IRON WORKERS' LOCALS NO. 15 AND 424 EXTENDED BENEFIT FUND

Summary Plan Description
Effective November 1, 2021

Iron Workers' Locals No. 15 and 424 Extended Benefit Fund

Effective on and after January 1, 2022 the Fund Office will be located at:
162 West Street, Building 2, Suite J
Cromwell, CT 06416
Phone: (203) 238-1204
Fax: (203) 639-0815
http://www.ctironworkers.org/

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The Board of Trustees consists of an equal number of employer and union representatives who serve without fees or compensation. A complete list of the employers' sponsoring the Fund may be obtained by participants and beneficiaries upon written request to the Fund Office and is also available for examination.

November 1, 2021

To All Active Members, Retired Members and Eligible Dependents:

The Board of Trustees of the Iron Workers' Locals No. 15 and 424 Extended Benefit Fund (the "Fund") are pleased to provide you with this updated Summary Plan Description ("SPD"), which describes in detail the benefits available to you and your Eligible Dependents through the Iron Workers' Locals No. 15 and 424 Extended Benefit Plan (the "Plan") as of November 1, 2021. Benefit plans, like our Plan, can change from time to time and different rules may have applied before November 1, 2021.

To comply with the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), this SPD sets out the information that must be given to participants, including a statement of your rights and protections under that law. The benefits described in this SPD are **not guaranteed** (meaning not vested) for any participant or Eligible Dependent. All benefits may be changed, reduced or eliminated at any time by the Board of Trustees in their full and complete discretion, to the maximum extent allowed by law. We urge you to read this SPD carefully so that you may fully understand the benefits available to you and any of your Eligible Dependents.

This SPD replaces all other SPDs previously published by the Fund. If any changes are made to the Plan's benefit provisions in the future, they will be communicated to you via a notice referred to as a Summary of Material Modification ("SMM") that will be sent to the last known mailing address the Fund Office has on file for you. Therefore, it is extremely important that you notify the Fund Office if you ever change your mailing address. You should keep all SMMs with this SPD so you have the most current information available. Also, as required by current federal law, you will also receive an annual Summary of Benefits and Coverage ("SBC") prior to the start of each new Plan Year. Please keep in mind that the SBC is a standardized document created by the federal government, and it is a short summary of the rules contained in our formal Plan document. To the extent there is ever a conflict between the SBC and the Plan, the Plan will control.

We suggest that you take the time to familiarize yourself with this SPD, share it with your Eligible Dependents, as applicable, and keep it as a point of reference for contact and benefit information. Unless defined elsewhere in this SPD, capitalized terms will be defined at the end of the SPD in the "Definitions" section.

Always remember, you must notify the Fund Office of changes in your life (for example, you divorce or legally separate, you marry, have a Child or adopt a Child, your Child reaches the age of 26, someone in your immediate family passes away, you plan to serve in the Uniformed Services, or you, your Spouse, or an Eligible Dependent becomes entitled to Medicare) within the deadlines noted in this SPD. Please also notify the Fund Office if you want to change your Beneficiary or if you are engaging in union iron work outside of Connecticut or you change your address or other contact information.

If you have any questions about your benefits, please call the Fund Office or make your request via a written letter (unfortunately, questions submitted via electronic mail cannot be honored due to the high volume of electronic emails the Fund receives from its sponsoring Unions, Contributing Employers, service providers and professional advisors). Our staff will be pleased to assist you.

Sincerely,

BOARD OF TRUSTEES, Iron Workers' Locals No. 15 and 424 Extended Benefit Fund

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INTRODUCTION

The Iron Workers' Locals No. 15 and 424 Extended Benefit Fund ("Fund") is a self-insured, multi-employer, Taft-Hartley trust fund subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Fund's trust fund is also tax-exempt under applicable rules of the Internal Revenue Code of 1986, as amended. This means that health care claims are paid directly from Fund assets, which are held in a trust and not taxed, and not through an outside insurance company. The sole exceptions are the Fund's Life Insurance and AD&D benefits, which are provided via insurance policies currently through ULLICO, and the Fund's Medicare Eligible Retirees Plan, which is currently provided through an insured product with United Healthcare (as administered by Labor First). Due to the fact that the Fund is self-insured, for the vast majority of benefits provided the Fund is not subject to state insurance law (including Connecticut's), but it is subject to federal laws.

Your benefits are provided as a result of a Collective Bargaining Agreement between your Employer and your Union (the Iron Workers' Local Unions No. 15 and 424). Your Collective Bargaining Agreement - your union contract - requires your Employer to make payments to the Fund on your behalf for health and welfare benefits. These Employer payments are called "contributions" and they go into the trust (a large pool of money used to pay the benefits) for all eligible iron workers and their families.

The Fund is run by an equal number of Union Trustees and Employer Trustees. The Trustees have a responsibility to run the Fund prudently, and in the best interests of all participants and beneficiaries. Only the full Board of Trustees of the Fund has the authority and discretion to interpret the terms of the Iron Workers' Locals No. 15 and 424 Extended Benefit Plan ("Plan") and the terms of this SPD. You should not rely on any statement or opinion from a medical provider, an Anthem representative, or any other individual or entity about whether you (or a family member) is covered and/or what benefits the Fund provides. The Fund Office handles the day-to-day administrative operations, including determining eligibility. However, the Fund has contracted with several vendors, including Anthem, EyeMed Vision Care, Delta Dental of New Jersey and Tri-State Employee Assistance Program, Inc. to provide access to networks of providers for your care, process your applicable claims, and perform other administrative functions.

With respect to Active Members and Retired Members in the Retirees Ages 58-65 Plan, as well as their Eligible Dependents, the Fund currently has an agreement with Anthem Blue Cross/Blue Shield ("Anthem") to access medical care through a Preferred Provider Organization ("PPO") Benefit Program (which we call a "Network"). The major advantage to you in using Anthem's Network (i.e., In-Network) of Physicians and hospitals is that the Fund receives negotiated discounted fees and rates with the Physicians and hospitals in the Network. Your use of the Network providers will also lower your out-of-pocket expenses. In addition, if you use a Network provider, you are not required to submit claim forms because the Anthem provider is required to submit claims on your behalf. If you visit an Out-of-Network provider (i.e., a Non-Participating Provider) for services, you are responsible for any applicable cost-shares or penalties, you also may have to pay higher cost sharing amounts, you may have to file claims and you must make sure any necessary pre-certification is done. Benefits for covered services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a covered service. When you use an

Out-of-Network provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. Also, please note that Deductibles, Coinsurance, and Maximum Out-of-Pocket expenses are based on the Maximum Allowed Amount, not the provider's billed charges.

With respect to Retired Members who are eligible for Medicare and in the Medicare Eligible Retirees Plan, and their Spouses, the Fund generally provides an insured benefit known as a Medicare Advantage Plan with a Part D Prescription Drug program or a "MAPD." Much more detail is provided in the section of this SPD entitled the "The Medicare Advantage Plan with Part D Prescription Drug or MAPD" starting on page 29.

The Fund is not designed to cover each and every health care expense you or your Eligible Dependents may incur, nor is it designed to pay for 100% of all medical costs. The Fund has finite resources, and it pays for Medically Necessary covered expenses, up to the limits, and under all of the terms and conditions, outlined in this SPD.

As you will see when reviewing the following Schedule of Benefits, in most instances, the amount of money you pay out-of-pocket (i.e., as Coinsurance) will depend on whether you and/or your Spouse (if applicable) have already met or will meet the Health Enhancement Program (HEP) rules of the Fund. Refer to page 38 for details on the Fund's HEP.

CONTACT INFORMATION

Effective on and after January 1, 2022 the Fund Office will be located at: 162 West Street, Building 2, Suite J Cromwell, CT 06416	Phone: (203) 238-1204 Fax: (203) 639-0815 http://www.ctironworkers.org/
Locating a Preferred Provider Organization "PPO" Provider (Active Members and Retired Members in the Retirees Ages 55 to 65 Plan)	See www.anthem.com or call the Anthem Provider Locator number 1-800-810-(BLUE) 2583 for a list of Medical In-Network Providers.
Anthem's Member Services for Utilization Review and Case Management	(833) 899-7070
Prescription Drug Program: IngenioRx	(833) 267-2133 or https://www.ingenio-rx.com/
Vision Benefits: EyeMed	1-866-939-3633 or www.eyemed.com
Dental Benefits: Delta Dental	1-800-452-9310 or www.deltadental.com
Employee Assistance Program: Tri- State EAP Services	(845) 228-8303 or email: TriStateEAP@outlook.com or visit https://www.tristateeap.com/
Hearing Benefits: UConn Speech and Hearing Clinic	(860) 486-2629 or https://slhs.uconn.edu/uconn-speech-and-hearing-clinic-hours-and-contact/
Life Insurance and AD&D Benefits: ULLICO	1-800-431-5425 or https://www.ullico.com/lifeandhealth
Medicare Advantage Program with Part D Prescription Drug administered through Labor First	(203) 403-6440 or Toll Free Phone: (833) 981-0654 or https://laborfirst.com/
Medicare	1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048

SCHEDULE OF BENEFITS: ACTIVE MEMBERS AND RETIREES AGES 58-65 PLAN

Please refer to the definitions section of this SPD starting on page 108 if you have any questions on the capitalized terms noted in this Schedule of Benefits. This Schedule of Benefits applies only to Active Members and their Eligible Dependents in the Active Plan and Retired Members and their Eligible Dependents in the Retirees Ages 58-65 Plan. Medicare Eligible Retirees should refer to page 29 for a discussion of your benefits in the Medicare Advantage Plan with Part D Prescription Drugs or MAPD.

