4) hours in a day in a licensed or certified facility or program.

"Participant" shall mean any Employee, Dependent, individual that is covered under the Plan through COBRA continuation coverage, or retiree who is eligible for benefits (and enrolled) under the Plan.

"Participating Health Care Facility" shall mean a Hospital or Hospital Outpatient department, critical access Hospital, Ambulatory Surgical Center, or other Provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

"Physician" shall mean a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Occupational Therapist, Physiotherapist, Speech Language Pathologist, psychiatrist, midwife, and any other practitioner of the healing arts who is licensed and regulated by a State or Federal agency, acting within the scope of that license.

"Plan Year" shall mean a period commencing January 1st and ending December 31st.

"Pregnancy" shall mean a physical state whereby a woman presently bears a child or children in the womb, prior to but likely to result in childbirth, miscarriage, and/or non-elective abortion. Pregnancy is considered an Illness for the purpose of determining benefits under this Plan.

"Preventive Care" is the care a Participant receives to prevent Illnesses or diseases. It also includes counseling to prevent health problems.

"Provider" shall mean an entity whose primary responsibility is related to the supply of medical care. Each Provider must be licensed, registered, or certified by the appropriate State agency where the medical care is performed, as required by that State's law where applicable. Where there is no applicable State agency, licensure, or regulation, the Provider must be registered or certified by the appropriate professional body. The Plan Administrator may determine that an entity is not a "Provider" as defined herein if that entity is not deemed to be a "Provider" by the Centers for Medicare and Medicaid Services ("CMS") for purposes arising from payment and/or enrollment with Medicare; however, the Plan Administrator is not so bound by CMS' determination of an entity's status as a Provider. All facilities must meet the standards as set forth within the applicable definitions of the Plan as it relates to the relevant provider type.

"Qualified Medical Child Support Order" or "QMCSO" shall mean a Medical Child Support Order, in accordance with applicable law, and which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or eligible Dependent is entitled under this Plan.

"Qualifying Payment Amount" means the median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan's third-party administrator (if calculated by the third-party administrator), for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning fewer than three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

"Recognized Amount" shall mean, except for Non-Network air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable and for Non-Network air ambulance services generally, the Recognized Amount shall mean the lesser of a Provider's billed charge or the Qualifying Payment Amount.

"Rehabilitation" shall mean treatment(s) designed to facilitate the process of recovery from Injury, Illness, or disease to as normal a condition as possible.

"Residential Treatment Facility" shall mean a facility licensed or certified as such by the jurisdiction in which it is located to operate a program for the treatment and care of Participants diagnosed with alcohol, drug, or Substance Use Disorder or mental illness.

"Room and Board" shall mean a Hospital's charge for any of the following:

1. Room and complete linen service.
2. Dietary service including all meals, special diets, therapeutic diets, required nourishment's, dietary supplements and dietary consultation.
3. All general nursing services including but not limited to coordinating the delivery of care, supervising the performance of other staff members who have delegated member care and member education.
4. Other conditions of occupancy which are Medically Necessary.

"Skilled Nursing Facility" shall mean a facility that fully meets all the following requirements:

1. It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a Physician.
3. It provides 24-hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, Custodial Care, or educational care.
7. It is approved and licensed by Medicare.

"Substance Use Disorder" shall mean any disease or condition that is classified as a Substance Use Disorder as listed in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, as listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or other relevant State guideline or applicable sources.

"Surgery"
"Surgery" shall in the Plan Administrator's discretion mean the treatment of Injuries or disorders of the body by incision or manipulation, especially with instruments designed specifically for that purpose, and the performance of generally accepted operative and cutting procedures, performed within the scope of the Provider's license.

"Telehealth" shall mean the use of electronic information and telecommunications to provide health care services to a Participant from an originating site to a distant site as substitution for an in-person visit. The Participant must be at an originating site unless he or she is being treated for a condition that requires remote patient monitoring. For a service to be considered eligible for Telehealth coverage, the interactive audio and video telecommunications must be real-time communication with electronic transmission of the Participant's health information, or pre-recorded videos known as "store and forward" technology. The purpose of electronic information and communication is to collect the Participant's health information and medical data for use in treatment and management of conditions that require frequent monitoring.