Plan Deductible:

	In-Network – You Pay	Out-of-Network – You Pay
Individual (HEP MET)	$500	$2,000
Family (HEP MET)	$1,000	$4,000
Individual (HEP *NOT* MET)	$1,500	$3,000
Family (HEP *NOT* MET)	$3,000	$6,000

Out-Of-Pocket Maximum Medical Benefits:

	In-Network – You Pay	Out-of-Network – You Pay
Individual (HEP MET)	$3,000	$4,000
Family (HEP MET)	$6,000	$8,000
Individual (HEP *NOT* MET)	$4,500	$6,000
Family (HEP *NOT* MET)	$9,000	$12,000

Out-Of-Pocket Maximum Prescription Drug Benefits:

	In-Network – You Pay
Individual (HEP MET)	$1,000
Family (HEP MET)	$2,000
Individual (HEP *NOT* MET)	$2,000
Family (HEP *NOT* MET)	$4,000

Life Insurance Benefit (see page 59 of this SPD for more information on the Fund's life insurance benefit):

Active Member	$40,000
Retired Member	$5,000

Provider Office Visits:

	In-Network – You Pay	Out-of-Network – You Pay
Preventive Care visit[1] (HEP MET)	No Charge	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Preventive Care visit[1] (HEP *NOT* MET)	No Charge	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Primary Care Provider Office Visits (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Primary Care Provider Office Visits (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Specialist Office Visits (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Specialist Office Visits (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Online Visits (HEP MET)	No Charge when you visit Live Health Online. For all other online visits you will pay 20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Online Visits (HEP *NOT* MET)	No Charge when you visit Live Health Online. For all other online visits you will pay 30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.

Outpatient Diagnostic Services:

	In-Network – You Pay	Out-of-Network – You Pay
Advanced Radiology - including MRI, CAT, CT, PET Scans, and other diagnostic services (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Advanced Radiology - including MRI, CAT, CT, PET Scans, and other diagnostic services (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Laboratory Services (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Laboratory Services (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.

[1] Age and frequency schedules may apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what the Fund will pay for.

Non-Advanced Radiology – including x-ray, Breast Tomosynthesis and other diagnostic services (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Non-Advanced Radiology – including x-ray, Breast Tomosynthesis and other diagnostic services (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.

Mental Health, Behavioral Health, or Substance Abuse Services:

	In-Network – You Pay	Out-of-Network – You Pay
Outpatient Services (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Outpatient Services (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Inpatient Services (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Inpatient Services (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.

Therapy Services (Outpatient Rehabilitative and Habilitative):

	In-Network – You Pay	Out-of-Network – You Pay
Physical, Occupational and Speech Therapy – up to 60 visits per calendar year – limits are combined for physical, occupational, and speech therapy (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Physical, Occupational and Speech Therapy – up to 60 visits per calendar year – limits are combined for physical, occupational, and speech therapy (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.

Home Health Care Services:

	In-Network – You Pay	Out-of-Network – You Pay
Home Health Care Services: up to 80 visits for nursing, private duty nursing, therapeutic, and home health aid services per calendar year provided by a Home Health Care Agency (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Home Health Care Services: up to 80 visits for nursing, private duty nursing, therapeutic, and home health aid services per calendar year provided by a Home Health Care Agency (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.

Other Services:

	In-Network – You Pay	Out-of-Network – You Pay
Chiropractic Care – up to 35 visits per calendar year (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Chiropractic Care – up to 35 visits per calendar year (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Diabetic Equipment and Supplies (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance u after the Deductible until the Out of Pocket Maximum is met.
Diabetic Equipment and Supplies (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Durable Medical Equipment (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Durable Medical Equipment (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Acupuncture – maximum 18 visits per calendar year (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Acupuncture – maximum 18 visits per calendar year (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Allergy Testing (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Allergy Testing (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Allergy Treatment – injection, immunotherapy, or other therapy treatments (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Allergy Treatment – injection, immunotherapy, or other therapy treatments (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Artificial Limbs – includes associated supplies and equipment (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Artificial Limbs – includes associated supplies and equipment (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Cardiac Rehab Therapy – unlimited visits per calendar year (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Cardiac Rehab Therapy – unlimited visits per calendar year (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Counseling - Includes Family Planning and Nutritional Counseling (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.

Counseling - Includes Family Planning and Nutritional Counseling (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Dialysis and Hemodialysis (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Dialysis and Hemodialysis (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Home Dialysis and Infusion Therapy (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Home Dialysis and Infusion Therapy (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Hospice (HEP MET)- lifetime maximum of 90 days	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Hospice (HEP *NOT* MET)- lifetime maximum of 90 days	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Nutritional Counseling for Eating Disorders (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Nutritional Counseling for Eating Disorders (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Other Therapy Services Including radiation, chemo, respiratory (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Other Therapy Services Including radiation, chemo, respiratory (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Prosthetics (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Prosthetics (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Pulmonary (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Pulmonary (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.

Facility Services:

	In-Network – You Pay	Out-of-Network – You Pay
Outpatient Services Including surgery, infertility, and diagnostic colonoscopy (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Outpatient Services Including surgery, infertility, and diagnostic colonoscopy (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Inpatient Hospital Acute Care Facility Including mental health, substance abuse, maternity, infertility, and Human Organ and Tissue Transplant Services (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the maximum out of pocket expense is met.
Inpatient Hospital Acute Care Facility Including mental health, substance abuse, maternity, infertility, and Human Organ and Tissue Transplant Services (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Inpatient Rehabilitation Facility - 60 days per calendar year, limit is combined for Skilled Nursing Facility and Inpatient Rehabilitation (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Inpatient Rehabilitation Facility- 60 days per calendar year, limit is combined for Skilled Nursing Facility and Inpatient Rehabilitation (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Skilled Nursing Facility Up to 60 days per calendar year, limit is combined for Skilled Nursing Facility and Inpatient Rehabilitation (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Skilled Nursing Facility Up to 60 days per calendar year, limit is combined for Skilled Nursing Facility and Inpatient Rehabilitation (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.

Emergency and Urgent Care:

	In-Network – You Pay	Out-of-Network – You Pay
Ambulance Services (includes air ambulance) (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Ambulance Services (includes air ambulance) (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.

Emergency Room – Copayment waived if admitted (HEP MET)	$150 Copayment per visit, plus 20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	$150 Copayment per visit, plus 20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Emergency Room – Copayment waived if admitted (HEP *NOT* MET)	$300 Copayment per visit, plus 30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	$300 Copayment per visit, plus 30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Urgent Care Services (HEP MET)	20% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	40% Coinsurance after the Deductible until the Out of Pocket Maximum is met.
Urgent Care Services (HEP *NOT* MET)	30% Coinsurance after the Deductible until the Out of Pocket Maximum is met.	50% Coinsurance after the Deductible until the Out of Pocket Maximum is met.

Accidental Death and Dismemberment Benefits (Active Members Only): see page 59 of this SPD

Weekly Disability Benefits (Active Members Only): see page 51 of this SPD

Vision Benefits: see page 40 of this SPD

Hearing Care Benefits (Active Members and their Eligible Dependents Only): see page 49 of this SPD

Dental Benefits (Active Members and their Eligible Dependents Only): see page 43 of this SPD

Prescription Drug Benefits: see page 45 of this SPD

ELIGIBILITY FOR COVERAGE – ACTIVE MEMBERS

This section tells you how an iron worker engaging in Covered Employment may become eligible as an Active Member under the Fund. To be eligible as an Active Member in the Active Plan, you need to be a qualified employee. You are a "qualified employee" if you are an employee of a Contributing Employer, you are working in Covered Employment, and you satisfy the hours requirements described in the applicable "Initial Eligibility" and "Continuing Eligibility" sections below. This section also discusses when your eligibility, and that of any of your Eligible Dependents, will end.

Please note that an Active Member who provides sufficient proof to the Fund Office of having worked hours in Covered Employment for which Employer contributions have not been received, may, under such non-discriminatory rules as shall be adopted by the Trustees, be credited with those hours as of the date the contributions for those hours worked should have been received. Notwithstanding the prior sentence, in situations where the Trustees determine that certain Employer contributions are uncollectible, in no event may an Active Member who has or had any ownership interest in the Contributing Employer, or an employee who is a Child, Spouse or parent of an individual who has or had any ownership interest in such Contributing Employer, be credited with any hours with respect to such uncollectible Employer contributions, regardless of when those hours were worked. Sufficient proof under this paragraph shall include, but is not be limited to, pay stubs, W-2 forms or other evidence of work in Covered Employment and a written statement from a job steward or foreman verifying work in Covered Employment.

Initial Eligibility

You become an Active Member and eligible for benefits for the first time on the January 1, April 1, July 1 or October 1 after the required Employer contributions have been made on your behalf by a Contributing Employer(s) for work you perform under a Collective Bargaining Agreement or Participation Agreement within the jurisdiction of the Fund. Your initial eligibility is based on the number of hours you work during the three months or six months immediately before the relevant initial eligibility date of January 1, April 1, July 1 or October 1. The first time you become eligible for benefits as an Active Member, you need to work at least 300 hours during the prior three months or at least 600 hours during the prior six months. Your Eligible Dependents, if any, are eligible for benefits at the same time you become eligible. Here are the rules in chart form:

To be Initially Eligible For 3 Months of Coverage Beginning:	***You Need to Work in Covered Employment:***
January 1	300 hours during the three-month period of the prior October, November, and December, **or** 600 hours during the six-month period of the prior July through December.
April 1	300 hours during the three-month period of the prior January, February, and March, **or** 600 hours during the six-month period of the prior October through March.

July 1	300 hours during the three-month period of the prior April, May, and June, **or** 600 hours during the six-month period of the prior January through June.
October 1	300 hours during the three-month period of the prior July, August, and September, **or** 600 hours during the six-month period of the prior April through September.

Continuing Eligibility

After you become initially eligible as an Active Member as outlined above, you need to be available for work in Covered Employment AND work a minimum number of hours to remain eligible for benefits. Again, the Fund will utilize quarterly eligibility dates. By the beginning of each quarter, on January 1, April 1, July 1, or October 1, you need to have worked: 300 hours during the prior three (3) months; or 600 hours during the prior six (6) months; or 1,000 hours during the prior twelve (12) months. In addition to meeting the hours requirements, you must be continuously either currently employed by a Contributing Employer or listed with a Local Union referral hall and available for, and actively seeking, work in Covered Employment.

After establishing your initial eligibility, you will maintain eligibility by having the following number of hours of Employer contributions:

To be Eligible for 3 Months of Continued Coverage Beginning:	***You Need to Work in Covered Employment:***
January 1	300 hours during the three-month period of the prior October, November, and December, **or** 600 hours during the six-month period of the prior July through December, **or** 1,000 hours during the twelve-month period of the prior January through December.
April 1	300 hours during the three-month period of the prior January, February, and March, **or** 600 hours during the six-month period of the prior October through March, **or** 1,000 hours during the twelve-month period of the prior April through March.
July 1	300 hours during the three-month period of the prior April, May, and June, **or** 600 hours during the six-month period of the prior January through June, **or** 1,000 hours during the twelve-month period of the prior July through June.
October 1	300 hours during the three-month period of the prior July, August, and September, **or** 600 hours during the six-month period of the prior April through September, **or** 1,000 hours during the twelve-month period of the prior October through September.

Special Continuing Eligibility Rule – the "2,000 Hour Rule"

If you do not meet any of the continuing eligibility tests noted above, you and any Eligible Dependents will still maintain Fund eligibility if you:

(a) have been credited with at least 200 hours of contributions in each of the seven (7) consecutive years prior to the date a claim is incurred, *and*

(b) had at least 2,000 hours of contributions made on your behalf during the two (2) years prior to the date the claim is incurred.

This is commonly known as the "2,000 Hour Rule." Under this rule a "year" is the twelve (12) full calendar months immediately preceding the month a specific claim is incurred, along with all prior twelve (12) consecutive month periods.

Additional Method to Continue Eligibility – Self-Payment

If you are an Active Member who is credited with at least 100 hours of contributions in a three-month eligibility quarter as outlined above, but you will lose your Fund eligibility solely because you do not have the required number of hours, then you are permitted to make a payment to the Fund (known as a "self-payment") at the regular contribution rate in the Fund's Collective Bargaining Agreement for the number of hours you need to reach either the 300 hour level (for a three-month period) or the 600 hour level (for a six-month period). If you make such a self-payment in a timely manner, then your Fund coverage will continue for the immediately following coverage quarter. In order to be eligible for this self-payment right, you must be available for work in Covered Employment and you must have never engaged in Non-Covered Employment. Your self-payment must be received by the Fund Office within 30 days of the date that the relevant coverage quarter commences. Here is an example:

EXAMPLE: Assume you are an iron worker who has coverage under the Active Member program for you and your Spouse that will otherwise end as of December 31, 2021. Also assume that you worked for 250 hours in the months of July through September 2021, and 275 hours for the months of October through December 2021. You are also available for work in Covered Employment and have never engaged in Non-Covered Employment, and assume that the Fund's hourly contribution rate under the Collective Bargaining Agreement at such time is $13.00. *Can you make a self-payment to continue your Fund Active Plan eligibility for you and your Spouse for the January through March 2022 coverage quarter?*

Answer: Yes, you may! Because you have at least 100 hours in the October through December 2021 eligibility quarter, this self-payment right is available to you. Assuming you remit a timely self-payment to the Fund Office, you and your Spouse could continue coverage under the Active Plan for the January through March 2022 coverage quarter. You would need to remit a check to the Fund in the amount of $325 (which would be the 25 additional hours at the $13.00 rate needed for the October through December 2021 time frame to get you to the 300 hour level, as 275 + 25 = 300). While this is obviously a less attractive financial option for you, you would also have the option to remit a check to the Fund in the amount of $975 (which would be the 75 additional hours needed for the July through December 2021 time frame to get you to the 600 hour level, as 275 + 250 + 75 = 600).

Feel free to contact the Fund Office if you ever have any questions about this self-payment option!

Limited Extension of Coverage in the event of an Active Member's death while covered under the Active Plan

If you as an Active Member die, your Spouse and any of your Eligible Dependents (if any) will continue to be covered under the Active Plan until the later of: (1) ninety (90) days from the end of the month in which you die, or (2) the date that your Active Plan coverage would have otherwise ceased under the Fund's continuing eligibility rules based on your work history as of the date of your death. No self-payment is required for this extended coverage, but such coverage may end earlier based on other normal Fund rules, including but not limited to the prohibition on engaging in Non-Covered Employment and loss of Fund coverage if an Eligible Dependent otherwise ceases to be an Eligible Dependent under Fund rules. When this limited coverage extension ends, your widow/widower and any of your Eligible Dependents may elect COBRA which is discussed in more detail starting on page 74 of this SPD.

Family Medical Leave Act (FMLA)

Your eligibility for FMLA leave and benefits will be determined by your Employer. If you have a question regarding your eligibility for FMLA leave, please contact your Employer. For more information on FMLA, including eligibility and leave entitlement please visit https://www.dol.gov/agencies/whd/fmla.

Eligibility While Disabled

If you are covered by the Active Plan when you become disabled, you and your Eligible Dependents may continue to be eligible for benefits for up to 104 weeks. To be disabled for purposes of this extended eligibility rule, you must meet the Fund's rules for Weekly Disability Benefits (see page 51 of this SPD), subject to certain limited modifications. Those modifications include that you: (a) may be receiving unemployment compensation, Workers' Compensation benefits, salary continuation benefits or Connecticut Paid Family and Medical Leave Act benefits due to your own serious health condition, and (b) cannot be receiving a monthly or periodic retirement benefit from any source. However, with respect to (b), in the event that you are receiving an occupational disability pension from the Iron Workers' Locals No. 15 and 424 Pension Fund, your eligibility under this special 104 week rule can continue only for a six month period as described on page 20 of this SPD. Assuming you are otherwise eligible, this special disability period begins with the date of your disability (as certified by your Physician on the disability claim form) and ends when you are no longer disabled.

When you are out on Workers' Compensation leave or are receiving benefits under the Connecticut Paid Family and Medical Leave Act due to your own serious health condition, you and your Eligible Dependents may continue to be covered by the Fund for up to 104 weeks, subject to the eligibility rules noted above. Also, assuming you qualify, the Fund will not pay for treatment for conditions that are related to the job-related Illness or Injury covered by Workers' Compensation during this period, and you must notify the Fund when you are on Workers' Compensation leave

and/or receiving benefits under the Connecticut Paid Family and Medical Leave Act due to your own serious health condition for your coverage to continue.

Assuming you meet the eligibility rules, you will receive 23-1/2 hours of credit for each of the first 26 full calendar weeks that you are disabled for purposes of your continuing eligibility, provided that you were credited with 300 hours in each of the four (4) calendar quarters immediately prior to the quarter in which you become disabled.

Any hours you earned prior to your disability will be frozen until they are needed to determine future eligibility.

Regaining Eligibility After You Lose It

An Active Member who loses coverage solely due to lack of hours of contributions may reinstate his or her eligibility by complying with the continuing eligibility section starting on page 17 of this SPD. An Active Member who loses coverage due to a Termination for Cause may reinstate his or her eligibility by complying with the initial eligibility section noted on page 16.

Retiring under the Iron Workers' Locals No. 15 and 424 Pension Fund;
How this will Interact with your Continuing Eligibility under the Fund

All of the continuing eligibility tests described above are intended to apply to iron workers who are either actively working in, or actively seeking work in, Covered Employment. Therefore, if you retire under the rules of the Iron Workers' Locals No. 15 and 424 Pension Plan and otherwise continue to maintain coverage in the Active Plan under this Fund, such Active Plan coverage will end *as of the earlier of*:

(a) the date your Active Plan coverage would otherwise end under the continuing eligibility rules described starting on page 17 of this SPD, or

(b) the last day of the six (6) month period which immediately follows the end of the calendar quarter (January through March, April through June, July through September, or October through December) in which you retired under the Iron Workers' Locals No. 15 and 424 Pension Fund.

However, if you retire on an occupational disability pension (as defined in the Iron Workers' Locals No. 15 and 424 Pension Plan) you can maintain your Active Plan coverage for the period described above in (b), even if your eligibility under the Active Plan coverage would otherwise end earlier under (a) above.

Also, this limitation has *no impact* on your eligibility for coverage under the Fund's Retiree Programs (whether the Retirees Ages 58-65 Plan or the Medicare Eligible Retirees Plan). Coverage for those Retiree Programs will be examined under the Fund's normal Retiree Program eligibility rules starting on page 26.

Here is an example of how the limitation described above works:

EXAMPLE: Assume you are an iron worker who is vested under the Iron Workers' Locals No. 15 and 424 Pension Fund and are considering retirement effective as of October 1, 2021. Also assume that if you simply stopped working as an iron worker on October 1, 2021, your Fund Active Plan eligibility could otherwise remain in effect through September of 2022 based on your work history. You then elect to retire under the Iron Workers' Locals No. 15 and 424 Pension Fund on a normal pension as of October 1, 2021. *How long will your Fund Active Plan eligibility last?*

Answer: Through June 30, 2022, provided that you comply with all other normal Fund rules. This is because your Active Plan coverage under the Fund is limited by the rule in (b). Specifically, as you retired from the Iron Workers' Locals No. 15 and 424 Pension Fund effective October 1, 2021, the calendar quarter in which you retired ended on December 31, 2021, and the immediately following six (6) month period ends on June 30, 2022. At that point, the Fund would offer you COBRA continuation coverage and, if you are otherwise eligible, an application for coverage under the applicable Fund Retiree Program.

Dependent Eligibility

As an Active Member, your Eligible Dependents include:

1. Your "Spouse," which means any individual who is: (a) lawfully married to an Active Member under applicable Connecticut law governing marriage; or (b) in a relationship with an Active Member that is recognized as a marriage under applicable Connecticut law governing marriage. An individual ceases to be a "Spouse" on the date that the marriage between the individual and an Active Member ends by divorce, dissolution, legal termination or separation, or annulment. Also, be aware that Connecticut law does not currently recognize domestic partnerships, so-called "common law" marriages, or other similar relationships.

2. Your "Child," which means any biological child, lawfully adopted child, foster child, or stepchild. Subject to the other rules of this SPD, your Child may remain an Eligible Dependent until the last day of the month in which he or she reaches age 26.