"Telemedicine" shall mean the delivery of health care services such as diagnosis, consultation, or treatment through the use of live interactive audio and video over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Telemedicine does not include the use of audio-only telephone, e-mail, or facsimile.

"Union" is the Bricklayers & Allied Craftworkers Local 1, New York.

"Utilization Review" shall mean a team of medical care professionals selected to conduct prior authorization review, emergency admission review, continued stay review, discharge planning, patient consultation, and case management. For more information, see the "Utilization Management" section of this document.

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

PART C - VACATION BENEFIT PROGRAM

TABLE OF CONTENTS

Eligibility C-2
Participants' Accounts C-2
Benefits C-2
Death Benefit C-2
Benefit Payment C-3
Miscellaneous C-4
Claim Denial and Appeal Procedure C-5
Definitions C-6

VACATION BENEFIT PROGRAM

The Vacation Benefit Program offers vacation benefits as a separate program, which has different eligibility rules and requirements. Please read the following sections for a description of the eligibility rules that apply and the benefits that are available under the Vacation Benefit Program (the "Program").

ELIGIBILITY

Before you can be eligible to secure a benefit from the Program, you must become a Participant in the Program and have a balance in your account.

You will become a Participant in the Program once your employer makes a required contribution to the Vacation Benefit Program on your behalf. Each employer is required to make specified contributions to fund benefits under this Program.

You will remain a Participant in the Program as long as there is a balance in your account under the Program.

PARTICIPANTS' ACCOUNTS

An account will be maintained for each Participant in the Program. Contributions made by the Participant's employer on their behalf will be added to their account. Benefit payments made to the Participant (or their beneficiary) will be subtracted from their account.

The contributions required to be made are withholdings from the Participants' compensation. Each Participant must have signed authorization for the payroll deductions to be accepted by the Vacation Benefit Program. Payroll deduction received by the Program without signed authorization will be held in escrow and if signed authorization is not received, the payroll deduction may be returned to the Participant's employer.

BENEFITS

The money that is in a Participant's account on the date of the last payday of October (valuation date) of each year is the amount of their Vacation Benefit for that year. Within two months following each valuation date, the Trustees will distribute a lump sum vacation benefit to each Participant who was a Participant on such valuation date.

DEATH BENEFIT

If a Participant dies while there is a balance in their account, their named beneficiary is entitled to apply for such balance in a lump sum.

The Participant shall have the unrestricted right to designate their beneficiary to receive the death benefit and to revoke such designation. Each such designation shall be made to the Fund Administrator in writing.

If the Participant fails to validly designate a beneficiary, or if the beneficiary they designated died before the Participant, the death benefit will be payable to the deceased Participant's estate upon proper application.

If the named beneficiary is a minor at the Participant's death, any benefit due them will be paid to their court-appointed guardian, upon proper application.

No death benefit is payable unless proper application is made to the Fund Administrator.

BENEFIT PAYMENT

Gross Distributions and Net Distributions

The amount of benefit distributions determined in this Program is a gross figure. Any withholding, payroll taxes, FICA contributions (both employer and participant) or any other taxes or payments required by law or authorized payment will be deducted from the gross distributions calculated before such distributions are indeed made. The actual payments will be net.

Benefit Payment and Record Keeping

An eligible participant or beneficiary who makes application under this Program will be entitled to receive the benefits subject to all the provisions of this Program.

Every employer, Participant, and beneficiary shall furnish to the Trustees any information or proof requested of them and reasonably required to administer this Program. Failure on the part of any person to comply with such requests promptly and in good faith will be sufficient grounds for denying or discontinuing benefits to such person. If a person makes a false statement material to their claim for benefits, they may be denied any or all benefits. The Trustees will have the right to recover any payments made in reliance on such false statement.

The Trustees will be the sole judges of the standard of proof required in any case. In the application and interpretation of the provisions of this Program, the decisions of the Board of Trustees will be final and binding on all parties, including Participants, employers, the Union, and other interested parties.

Indirect Payment of Benefits

If any Participant is, in the judgment of the Trustees, legally, physically, or mentally incapable of personally receiving and receipting for any payment, hereunder, payment may be made to the guardian or other legal representative of such Participant or their beneficiary, or if none, to such other person or institution who, in the opinion of the Trustees, is then maintaining or has custody of such Participant or beneficiary. Such payments will constitute a full discharge of the Trustees with respect thereto.