Your Eligible Dependents become eligible for Fund coverage on the date you become eligible for Fund coverage.

Disabled Dependent Child: A disabled Child who is incapable of sustaining employment by reason of physical or mental condition, may continue as an Eligible Dependent after he or she attains age 26 provided that:

- The disability began before age 26; and
- You maintain coverage under the Fund; and
- You provide proof of the Child's condition to the Fund Office no later than 30 days before the date the Child reaches age 26. If you do not notify the Fund Office within this 30 day limit, the Child's coverage with the Fund will terminate as of the last day of the month of the Child's 26th birthday. It is possible to reinstate coverage for such a Child who had a

disability which began before age 26 on a *prospective basis only* by notifying the Fund Office of the Child's continued disability and providing appropriate evidence to the Fund.

Qualified Medical Child Support Orders

A Child of an Active Member that is not otherwise covered by the Fund may become eligible for coverage as a consequence of a legal order known as a "medical child support order" issued by a state court or administrative agency to a divorced or custodial parent which applies to the Active Member. If you receive such an order, please provide it to the Fund Office immediately so that the Fund can determine whether it meets applicable legal rules so as to be a "qualified" order. Enrollment under the Fund for a Child noted on such an order may be required even in circumstances in which the Child was not previously enrolled under the Fund. For further information concerning medical child support orders, and the Fund's procedures for implementing such orders (which may be obtained free of charge), contact the Fund Office.

Getting Legally Separated or Divorced

If you and your Spouse get a legal separation or divorce, your former Spouse will no longer be eligible for coverage as an Eligible Dependent through the Fund. However, your former Spouse may elect to continue coverage under COBRA for up to 36 months. You or your former Spouse MUST notify the Fund Office within 60 days of the divorce or legal separation for your former Spouse to obtain COBRA continuation coverage. Please keep this date in mind! See page 74 of this SPD for more information on COBRA.

Also remember that the Fund is not a party to a legal separation or divorce action, so never assume that the Fund Office will be aware of your marital status or that any attorney you are working with will notify the Fund that your marital status has changed. In addition, upon divorce or legal separation, you should review any Beneficiary designations you may have made under this Fund, and any other health benefit or retirement funds you participate in, to be sure that such designations continue to reflect your intentions.

Eligibility for Coverage During Military Service

If you enter qualified military service (such as active or inactive duty training or active duty in the United States armed forces or National Guard), any hours in Covered Employment you have earned and any contributions credited to your benefit with respect to initial eligibility in the Fund may be protected during the qualified military service leave of absence. However, in accordance with the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), you must return to work or seek re-employment with a Contributing Employer following a discharge, under not less than honorable conditions, within the minimum time period allowed. If you do not return to work in Covered Employment or seek re-employment in Covered Employment within the required time period, you will forfeit your continued eligibility rights. In order to ensure protection of your rights under USERRA, you must give your Contributing Employer and the Fund Office advance notice of your military service, unless you are unable to do so because of military necessity, or advance notice is impossible or unreasonable under the circumstances.

If you are covered under the Fund at the time your qualified military service leave of absence begins, your health coverage will be continued by the Fund during your first 31 days of military service. If you are on uniformed services leave for more than 31 days, you will be permitted to continue benefits for yourself and your Eligible Dependents. If you elect coverage under USERRA, you generally may continue coverage for yourself and your Eligible Dependents for up to 24 months.

Your right to maintain and reinstate coverage by reason of qualified military service will be administered and interpreted by the Fund in accordance with the requirements of USERRA. The contributions, if any, credited to you will be kept on the Fund's records during the qualified military service leave of absence, and your coverage and your Eligible Dependents' coverage will be reinstated, provided you return to work in Covered Employment or seek re-employment with a Contributing Employer within the time period protected under USERRA.

When Eligibility Ends

Your eligibility as an Active Member, along with any Eligible Dependents, will end on the first to occur of these dates:

1. The date the Fund is discontinued or terminated;
2. The last day of the month for which you fail to satisfy the continuing eligibility rules discussed on page 17;
3. The date you, or an Eligible Dependent, are Terminated for Cause (as defined on page 113);
4. Subject to the rules outlined on page 20, the date you retire under the terms of the Iron Workers' Locals No. 15 and 424 Pension Fund;
5. Subject to the rules outlined on page 19, the date you die;
6. You attain age 65 (or another age, if applicable) and are eligible for Medicare, except as required by law; or
7. The date you, or an Eligible Dependent, engages in any Non-Covered Employment (as defined on page 111).

In addition, coverage for any Eligible Dependent will end on the date he or she no longer qualifies as an Eligible Dependent under the rules outlined on page 21. Benefits will not be paid after Fund coverage ends.

In the event that your coverage, or the coverage of an Eligible Dependent, is terminated (other than being Terminated for Cause), you and/or the applicable Eligible Dependent(s) will be offered COBRA on a self-pay basis. See page 74 for more information on COBRA.

If you receive Fund benefits after the date your coverage terminates and/or the Fund mistakenly pays claims on your behalf or on behalf of one of your Eligible Dependents, the Fund will seek reimbursement from you for the cost of those benefits paid to you or paid to any providers on your behalf. In addition, you will be responsible for the cost of any attorney and administrative fees incurred to obtain reimbursement from you.

Rescission of Coverage

The Fund may rescind your health coverage for fraud, intentional misrepresentation of a material fact, or material omission after the Fund provides you with 60 days' advance written notice of that rescission of coverage. The Trustees have the right to determine, in their sole discretion, whether there has been fraud, an intentional misrepresentation of a material fact, or a material omission. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you shouldn't have been covered by the Fund. The following situations will not be considered rescissions of coverage and do not require the Fund to give you 60 days' advance written notice:

- The Fund terminates your coverage back to the date of your loss of employment when there is a delay in administrative recordkeeping between your loss of employment and notification to the Fund of your termination of employment.
- The Fund retroactively terminates your coverage because of your failure to pay required premiums or other contributions for your coverage in a timely manner.
- The Fund retroactively terminates your former Spouse's coverage back to the date of your divorce.

For any other unintentional mistakes or errors under which you and your Eligible Dependents were covered by the Fund when you should not have been covered, the Fund will cancel your coverage prospectively – for the future – once the mistake is identified. Such cancellation will not be considered a rescission of coverage and does not require the Fund to give you 60 days' advance written notice.

Special Enrollment Rights

Special enrollment allows individuals who are not covered by the Fund to enroll for coverage. There are two types of special enrollment – upon loss of eligibility for other coverage and upon certain life events such as marriage, birth, and adoption.

There are additional special enrollment rights available to those who are eligible for assistance under Medicaid or CHIP (which is the "Children's Health Insurance Program" offered by a number of states, but not Connecticut at this time). In such instances, the Fund is required to permit you and your otherwise Eligible Dependents to enroll in the Fund, as long as you and your dependents are eligible, but not already enrolled. You must make a written request for Fund coverage within 60 days of being determined eligible for this assistance.

Here is an example of how special enrollment rights work for a loss of other coverage:

- You are an Active Member that then retires from the Iron Workers' Locals No. 15 and 424 Pension Plan and are eligible for, and apply to be covered under, the Fund's Retirees Ages 58 to 65 Plan. However, your Spouse has other health coverage available from her employer, so you notify the Fund Office of that on your application and you defer electing coverage for her in the Retirees Ages 58 to 65 Plan. A year later, at a time when you are still covered by the Retirees Ages 58 to 65 Plan, your Spouse then terminates her employment and loses her health coverage that was provided by her employer. If you

notify the Fund Office within 30 days of the loss of that other health coverage, your Spouse can then be enrolled with you in the Retirees Ages 58 to 65 Plan.

Here are some examples of how special enrollment rights work for certain life events:

- If you marry and already have Fund coverage, your new Spouse will become covered on the first day of the month after your marriage, provided you notified the Fund Office within 30 days of your marriage.

- If you already have Fund coverage and you have a newborn biological Child, or you adopt a Child, such Child will become covered on the date of birth (for a newborn biological Child) or the date the Child is adopted or placed in your home (for an adopted Child), provided you notified the Fund Office within 30 days of the birth or adoption, whichever applies.

To ensure a new dependent receives Fund coverage through a special enrollment right, you must notify the Fund Office within the required time frames noted above!!

RETIREE BENEFITS

The Fund generally covers two types of Retirees: (1) Retirees who are ages 58 to 65 and are not yet eligible for Medicare, and (2) Retirees who are eligible for Medicare. The details of coverage for both groups of Retirees can be found below. Assuming you are eligible, always keep in mind that a monthly self-payment must be made in a timely manner to continue your Fund Retiree coverage.

I. RETIREES AGES 58 TO 65 PLAN

If you are eligible for the Fund's Retirees Ages 58 to 65 Plan, you are eligible for many of the same benefits that you received as an Active Member. Your medical and prescription drug benefits will continue to be provided through Anthem/IngenioRx, you will have access to the Fund's EAP and you will have vision coverage. Please be aware that you and any of your Eligible Dependents will need to satisfy the rules of the Fund's Health Enhancement Program or "HEP" (see page 38) or you will pay higher Deductibles, higher Copayments, and the Fund will provide lower Coinsurance as described in the Schedule of Benefits (see page 9).

However, there are a few important differences when you become eligible for the Retirees Ages 58 to 65 Plan, as compared to being an Active Member, and here are those which you should note:

- You need to make the required monthly self-payments in a timely manner;
- Your Fund life insurance benefit is reduced from $40,000 to $5,000.00;
- You are not eligible for dental benefits;
- You are not eligible for hearing benefits;
- You are not eligible for the Fund's Accidental Death and Dismemberment benefits; and
- You are not eligible for weekly disability benefits.

Your Eligible Dependents may also be covered under the Fund's Retirees Ages 58 to 65 Plan, but only when you are eligible for benefits and the required monthly self-payments are made on their behalf as well. Once you become eligible for coverage under the Retirees Ages 58 to 65 Plan, you and your Eligible Dependents are no longer eligible for Active Member coverage. You may, however, become eligible for Active Member coverage if you go back to work in Covered Employment and have a sufficient number of hours to reinstate your eligibility as an Active Member.

Initial Eligibility

You are eligible for Fund coverage under the Retirees Ages 58 to 65 Plan if:

- You are at least 58 years of age, but not yet 65 years of age;
- You are vested in the Iron Workers' Locals No. 15 and 424 Pension Plan;
- You have been employed in Covered Employment with contributions of at least 200 hours made to the Fund in your name by Contributing Employers during each of the seven consecutive years prior to the later of you reaching age 58 or your last day of work in Covered Employment;

- You had a continuous attachment to the iron working trade or craft through work in Covered Employment as your primary occupation and source of wages during the seven consecutive years prior to the later of you reaching age 58 or your last day of work in Covered Employment;
- You file a timely Application for Retiree Health Benefits provided by the Fund Office; and
- You have stopped working in the iron working trade or craft, are not engaged in Covered Employment or Non-Covered Employment, are not an Active Member and, after becoming an Active Member, did not engage in Non-Covered Employment at any time.

You will also be eligible for Fund coverage under the Retirees Ages 58 to 65 Plan if:

- You are at least 58 years of age, but not yet 65 years of age;
- You meet any one of the following three requirements with respect to the Iron Workers' Locals No. 15 and 424 Pension Plan:
    - You are receiving a Service Pension, a Rule of 85 Pension or a Rule of 89 Pension, or
    - You are receiving a Disability Pension (subject to applicable rules governing Medicare), or
    - You initially retired on a Disability Pension, you recovered from your disability sufficiently and returned to work in Covered Employment or equivalent work, and you again retired under the terms of the Iron Workers' Locals No. 15 and 424 Pension Plan; and
- You file a timely Application for Retiree Health Benefits provided by the Fund Office; and
- You have stopped working in the iron working trade or craft, are not engaged in Covered Employment or Non-Covered Employment, are not an Active Member and, after becoming an Active Member, did not engage in Non-Covered Employment at any time.

When Your Coverage Begins

You **must** apply for coverage in the Retirees Ages 58 to 65 Plan when you initially retire from the Iron Workers' Locals No. 15 and 424 Pension Fund, and subject to a limited exception noted below, you must also elect the Eligible Dependents that you wish to cover. If you do not apply in a timely manner, you will not be eligible for Retirees Ages 58 to 65 Plan coverage or the Medicare Eligible Retirees Plan at any future time. Your coverage in the Retirees Ages 58-65 Plan will begin on the first of the month after your application is approved by the Fund and your Active Member coverage has ended. Your Eligible Dependents for whom you make an election are eligible for benefits at the same time that you become eligible for Retirees Ages 58 to 65 Plan coverage. The Fund does allow a limited exception, in that you may defer electing coverage in the Retirees Ages 58 to 65 Plan for your Eligible Dependents who have other health coverage. However, to then enroll any such Eligible Dependent(s) in the Retirees Ages 58 to 65 Plan at a future date, you must still have Retirees Ages 58 to 65 Plan coverage and the Fund Office must be notified within 30 days of the loss of that Eligible Dependent's other health coverage in accordance with the special enrollment right section of this SPD on page 24.

In addition, you may wait to apply for coverage in the Retirees Ages 58 to 65 Plan if you are disabled and covered as an Active Member; or you elect COBRA and are covered as an Active

Member, assuming you otherwise meet the initial eligibility rules above and submit a timely application to the Fund Office. **Please contact the Fund Office for further information on how to apply for Retirees Ages 58 to 65 Plan benefits**.

Your Share Of The Cost For Your Benefits

You are required to make a monthly self-payment to cover a portion of the cost of your coverage in the Retirees Ages 58 to 65 Plan. As a general rule, this monthly self-payment (called a "Required Contribution Payment" or "RCP") is deducted from your monthly pension benefit from the Iron Workers' Locals No. 15 and 424 Pension Plan. As part of the application process in the Retirees Ages 58 to 65 Plan, you will complete an assignment form which allows this RCP to be deducted from your Iron Workers' Locals No. 15 and 424 Pension Plan benefit and paid over to this Fund. If this assignment process is not followed, or your monthly Iron Workers' Locals No. 15 and 424 Pension Plan benefit is not enough to cover the RCP, you are still responsible for paying the RCP in a timely manner. Contact the Fund Office for current rates and self-payment procedures.

Termination of Coverage

You, and any of your Eligible Dependents for whom you have elected coverage, are no longer eligible for benefits from the Retirees Ages 58 to 65 Plan when:

- You reach age 65 or you otherwise become eligible for Medicare;
- You do not pay the RCP, discussed above, in full and on time;
- You engage in conduct which constitutes a Termination for Cause (as defined on page 113);
- The Retirees Ages 58 to 65 Plan is terminated; or
- You die.

Please note: When you become eligible for Medicare, you and your Spouse may be eligible for coverage under the Medicare Eligible Retirees Plan offered through the Fund. Refer to the information beginning on page 29.

Also, any Eligible Dependent of yours will lose coverage under the Retirees Ages 58 to 65 Plan when:

- The Eligible Dependent engages in conduct which constitutes a Termination for Cause (as defined on page 113);
- The Eligible Dependent ceases to be eligible for coverage under the Fund as an Eligible Dependent;
- The Eligible Dependent reaches age 65 or otherwise becomes eligible for Medicare; or
- The Retirees Ages 58 to 65 Plan is terminated.

Once eligibility for benefits ends in the Retirees Ages 58-65 Plan, it cannot be restored.

Important: When your Active Plan eligibility runs out, you will be given an option to either maintain your Active Plan benefits by making COBRA self-payments or, if eligible, you may elect coverage under the Fund's retiree program, if applicable. Retiree benefits are a one-time election and must be a continuation of your Active eligibility. If you elect not to participate in the retiree program when first available, you will not be given another opportunity.

Limited Extension of Coverage for Widows of Retired Members in the Retirees Ages 58-65 Plan: If you die, your widow (if any) will continue to be covered under the Retirees Ages 58 to 65 Plan for three months from the end of the month in which you die. No self-payment is required for the extended coverage. When this automatic three month coverage extension ends, your widow and any of your Eligible Dependents may elect COBRA which is discussed in more detail starting on page 74 of this SPD.

II. THE MEDICARE ADVANTAGE PLAN WITH PART D PRESCRIPTION DRUG OR MAPD (FOR MEDICARE ELIGIBLE RETIRED MEMBERS)

Although there are certain instances in which you may qualify earlier, generally, you become eligible for Medicare coverage once you reach age 65. Once you reach this age, you must sign up for Medicare Part A, which covers hospital expenses, and Medicare Part B, which covers Physician expenses. There are also two optional parts of Medicare—Parts C and D. Medicare Part C plans, often referred to as Medicare Supplements or Medigap Plans, have monthly premiums and cover expenses that Parts A and B do not, such as Deductibles, Copayments and Coinsurance. Medicare Part D is Medicare's prescription drug plan.

The Fund offers Medicare Eligible Retirees an alternative to buying a Medicare Supplement Plan and/or a Part D Prescription Drug Plan — it is a Medicare Advantage Plan with Part D Prescription Drug or MAPD, which the Fund calls the Medicare Eligible Retirees Plan. The Fund has retained Labor First, a firm that specializes in the implementation and ongoing retiree service of union retiree health and drug programs, to help you with the Medicare Eligible Retirees Plan which, at the time this SPD was printed, is offered through an insurance company, United Healthcare. You can contact Labor First by calling (203) 403-6440 (TTY 711) or (833) 981-0654 (TTY 711) toll-free if you have any questions.

If you are eligible for Medicare, you must enroll in the Medicare Eligible Retirees Plan with Labor First in order to get coverage through the Fund. Any of your Eligible Dependents who are themselves eligible for Medicare are also eligible for benefits under the Medicare Eligible Retirees Plan. If your Spouse is not Medicare eligible, then he or she may also maintain coverage through the Fund at a higher Required Contribution Payment. If you choose to opt out of the Medicare Eligible Retirees Plan, you will no longer have medical or prescription drug benefits provided through the Fund.

Please keep in mind that with respect to the Medicare Eligible Retirees Plan, the Fund enters into a contract with the MAPD provider through a fully-insured arrangement. This means that eligibility, premiums, and coverage terms and conditions, including but not limited to prescription drug formularies, limits, maximum out-of-pocket amounts, copayments and residency

requirements, will be determined and administered entirely by the insurance company. The Fund's Board of Trustees may, in its full and complete discretion: (1) provide the services currently provided by Labor First itself, or utilize another company to provide such services, and (2) contract with another insurance company to provide a Medicare Advantage Plan with or without a Medicare Part D prescription drug plan. Contact Labor First by calling (203) 403-6440 (TTY 711) or (833) 981-0654 (TTY 711) toll-free for a description of the benefits offered under this Medicare Eligible Retirees Plan.

Initial Eligibility

You will be eligible for coverage under the Medicare Eligible Retirees Plan if you meet the following eligibility requirements:

- You are at least 65 years of age; and
- You are vested in the Iron Workers' Locals No. 15 and 424 Pension Plan; and
- You are entitled to receive benefits under Medicare Parts A and B; and
- You were either:
    - covered under the Fund's Retirees Ages 58 to 65 Plan until you became age 65 or otherwise eligible for Medicare, or
    - employed in Covered Employment with contributions of at least 200 hours made in your name by Contributing Employers during each of the seven consecutive years prior to age 65, if you are then retired, or your last day of work in Covered Employment after age 58, whichever applies, and you had a continuous attachment to the iron working trade or craft through work in Covered Employment as your primary occupation and source of wages for such seven consecutive year period; and
- You have stopped working in the iron working trade or craft, are not engaged in Covered Employment or Non-Covered Employment, are not an Active Member, and, after becoming an Active Member or a Retired Member, did not engage in Non-Covered Employment at any time, and
- You file a timely Application for Retiree Health Benefits.