Alternate Application

If any Participant or beneficiary under this Program becomes bankrupt or attempts to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge any benefit under this Program contrary to the terms hereof, or if any benefit will be levied upon, garnished, or attached, then such benefit will, in the discretion of the Trustees, cease and be determined and in that event the Trustees may hold or apply the same or any part thereof to or for the benefit of such Participant or beneficiary, their spouse, children or other dependents, or any of them in such manner and in such proportion as the Trustees may deem proper.

Unclaimed Accounts

If during a period of five consecutive years, no payroll deductions are received by the Program for a Participant and no benefit distributions are made from the Participant's account, any value remaining in their account hereunder will be forfeited and used only for the costs of the Bricklayers and Craftworkers Local 5, New York Welfare Fund and its programs.

MISCELLANEOUS

Modification

This Program will be subject to amendments, modifications, or terminations as set forth in the Agreement and Declaration of Trust.

In the event that any revision in this Program is necessary to obtain or retain the approval by the Internal Revenue Service of the Fund and this Program as qualified for exemption from Federal Income taxes under applicable provision of the Internal Revenue Code as now in effect or hereafter amended, the Trustees will make such changes as are necessary to receive or retain such qualifications, adhering as closely as possible to the intent of the Trustees, as expressed in this Program and the Agreement and Declaration of Trust.

Termination of Program

In the event of the termination of the Program, the Trustees will distribute to each Participant the value of their account at the time of termination in such manner as will best effectuate this Program's intent. No part of the funds will ever revert to any employer or to the Union.

No Vesting

No Participant or employer, or the estate, heirs, administrator, beneficiaries and assigns of any of the foregoing, will have any vested interest or vested rights to any of the funds under this Program.

Separability

The sections of this Program will be deemed separable so that the invalidity of any portion hereof will not affect the validity of the remainder.

CLAIM DENIAL AND APPEAL PROCEDURE

Claim Denial

The Trustees will make determinations regarding claims for benefits under the Program by Participants and beneficiaries.

In the event a claim is denied, wholly or in part, the Trustees will furnish a written notice to a claimant whose claim has been denied stating:

a. The specific reason(s) for the denial.

b. The specific reference(s) to the Program provisions on which the denial is based.

c. A description of any additional information that might be required and an explanation of why it is needed.

d. An explanation of the Program's appeal procedure.

Claims Appeal

Any claimant whose claim for benefits has been denied has a right to appeal to the Trustees for a review of their decision, provided that the claimant requests such an appeal in writing within 60 days from the receipt of the denial.

The claimant (or their authorized representative) may present their views in writing and/or appear in person before the Trustees at a date set for such hearing, with an opportunity to review the pertinent records and documents that relate to the claim.

Decision on Review

Decision on the review of a denied claim will be made by the Board of Trustees. The Board of Trustees shall make a decision at its next regularly scheduled meeting. However, if the request is received less than 30 days before a meeting, the decision may be made at the second meeting following receipt of the request. If special circumstances require an extension of time for processing, a decision may be made at the third meeting following the date the request for a review is made. The decision of the Board of Trustees shall be in writing and shall include the specific reason(s) for the decision and specific references to Program provisions on which the decision is based. If you request a review of a denied claim, you will be notified of the approximate date that you can expect to receive a decision.

The final decision of the Board of Trustees with respect to their review of your claim shall be final and binding upon you since the Trustees have exclusive authority and discretion to determine all questions of eligibility and entitlement under the Program.

DEFINITIONS

The following terms will have the meaning specified below when used in this Vacation Benefit Program. **PLEASE READ THEM CAREFULLY.** It can help you to better understand your Vacation benefits.

1. "Agreement and Declaration of Trust" means the Agreement and Declaration of Trust, as amended from time to time, which created the Bricklayers and Allied Craftworkers Local 5, New York Welfare Fund.

2. "Employer" means an employer who enters into a contractual agreement with the Union to make contributions to this Program in accordance with said agreement.

3. "Fund" means the trust estate created by the Agreement and Declaration of Trust.

4. "Participant" is an individual whose employer makes a required contribution to the Vacation Benefit Program on their behalf and has a balance in their account.