You will also be eligible for coverage under the Medicare Eligible Retirees Plan if:

- You are at least 65 years of age;
- You are entitled to receive benefits under Medicare Parts A and B; and
- You are receiving a Service Pension, a Rule of 85 Pension or a Rule of 89 Pension, or a Disability Pension from the Iron Workers' Locals No. 15 and 424 Pension Plan; and
- You file a timely Application for Retiree Health Benefits provided by the Fund Office; and
- You have stopped working in the iron working trade or craft, are not engaged in Covered Employment or Non-Covered Employment, are not an Active Member and, after becoming an Active Member, did not engage in Non-Covered Employment at any time.

When Your Coverage Begins

Coverage will begin as of the first day of the month coinciding with or next following the day on which you meet the eligibility requirements, including the filing of an application and authorization to have the required monthly self-payment deducted from your pension check as described below.

Once you become a Retired Member in the Medicare Eligible Retirees Plan you are no longer eligible for benefits as a Retired Member in the Ages 58-65 Plan or as an Active Member unless you re-establish your eligibility for benefits as an Active Member by working in Covered Employment and having the required number of hours of contributions.

A former Active Member who elects COBRA upon loss of his or her status as an Active Member may become a Retired Member in the Medicare Eligible Retirees Plan upon the termination of his or her COBRA, assuming he or she otherwise meets the initial eligibility rules above and submits a timely application to Labor First.

Your Share Of The Cost For Your Benefits

In order to participate in the Medicare Eligible Retirees Plan, you must enroll in Medicare Parts A and B. You are also required to make a monthly self-payment to cover a portion of the cost of your coverage in the Medicare Eligible Retirees Plan. As a general rule, this monthly self-payment (called a "Required Contribution Payment" or "RCP") is deducted from your monthly pension benefit from the Iron Workers' Locals No. 15 and 424 Pension Plan. As part of the application process, you will complete an assignment form which allows this RCP to deducted from your Iron Workers' Locals No. 15 and 424 Pension Plan benefit and paid over to this Fund. If this assignment process is not followed, or your monthly Iron Workers' Locals No. 15 and 424 Pension Pension Plan benefit is not enough to cover the RCP, you are still responsible for paying the RCP in a timely manner. Contact the Fund Office for current rates and self-payment procedures.

How to Enroll

If you want coverage under the Medicare Eligible Retirees Plan, you must apply for coverage by completing and submitting an Application for Retiree Benefits with Labor First by calling (203) 403-6440 (TTY 711) or (833) 981-0654 (TTY 711).

Termination of Coverage

You, and any of your Eligible Dependents for whom you have elected coverage, are no longer eligible for coverage under the Medicare Eligible Retirees Plan when:

- You do not pay the RCP, discussed above, in full and on time;
- You engage in conduct which constitutes a Termination for Cause (as defined on page 113);
- The Medicare Eligible Retirees Plan is terminated; or

- You die.

Also, any Eligible Dependent of yours will lose coverage under the Medicare Eligible Retirees Plan when:

- The Eligible Dependent engages in conduct which constitutes a Termination for Cause (as defined on page 113);
- The Eligible Dependent ceases to be eligible for coverage under the Fund as an Eligible Dependent; or
- The Medicare Eligible Retirees Plan is terminated.

IMPORTANT: If you otherwise qualify for coverage under the Medicare Eligible Retirees Plan and do not elect coverage, you will NOT be permitted to elect coverage for yourself or your Eligible Dependents at any future time.

Limited Extension of Coverage for Widows of Retired Members in the Medicare Eligible Retirees Plan: If you die, your widow (if any) will continue to be covered under the Plan for three months from the end of the month in which you die. No self-payment is required for the extended coverage. When this automatic three-month coverage extension ends, your widow and any of your Eligible Dependents covered by Medicare may elect COBRA.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call the Connecticut Program for Health Insurance Assistance, Outreach, Information and Referral, Counseling and Eligibility Screening (CHOICES) ((800) 994-9422) or see your copy of the "Medicare & You" handbook for telephone numbers for other states.
- Call (800) MEDICARE ((800) 633-4227). TTY users should call (877) 486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov or call (800) 772-1213 (TTY (800) 325-0778).

RECIPROCAL AGREEMENTS

You may be able to maintain your eligibility for benefits through this Fund while working in other local union jurisdictions. The Fund has reciprocal arrangements with iron workers health and welfare funds in other jurisdictions in order to provide benefits for an Active Member who would otherwise not have health coverage because he or she has been working between jurisdictions covered by different iron workers plans. Specifically, effective January 1, 2013, the Fund's Trustees adopted the Reciprocal Health and Welfare Agreement sponsored by the International Association of Bridge, Structural and Ornamental Iron Workers, otherwise known as the International Reciprocity Agreement.

There are two forms of reciprocity under the International Reciprocity Agreement which may allow you to continue to receive health benefits: "Point of Claim" and "Money Follows The Man." Please know that while our Fund permits both forms of reciprocity, iron workers health and welfare funds in other local union jurisdictions have the option of electing *only* Point of Claim, *or both* Point of Claim and Money Follows The Man. Remember, you MUST notify the Iron Workers' Locals No. 15 and 424 Extended Benefit Fund when you are working in another jurisdiction.

For the purposes of this section on reciprocal agreements, "Home Fund" generally means the fund that your local union participates in. "Cooperating Fund" means any other health fund which the Board of Trustees has approved participation in and executed the International Reciprocal Agreement.

Point of Claim

Under the "Point of Claim" portion of the International Reciprocity Agreement, if you are working in a different jurisdiction than your Home Fund:

- All health benefit claims continue to be filed with your Home Fund as long as you remain eligible in your Home Fund. This applies even if you are working in the jurisdiction of a Cooperating Fund when the claim would otherwise be filed.
- If you are no longer eligible for health benefits in your Home Fund, but are eligible for health benefits in another Cooperating Fund, your health benefit claims must be filed with that Cooperating Fund.
- If you are not eligible for health benefits in your Home Fund or any other Cooperating Fund, then your health benefit claims are filed with your Home Fund. Your Home Fund will then contact the other Cooperating Funds in the jurisdictions where you have been working to determine whether a transfer of contributions will reinstate your eligibility in the Home Fund at the time (or times) the applicable claims were incurred.

Money Follows the Man

Under "Money Follows The Man" if you are working in the jurisdiction of another iron workers health and welfare fund that also participates in the Money Follows The Man portion of the International Reciprocal Agreement, then:

- You must file a written request with the Cooperating Fund BEFORE you begin working in that jurisdiction to transfer contributions to your Home Fund on your behalf.
- The written transfer request must be signed and dated by you.
- To have all your hours transferred, you must sign the transfer request BEFORE you start working in another jurisdiction – only hours worked after the date on your signed request will be transferred.
- You must submit the request no later than 60 days after you start work in that jurisdiction.
- If you do not file the request on time, the Point of Claim provisions will apply.

If you have any questions regarding reciprocity, or how these rules would operate in your specific situation, please contact the Fund Office. Also, please keep in mind that there may be some iron workers health and welfare funds that have chosen *not* to participate in the International Reciprocal Agreement. If that is the situation, then our Fund is not permitted to utilize either method of reciprocity as described above unless our Fund has a separate and distinct "two-party" reciprocity agreement with the other iron workers health and welfare fund.

MISCELLANEOUS PROVISIONS AND OTHER IMPORTANT FUND RULES

Amendment or Termination. The Board of Trustees, acting as a body, and only the Board of Trustees, in its sole and complete discretion, has the right to amend or terminate the benefits described in this SPD, the Plan and the Trust Agreement. Any discretionary action taken by the Board of Trustees in determining any matter, including your rights or benefits under the Fund will be decided in a nondiscriminatory manner, as required by law.

Change or Discontinuance of Benefits. The Board of Trustees reserves the right to change or discontinue the types and amounts of benefits under the Fund and the eligibility rules for extended or accumulated eligibility, even if extended eligibility has already been accumulated.

Fund benefits and eligibility rules:

- Are not guaranteed (meaning they are not "vested" in any way);
- May be amended, changed or discontinued by the Board of Trustees, in their full and complete discretion;
- Are subject to the terms of the Plan document and Trust Agreement, which establishes and governs the Fund's operations;
- Are subject to the provisions of any group or other insurance policies purchased by the Board of Trustees; and
- Are subject to changing legislation.

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

In the event the Fund terminates, only claims and expenses incurred prior to the termination date will be paid. Payment will be made from the assets remaining in the Fund, including any insurance policies issued to the Fund, for the purpose of providing benefits. If there are not enough assets remaining to pay all outstanding claims, the Trustees will decide the manner in which the remaining assets will be used.

Interpretation of Terms of this SPD and Trust. The Board of Trustees, acting as a body, and only the Board of Trustees, has the sole and exclusive discretionary authority to interpret and construe the terms of this SPD, the Plan and the Trust, including ambiguous terms and provisions, such as establishing eligibility for benefits, the manner in which hours of work are credited for eligibility, the continuance or discontinuance of benefits, the status of any person as a covered or non-covered participant, and the level and type of benefits, as well as all other matters. 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.

Also, the Trustees have sole discretionary authority to make final determinations regarding any application for benefits, the interpretation of this SPD, any administrative rules adopted by the Trustees, as well as any determinations of fact (e.g., whether an individual meets the Fund's eligibility rules). Benefits under the Fund are paid only if and when the Trustees, or persons to

whom such decision making authority has been delegated by the Trustees, in their sole and broad discretion decide an individual is entitled to such benefits. The Trustees' decisions in such matters are final and binding on all persons dealing with the Fund or claiming a benefit from the Fund. If a decision of the Trustees is challenged in court, it is the intention of the parties to the Trust that the Trustees' decision is to be given full judicial deference to the extent permitted by law and to be upheld unless it is determined to be arbitrary or capricious.

Fund Authority. No Union officer, business manager, business agent, Union employee, Contributing Employer or employer representative, association or association representative, individual trustee, Fund Office personnel, consultant, attorney or any other person is authorized to speak for, or on behalf of this Fund, or to commit or to legally bind the Board of Trustees of this Fund in any matter whatsoever relating to the Fund, unless such person will have been given express written authority from the Board of Trustees to act in such matter. All inquiries, requests for rulings, interpretations, and decisions must be directed to the full Board of Trustees via a written letter sent in care of the Fund Office.

Anti-Assignment; Direct Payment of Fund Benefits. The coverage provided under this Fund, any benefits provided under this Fund, and any cause of action which may accrue due to the existence of this Fund, are personal to the Eligible Individual and are not assignable or transferrable, in whole or in part, to any person, hospital, medical provider, or any other entity under any circumstances without the express written consent of the Fund, acting through its Board of Trustees. Nothing contained in this Fund shall be construed to make the Fund, the Board of Trustees, or any other party affiliated with the Fund liable to any third party to whom an Eligible Individual may be liable for medical care, treatment, or services. The Fund will not honor claims for benefits, or any other cause of action, brought by a third-party; such third-party shall not have standing to bring any such claim either independently, as an Eligible Individual or Beneficiary, or derivatively, as an assignee of an Eligible Individual or Beneficiary. Finally, solely as a convenience to an Eligible Individual, the Fund may pay benefits properly payable under the Fund on behalf of an Eligible Individual directly to a provider of medical care, treatment, or services instead of the Eligible Individual pursuant to a duly executed direct payment authorization; when such direct payment is made, all of the Fund's obligations to the Eligible Individual with respect to such benefit shall be discharged by such payment.

Statute of Limitations. No lawsuit to recover benefits under this Fund may be started more than one (1) year and one hundred and twenty (120) days after the date of the Fund's decision on a claim denial, or an appeal of a claim denial, as may be applicable.

Venue. Any lawsuit brought against this Fund, or relating to the Fund, must be brought in Federal District Court, or in State Court. in Hartford, Connecticut.

Misrepresentation and Fraud. In the event that any Active Member, Retired Member and/or Eligible Dependent receives benefits, as a result of misleading representation or any type of false information or other fraudulent representations to the Fund, such individual will lose Fund coverage and be liable to repay all amounts paid by the Fund. Examples of fraud include a covered person's failure to disclose any other group health coverage in which such person is entitled to receive reimbursement of a claim submitted to the Fund for payment, or a covered Active Member

or Retired Member not promptly informing the Fund that his or her marriage has legally terminated such that the Fund continues paying benefits on behalf of the former Spouse under the incorrect assumption that such individual continues to be eligible as a Spouse. The Active Member, Retired Member and/or Eligible Dependent may also be prosecuted for fraud and held liable for all costs of collection, including interest and attorney's fees.

Overpayment and Erroneous Payments. If a claim payment is made which is later determined to be an overpayment, erroneous for any reason or fraudulent, the Fund may offset future claim payments or take any other action it deems appropriate in order to recover the overpayment or erroneous payment.

HEALTH ENHANCEMENT PROGRAM

One of the Fund's primary goals is to encourage all Active and Retired Members in the 58-65 Plan (and their respective Spouses, if applicable) to adopt healthy lifestyles and to lead healthier lives. In order to encourage you to take affirmative control of your own health care, the Fund has a "Health Enhancement Program" (HEP), which is tied to the Plan's benefit design. This HEP is not offered to Retired Members who are in the Medicare Eligible Retirees Plan.

Under the HEP, the Fund offers a number of preventive services, including annual physicals and blood tests, at no cost to you (provided you use an in-network provider). As you will see when reviewing the Schedule of Benefits starting on page 9, in certain instances, the amount of money you pay out-of-pocket (i.e., Coinsurance and Copayments) will depend on whether you, and/or your Spouse if applicable, meet the Fund's following HEP rules.

If you (and your Spouse, if you are married) take certain steps, you will be able to avoid having to pay higher amounts for certain covered health care services you may receive. For newly eligible Active Members of the Fund, you and your Spouse (if you are married) must complete three of the following four activities within 12 calendar months of either: (1) your initial eligibility date with the Fund, or (2) the date you receive the Important HEP Notice from the Fund, whichever occurs later. Each year thereafter you and your Spouse (if you are married) must complete three of the following four activities within 12 calendar months of the date you receive the Important HEP Notice from the Fund in order to continue to remain in the HEP and avoid having to pay the higher amounts for certain covered health care services.

NOTE: For newly eligible Active Members, the Fund will recognize any routine physical exam(s) and associated blood test(s) which took place during the twelve (12) calendar months immediately prior to your initial Fund eligibility date. So, if you became initially eligible under the Fund on October 1, 2021, and you had a routine physical with your primary care physician and blood tests performed on September 5, 2021, then you would already meet three required HEP rules.

The activities that you and your Spouse (if married) must complete are as follows:

1. **Choose a primary care physician (PCP) in the Anthem network**. You can get a list of local Anthem PCPs online at https://www.anthem.com/find-care/ or by calling Anthem. The Fund Office can also provide you with a list. If you already have a PCP, you only need to complete two other activities.

2. **Have a routine physical examination with your PCP**. If your PCP is a network provider, the exam will not cost you anything.

3. **Have a metabolic syndrome blood workup associated with your routine physical**. If the tests are performed by a network provider, they will not cost you anything.

4. **If you smoke tobacco, enroll in a Fund-approved smoking cessation program**. Contact Anthem for a list of approved programs.

To be perfectly clear on how the HEP works:

- ✓ If you are single and you don't comply with the HEP by the required deadline, then you and any of your covered Eligible Dependent Children will pay higher Copayments and Coinsurance amounts (i.e., listed in the Schedule of Benefits as "HEP *NOT* MET") commencing on the first day of the second month following your deadline and **such increased cost sharing will remain in effect for at least six months, and until the July 1st or January 1st that follows your completion of the three requirements**. To be clear, if you don't comply in time and have Eligible Dependent Children covered under the Fund, then such increased cost sharing will also apply to them.

- ✓ If you are married, then **BOTH** you and your Spouse must complete at least three (3) of the activities by the required deadline. If either one of you, or both of you, don't comply, then you and any Spouse (as well as any of your covered Eligible Dependent Children) will pay higher Copayments and Coinsurance amounts (again, listed in the Schedule of Benefits as "HEP *NOT* MET") commencing on the first day of the second month following your deadline and **such increased cost sharing will remain in effect for at least six months and until the July 1st or January 1st that follows completion of the three requirements by you and/or your Spouse**. Again, if you and/or your Spouse don't comply in time and have any Eligible Dependent Children covered under the Fund, then such increased cost sharing will also apply to them.

  EXAMPLE - You initially became eligible as an Active Member with the Fund on July 1, 2021 and received your "Important HEP Notice" from the Fund on August 1, 2021. This means you, and your Spouse (if married), have one year from the date you received the Important HEP Notice (as that is later than one year from your initial eligibility date with the Fund) – in this example until July 31, 2022 – to complete at least three of the listed activities to comply with the HEP. If you and your Spouse (if married) do not complete at least three of those listed activities by the July 31, 2022 deadline and you and your Eligible Dependents continue to remain eligible, then the cost you pay for certain health care services, along with those of any of your Eligible Dependents, would be determined under the various "HEP *NOT* MET" categories listed in the Schedule of Benefits effective as of September 1, 2022 and would continue until at least July 1, 2023.

We also want you to be aware that the rules of the HEP apply to former Active Members and/or Spouses who have coverage under the Fund through COBRA continuation coverage and any of the Fund's other self-pay programs.

VISION BENEFITS

The Fund currently provides vision care benefits for Active Members, Retired Members (both in the Retirees Ages 58-65 Plan and the Medicare Eligible Retirees Plan) and Eligible Dependents through EyeMed. You can register on eyemed.com or download the mobile app (via the App store or Google Play) to print another ID card, check the status of a claim, locate a provider and download an explanation of benefits. You can also call EyeMed at 1-866-939-3633.

Here are the details of the Fund's vision benefits, and remember when the term "Plan Year" is used below that means a period running from July 1st to the immediately following June 30th.

Eye Examination

Eligible Individuals receive full coverage for one complete eye examination once every Plan Year when done by an EyeMed participating network provider. If you have an eye examination done by an out of network provider, then the maximum reimbursement you will receive from the Fund for that eye exam is $40.

Eyeglasses (frames)

Eligible Individuals receive an eyeglass frame once every *other* Plan Year, subject to the limits noted in the chart below:

VISION CARE SERVICES	IN-NETWORK ELIGIBLE INDIVIDUAL COST	OUT OF NETWORK ELIGIBLE INDIVIDUAL REIMBURSEMENT
Eyeglass frame	80% of balance over $200 allowance	Up to $105

Eyeglasses (lenses)

Eligible Individuals receive eyeglass lenses once every *other* Plan Year, in lieu of contacts, subject to the limits noted in the chart below:

VISION CARE SERVICES	IN-NETWORK ELIGIBLE INDIVIDUAL COST	OUT OF NETWORK ELIGIBLE INDIVIDUAL REIMBURSEMENT
Single vision	$0 copay	Up to $30
Bifocal		Up to $50
Trifocal		Up to $70
Lenticular		Up to $70
Progressive - standard		Up to $50
Progressive – Premium Tier 1	$85 copay	Up to $50
Progressive – Premium Tier 2	$95 copay	
Progressive – Premium Tier 3	$110 copay	
Progressive – Premium Tier 4	$175 copay	

Anti-Reflective Coating - standard	$45 copay	Up to $23
Anti-Reflective Coating - Premium Tier 1	$57 copay	
Anti-Reflective Coating - Premium Tier 2	$68 copay	
Anti-Reflective Coating - Premium Tier 3	$85 copay	
Photochromic – non-glass	$75 copay	Not covered
Polycarbonate – standard	$40 copay	
Scratch Coating – standard plastic	$15 copay	
Tint – solid and gradient		
UV treatment		
All other lens options	20% off retail price	

EXAMPLE: Assuming you were eligible for vision benefits during all relevant Plan Years, if you obtained an eyeglass frame and lenses on July 20, 2021, you could next obtain a new frame and new lenses during the Plan Year starting on July 1, 2023. Note that the July 1, 2022 through June 30, 2023 Plan Year would be your "skip" year.