5. "Program" is the system of benefits and rules and regulations contained herein. The name of the program shall be "The Vacation Benefit Program".

6. "Signed Authorization" is a signed authorization by the participant allowing for payroll deductions.

7. "Trustee" is a trustee named in the Agreement and Declaration of Trust and successor.

8. "Union" is the Bricklayers & Allied Craftworkers Local 1, New York.

9. "Valuation Date" is the date of the last payday in October of each year. The value of a participant's account as of any date will be the value of the account as of the preceding valuation date (if any) plus the contributions credited to this account since the prior valuation date, less any benefit distributions made since the prior valuation date.

10. "Week" is seven consecutive days, Monday through Sunday.

11. "Year" is the calendar year, January through December.

PART D – PLAN ADMINISTRATION

TABLE OF CONTENTS

Summary of Plan Information D-2
Plan Administration D-5
- Discretionary Authority of the Trustees and Designees D-5
- Duties of the Plan Administrator D-5
- Amending and Terminating the Plan D-6
- Misuse of Identification Card D-6
- Fraud D-6
- Facility of Payment D-7
- Right of Recovery D-7
- Anti – Assignment Provision D-7
- No Liability for Practice of Medicine or Dentistry D-7
- Privacy, Confidentiality, and Release of Records or Information D-8
- Right to Receive and Release Information D-8

HIPAA: Use and Disclosure of Protected Health Information D-10
Statement of ERISA Rights D-16

SUMMARY OF PLAN INFORMATION

Official Name of Plan

Bricklayers and Allied Craftworkers Local 5, NY Welfare Fund

Plan Sponsor

Board of Trustees
Bricklayers and Allied Craftworkers Local 5, NY Welfare Fund
66-05 Woodhaven Blvd.
Rego Park, NY 11374
Telephone: (718) 459-5800

Fund Administrator

Jorge Cano

Employer Identification Number (EIN)

14-6022899

Plan Year

January 1 through December 31

Plan Number

501

Type of Plan

This is a Welfare Plan. The following benefits are covered by the Bricklayers and Allied Craftworkers Local 5, NY Welfare Fund:

- Hospital and Medical
- Prescription Drug
- Dental
- Vision
- Death
- Vacation

Type of Funding

Contributions are made to the Fund by contributing employers according to the terms of the collective bargaining agreement(s) between the employers and the Union. Contact the Fund Office

for a list of contributing employers or to find out if an employer is a contributing employer. You may also request a copy of the collective bargaining agreement from the Fund Office as well as from your Union.

Agent for Service of Legal Process

The Board of Trustees
Bricklayers and Allied Craftworkers Local 5, NY Welfare Fund
66-05 Woodhaven Blvd.
Rego Park, NY 11374

Service of legal process may be made upon the Board of Trustees at the Fund Office.

Board of Trustees

Union Trustees	Employer Trustees
Michael Clifford Bricklayers and Allied Craftworkers Local 1 4 Court Sq W 2nd Fl Long Island City, NY 11101	Daniel Depew Construction Contractors Association 330 Meadow Avenue Newburgh, NY 12550
David Williams Bricklayers and Allied Craftworkers Local 1 4 Court Sq W 2nd Fl Long Island City, NY 11101	Matthew Pepe Construction Industry Council of Westchester & Hudson Valley, Inc. 629 Old White Plains Road Tarrytown, NY 10591

Service Providers

The Fund self-insures the hospital, medical, and dental benefits, which are administered by MVP Health Care; the vision benefits, which are administered by CPS Optical; the prescription drug benefits, which are administered by Express Scripts, Inc.; and the death benefit is administered by the Fund Office.

The addresses and telephone numbers of the entities that administer Fund benefits are shown below:

Medical Benefits	**Vision Benefits**
MVP Select Care, Inc. PO Box 2207 Schenectady, NY 12301 Phone: East: 800-229-5851 West: 800-767-1678 Website: ***.mvphealthcare.com	CPS Optical 11 Hanover Square, 8th Floor New York, NY 10005 212-675-5745 **********.cpsoptical.com/

Dental Benefits MVP Select Care, Inc. PO Box 2207 Schenectady, NY 12301 Phone: East: 800-229-5851 West: 800-767-1678 Website: ***.mvphealthcare.com	**Prescription Drug Benefits** Express Scripts 225 Summit Avenue Montvale, NJ 07645 1 (866) 713-8004
Death Benefits Bricklayers and Allied Craftworkers Local 5, NY Welfare Fund 66-05 Woodhaven Blvd. Rego Park, NY 11374 Telephone: (718) 459-5800	

Circumstances That May Affect Benefits

Circumstances that may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of any benefits are:

- ♣ The Participant's failure to work the hours required to maintain eligibility.
- ♣ In the case of persons who are dependents, they may become ineligible if they are no longer dependents as defined in the Plan.
- ♣ The failure of the Participant or dependent to file a claim form within the time limits established by the Plan.
- ♣ The failure of the Participant or dependent to file a complete and truthful claim form.
- ♣ Where the Participant or dependent has other group insurance coverage, it is possible that benefits payable under this Plan may be reduced or denied due to "coordination of benefits" between the two plans.
- ♣ The death of the Participant.

PLAN ADMINISTRATION

Discretionary Authority of the Trustees and Designees

In carrying out their respective responsibilities under the Plan, the Board of Trustees, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan, and to decide any fact related to eligibility for and entitlement to Plan Benefits. Any interpretation or determination under such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Board of Trustees in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Board of Trustees in a fashion consistent with its intent, as determined by the Board of Trustees. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Board of Trustees. All actions taken and all determinations by the Board of Trustees shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal procedures of the Plan.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms.
2. To determine all questions of eligibility, status and coverage under the Plan.
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms.
4. To make factual findings.
5. To decide disputes which may arise relative to a Participant's rights and/or availability of benefits.
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them, and to uphold or reverse such denials.
7. To keep and maintain the Plan documents and all other records pertaining to the Plan.
8. To appoint and supervise a Claims Administrator to pay claims.
9. To perform all necessary reporting as required by ERISA.
10. To establish and communicate procedures to determine whether a Medical Child Support Order is a QMCSO.
11. To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate.
12. To perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan

This Plan was established for the exclusive benefit of the Participants and their Beneficiaries with the intention it will continue indefinitely; however, the Board of Trustees, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

All amendments to this Plan shall become effective as of a date established by the Board of Trustees. If this Plan is amended, all of the care a Participant or covered Dependent receives after the effective date of the amendment will be subject to the amendment, even if the Participant or covered Dependent were receiving care before the amendment became effective.

If the Plan is terminated, the rights of the Participants are limited to expenses incurred before termination. In connection with the termination, the Plan Sponsor may establish a deadline by which all claims must be submitted for consideration. Benefits will be paid only for Covered Expenses incurred prior to the termination date and submitted in accordance with the rules established by the Board of Trustees. Upon termination, any Plan assets will be used to pay outstanding claims and all expenses of Plan termination. As it relates to distribution of assets upon termination of the Plan, plan assets will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration and will not inure to the benefit of the Employer.

Misuse of Identification Card

If a Participant or covered Dependent permits any person who is not a covered Participant of the family unit to use any identification card issued, the Plan Sponsor may give the Participant written notice that their (and their family's) coverage will be terminated in accordance with the Plan’s provisions.

Fraud

Under the Plan, coverage may be retroactively canceled or terminated (rescinded) if a Participant acts fraudulently or intentionally makes material misrepresentations of fact. It is a Participant’s responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Participant’s responsibility to update previously provided information and statements. Failure to do so may result in the Participant’s coverage being canceled, and such cancellation may be retroactive.

If a Participant, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Participant of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a Participant is aware of any instance of fraud and fails to bring that fraud to the Plan Administrator’s attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Participant and their entire

family unit of which the Participant is a member. In the event any claim is paid as the result of such a fraudulent statement or submission, which is determined as fraudulent, the full penalty of the law will be applied, the amount of the claim paid will be recovered with interest and the Participant's and their covered Dependents' eligibility for all benefits under the Fund would be indefinitely suspended.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Participant whose coverage is being rescinded will be provided a 30-day notice period as described under the Affordable Care Act ("ACA") and regulatory guidance. Claims incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan and subject to recovery.

Facility of Payment

A payment made under any other plan may include an amount that should have been paid under this Plan. The Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted to satisfy the intent of this provision. Any such amount paid under this provision shall be deemed to be benefits paid under this Plan. The Plan Administrator will not have to pay such amount again and this Plan shall be fully discharged from liability.

Right of Recovery

In the event of any overpayment by this Plan, the Plan will have the right to recover the overpayment. If you are paid a benefit greater than allowed by the Plan, you will be requested to refund that overpayment within sixty (60) days. If an overpayment is made on your behalf to a hospital, doctor, or other provider, the Plan will request a refund of the overpayment from that provider. If the refund is not received from you or the provider, the amount of the overpayment, to the extent permitted by law, may be deducted from any future benefits for claims submitted on your behalf.

Anti – Assignment Provision

The benefits contained in this Plan, and any right to reimbursement or payment arising out of such benefits, are not assignable or transferrable, in whole or in part, in any manner or to any extent, to any person or entity. Any payment by the Plan directly to a provider pursuant to a written election or purported assignments submitted by a Participant are provided at the discretion of the Board of Trustees as a convenience to the Participant and does not imply an enforceable assignment of any benefits or the right to pursue a claim or cause of action by the provider.

No Liability for Practice of Medicine or Dentistry

The Plan, the Board of Trustees, or any of their designees are **not** engaged in the practice of medicine or dentistry, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered by any Health Care Provider. Neither

the Plan, the Board of Trustees, nor any of their designees, will have any liability whatsoever for any loss or injury caused by any Health Care Provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Privacy, Confidentiality, and Release of Records or Information

The Plan is required to protect the confidentiality and electronic security of your protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the rules issued by the U.S. Department of Health and Human Services. Any information collected by the Plan will be treated as confidential information, and will not be disclosed to anyone without your written consent, except as follows:

- Information will be disclosed to those who require that information to administer the Plan or to process claims.
- Information relating to duplicate coverage will be disclosed to the plan or provider that provides duplicate coverage.
- Information needed to determine whether health care services or supplies are Medically Necessary or if the charges for them are reasonable and customary will be disclosed to the individual or entity consulted to assist the Fund Administrator or its designee to make those determinations.
- Information will be disclosed as required by law or regulation or in response to a duly issued subpoena.

You may find a complete description of your rights under HIPAA in the Plan's Privacy Notice that describes the Plan's privacy policies and procedures and outlines your rights under the privacy rules and regulations. Your rights under HIPAA include the right to:

- Receive confidential communications of your protected health information, as applicable;
- See and copy your health information;
- Receive an accounting of certain disclosures of your health information;
- Amend your health information under certain circumstances; and
- File a complaint with the Plan or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

If you need a copy of the Privacy Notice, please contact the Plan's Privacy Official at the Fund Office.

Right to Receive and Release Information

The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or person any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine and apply the provisions and benefits of this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action.

Any Participant claiming benefits under this Plan shall furnish the Plan Administrator such information as requested and as may be necessary to implement this provision.

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH"), requires that group health plans like this one maintain the privacy of your personally identifiable health information (called Protected Health Information or "PHI").

The term "Protected Health Information" includes all information related to your past, present, or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic, or any other form.

PHI does not include health information contained in employment records held by an employer who participates in this Fund in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, Family and Medical Leave ("FMLA"), and Paid Family Leave ("PFL").

A complete description of your rights under HIPAA can be found in the Plan's Notices of Privacy Practices which were previously distributed to you. A Notice of Privacy Practices is available from the Fund Office upon request. Information about HIPAA in this document is not intended to and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan, and the Plan Sponsor will not use or further disclose information that is protected by HIPAA except as necessary for treatment, payment, health care operations, and Plan administration, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor. When referred to in this section, the Plan means the Fund.

Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal, or for other reasons related to the administration of the Plan.

A. **The Plan's Use and Disclosure of PHI:** The Plan will use PHI, without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

    1. **Treatment** is the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your Health Care Providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.

2. **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:

    i. Determination of eligibility, coverage, cost sharing amounts (e.g., cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), and establishing employee contributions for coverage;

    ii. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing; and

    iii. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification, concurrent review, and/or retrospective review.

3. **Health Care Operations** includes, but is not limited to:

    i. Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment, and patient safety activities;

    ii. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of Health Care Providers and patients with information about treatment alternatives and related functions;

    iii. Underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

    iv. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

    v. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.

vi. Compliance with and preparation of documents required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500s, Summary Annual Reports and other documents.

B. Generally, the Plan will require that you sign a valid authorization form in order for the Plan to use or disclose your PHI other than when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instances in which HIPAA explicitly permits the use or disclosure without authorization.

C. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:

1. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law;

2. Ensure that any agents, including their subcontractors, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules;

3. Not use or disclose the information for employment-related actions and decisions;

4. Not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices);

5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

6. Make PHI available to the individual in accordance with the access requirements of HIPAA;

7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

8. Make available the information required to provide an accounting of PHI disclosures;

9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of theDepartment of Health and Human Services ("HHS") for the purposes of determining the Plan's compliance with HIPAA;

10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

11. Notify you if a breach of your unsecured PHI occurs.

D. In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained in accordance with HIPAA, only designated Fund Office staff and business associates under contract to the Fund may be given access to use and disclose PHI.

E. The persons described above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Fund. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. Issues of noncompliance (including disciplinary sanctions as appropriate) will be investigated and managed by the Fund's Privacy Officer.

F. In compliance with HIPAA Security regulations, the Plan Sponsor:

1. Has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the group health plan;

2. Will ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures;

3. Will ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and

4. Will report to the Plan any security incident of which it becomes aware concerning electronic PHI.

G. For purposes of complying with HIPAA Privacy rules, this Plan is a "hybrid entity" because it has both group health plan functions (a health care component of the entity) and non-group health plan functions. The Plan designates that its health care group health plan functions are covered by the privacy rules. The health care group health plan functions include the self-funded medical plan options, prescription drug benefits, mental health and substance use disorder benefits, hearing aid benefits, self-funded dental plan, self-funded vision plan, and COBRA administration.

H. The Plan Sponsor has:

1. Implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the group health plan;

2. Ensured that the adequate separation between the Plan and Plan Sponsor, specific to electronic PHI, is supported by reasonable and appropriate security measures;

3. Ensured that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and

4. Agreed to report to the Plan any security incident of which it becomes aware concerning electronic PHI.

Breach Notification Rights for Unsecured Protected Health Information under HIPAA

The HITECH Act requires the Plan Sponsor to provide notification to you following the discovery of a breach of your unsecured PHI. In addition, the Plan Sponsor is also required to notify the United States Department of Health and Human Services ("HHS") if there is a breach. Further, if the breach involved more than 500 individuals, the Act requires the Plan Sponsor to provide notification to the media.

For purposes of this section, a breach means the acquisition, access, use, or disclosure of PHI in a manner not permitted under HITECH, which compromises the security or privacy of the PHI.

If your unsecured PHI is breached, the Plan Sponsor will notify you without unreasonable delay and in no case no later than 60 calendar days after discovery of the breach. Notice will be provided by first-class mail where possible, so it is important to keep the Fund up to date with your current mailing address.

Under HIPAA, you have a statutory right to file a complaint with the Plan Sponsor or the HHS Secretary if you believe that your privacy rights have been violated. The HITECH Act specifically provides that you also have a right to file such a complaint should you feel that the Plan Sponsor has improperly followed the breach notification process.

Questions or Complaints

If the Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated their privacy rights, please contact the Plan using the following information. The Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Participant with the address to file their complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information

Privacy Officer Contact Information:

Jorge Cano
Fund Administrator
Bricklayers & Allied Craftworkers Local 5, New York Welfare Fund
66-05 Woodhaven Blvd
Rego Park, NY 11374
Tel: (718) 459-5800

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration ("EBSA");

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, 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); and

- Receive a summary of the Plan's annual financial report, which the Plan Administrator is required by law to provide to each Participant.

Continue Group Health Plan Coverage

You also have the right to:

- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. (You or your dependents may have to pay for such coverage; review this Summary Plan Description and any 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 the plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's 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 you believe that Plan fiduciaries have misused the Plan's money, or if you believe that you have been 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 EBSA, U.S. Department of Labor, listed in your telephone directory or at:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

The New York office is located at:
Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
201 Varick St.
Room 746
New York, NY 10014
(212) 607-8600

For more information on your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by:

- Calling (866) 444-3272; or
- Visiting the Web site of the EBSA at ***.dol.gov/ebsa.