Contact Lenses

Eligible Individuals can receive contacts lenses once every *other* Plan Year, in lieu of eyeglasses, subject to the limits noted in the chart below:

VISION CARE SERVICES	IN-NETWORK ELIGIBLE INDIVIDUAL COST	OUT OF NETWORK ELIGIBLE INDIVIDUAL REIMBURSEMENT
Contact fit and follow up – standard	Up to $40; contact lenses fit and two follow up visits	Not covered
Contact fit and follow up – premium	10% off retail price	
Contacts – conventional	85% of balance over $150 allowance	Up to $105
Contacts - disposable	100% of balance over $150 allowance	
Contacts – Medically Necessary	$0 copay; paid in full	Up to $210

LASIK

For more information on LASIK, please call 1-800-988-4221. The Fund does not provide coverage of LASIK surgery or any associated treatment. However, if an Eligible Individual chooses to have a LASIK procedure performed with an EyeMed provider, EyeMed will provide that individual with a 15% discount off of their retail price, or a 5% discount off of any promotional price offered. Any remaining charges would be the responsibility of the Eligible Individual.

Safety Eyeglasses

Only Active Members can receive safety glasses (frames and lenses) once every *other* Plan Year, subject to the limits noted in the chart below. Retired Members (both in the Retirees Ages 58-65 Plan and the Medicare Eligible Retirees Plan) and Eligible Dependents are NOT eligible for safety glasses.

<table>
<tr><th>VISION CARE SERVICES</th><th>IN-NETWORK ACTIVE MEMBER COST</th><th>OUT OF NETWORK ACTIVE MEMBER REIMBURSEMENT</th></tr>
<tr><td>Safety eyeglass frame</td><td>$0 copay; 80% of balance over $130 allowance</td><td>Up to $91</td></tr>
<tr><td>Safety glass Single vision lenses</td><td rowspan="4">$0 copay</td><td>Up to $30</td></tr>
<tr><td>Safety glass Bifocal lenses</td><td>Up to $50</td></tr>
<tr><td>Safety glass Trifocal lenses</td><td>Up to $70</td></tr>
<tr><td>Safety glass Lenticular lenses</td><td>Up to $70</td></tr>
<tr><td>Safety glass Progressive lenses – standard</td><td>$55 copay</td><td>Up to $50</td></tr>
<tr><td>Safety glass Progressive lenses – Premium Tier 1 - 4</td><td>$85 - $175 copay</td><td>Up to $50</td></tr>
<tr><td>Safety glass Anti-Reflective Coating lenses - standard</td><td>$45 copay</td><td rowspan="2">Up to $23</td></tr>
<tr><td>Safety glass Anti-Reflective Coating lenses - Premium Tier 1-3</td><td>$57 -$85 copay</td></tr>
<tr><td>Safety glass Photochromic lenses – non-glass</td><td>$75 copay</td><td>Not covered</td></tr>
<tr><td>Safety glass Polycarbonate lenses – standard</td><td>$0 copay</td><td>Up to $20</td></tr>
<tr><td>Safety glass Scratch Coating lenses – standard plastic</td><td rowspan="3">$15 copay</td><td rowspan="4">Not covered</td></tr>
<tr><td>Safety glass Tint – solid and gradient</td></tr>
<tr><td>Safety glass UV treatment</td></tr>
<tr><td>Safety glass all other lens options</td><td>20% off retail price</td></tr>
</table>

DENTAL AND ORTHODONTIC BENEFITS

The Plan covers Reasonable and Customary dental expenses for Active Members and their Eligible Dependents. Retired Members (both in the Retirees Ages 58-65 Plan and the Medicare Eligible Retirees Plan) and their Eligible Dependents are NOT eligible for dental benefits from the Fund. The Fund has entered into an arrangement with Delta Dental to provide access to Delta Dental participating Dentists, process dental benefit claims and provide certain other services.

Delta Dental maintains a network of Dentists and you can find a network Dentist in your area by calling the Fund Office or Delta Dental (1-800-452-9310), or by accessing Delta Dental's website at www.deltadental.com. Although the plan of benefits is the same if you use a network or non-network Dentist, network Dentists have agreed to accept Delta's reimbursement level and, therefore, there is no balance billing for charges in excess of Reasonable and Customary allowance. The Fund encourages you to always use an in-network Dentist.

Dental Calendar Year Maximum

The calendar year benefit maximum per eligible individual (i.e., an Active Member and his/her Eligible Dependents) for the vast majority of dental services is $1,500. However, this calendar year benefit maximum does not apply for eligible Dependent Children under age 19, and it excludes orthodontia, implant/oral surgery services/bone grafts, which are subject to separate limits. The calendar year benefit maximum per eligible individual for implant/oral surgery services/bone grafts is $5,000, and the limit for orthodontia is discussed on page 44.

Your Share of the Dental Cost

You pay nothing ($0) for preventive care dental services when you use an in-network Dentist. For basic and major restorative dental care, there is a separate calendar year Deductible of $100 per person or $300 per family. Each calendar year after you meet this Deductible, you then pay your share of the cost of your care (you pay 20% Coinsurance for basic dental services and 50% Coinsurance for major restorative dental services).

Preventive Care Dental Services

The Fund pays 100% of the Reasonable and Customary dental fees for the following preventive care dental services, which include but are not limited to:

- Oral examinations, scaling and cleaning of teeth or gums, up to twice in a calendar year.
- X-rays full mouth series or panoramic (either one), once in three years.
- X-rays Bitewing, up to once per calendar year.
- Space maintainers used in place of prematurely lost teeth.
- Fluoride treatments for Dependent Children to age 19, up to twice in a calendar year.
- Space maintainers for Dependent Children to age 19, up to twice per lifetime.
- Sealants for Dependent Children to age 19, once per tooth per year.

Basic Restorative Dental Services

You pay 20% of the Reasonable and Customary dental fees, after the calendar year Deductible is met, for the following basic restorative dental services, which include but are not limited to:

- Fillings, extractions and root canals.
- Repair of dentures.
- Stainless steel crowns.

Major Restorative Dental Services

You pay 50% of the Reasonable and Customary dental fees, after the calendar year Deductible is met, for the following major restorative dental services, which include but are not limited to:

- Crowns, gold restorations.
- Bridgework, full and partial dentures.
- Periodontal, oral surgery, anesthesia.

A complete list of dental procedures covered by this benefit under preventive, basic, and major restorative services may be obtained from Delta Dental.

Orthodontic Services (For Eligible Dependent Children of Active Members Up to Age 26)

You pay 50% of orthodontic treatment up to a $2,500 lifetime maximum per eligible Dependent Child. There is no Deductible for orthodontic treatment.

Dental Limitations and Exclusions

In addition to excluding any services not set forth in this SPD, no benefits are payable under this section for the following dental care or services, which include but are not limited to:

- Charges for any dental procedures, which are included as covered medical expenses under the comprehensive medical expense benefits.
- Charges for treatment by other than a Dentist, except that cleaning or scaling of teeth, may be performed by a licensed dental hygienist, if such treatment is rendered under the supervision and direction of the Dentist.
- Charges for services and supplies that are partially or wholly cosmetic in nature, including charges for personalization or characterization of dentures and teeth whitening or bleaching.
- Experimental procedures, materials, and techniques and procedures not meeting generally accepted standards of dental care.
- Dental services performed prior to the date the individual became eligible for benefits.
- Services for the treatment of temporomandibular joint disorder.
- Charges which would not be payable according to the "Limitations and Exclusions" as set forth starting on page 63.

PRESCRIPTION DRUG BENEFITS

The Fund has contracted with Anthem/IngenioRx to administer its prescription drug benefit for Active Members and their Eligible Dependents and Retired Members in the Retirees Ages 58-65 Plan and their Eligible Dependents. The Plan covers the Reasonable and Customary charges associated with Medically Necessary drugs prescribed for the care and treatment of an Injury or Illness. In order for a medication to be covered by the Plan, it must be prescribed by a Physician and filled at a network retail pharmacy, through the IngenioRx mail order facility, or through the IngenioRx specialty pharmacy. This means there is no coverage for prescription drugs when obtained outside of the IngenioRx network and in such circumstances, you will be obligated to pay 100% of the undiscounted cost of the prescription yourself. To confirm your preferred pharmacy is in the IngenioRx national network, either call IngenioRx at the phone number on the back of your Anthem ID Card, which currently is (833) 267-2133 or visit their website at https://www.ingenio-rx.com/.

Your Anthem ID Card

Your Anthem ID card is required to access pharmacy benefits. You must present your Anthem ID card to a local retail pharmacy when filling your prescription or refills of an existing prescription. You will also need the information on your Anthem ID card to fill a mail order prescription or a specialty drug prescription at IngenioRx specialty pharmacy. New Eligible Individuals will receive their Anthem ID card in the mail shortly after becoming eligible for Fund coverage.

In order to use your Anthem ID card, simply go to any participating pharmacy, present your Anthem ID card to the pharmacist, and pay the applicable Coinsurance. Assuming the prescription is covered under applicable Fund rules, the remainder of the charge will be billed directly to and paid by the Fund. Your required Coinsurance is not reimbursable by the Fund, so a request for reimbursement should not be submitted to the Fund Office. If your Anthem ID card is lost or stolen, please contact the Fund Office immediately.

Also remember, there is no separate Deductible on your prescription drug benefits like there is for medical benefits.

Calendar Year Out-of-Pocket Maximum for Prescription Drug Expenses

You are required to pay up to a maximum amount of the prescription drug expenses you incur out-of-pocket each calendar year before the Fund pays 100% of most (but not necessarily all) of your covered charges for prescription drug expenses. The maximum amount is $1,000 for an individual and $2,000 for a family when the HEP rules are met, and $2,000 for an individual and $4,000 for a family when the HEP rules are not met. Once you (or one of your Eligible Dependents) reach an applicable individual out-of-pocket maximum (or your family reaches the applicable out-of-pocket family maximum), generally 100% of all covered prescription drug expenses will be paid by the Fund for the remainder of the calendar year.

Retail Pharmacy Benefits

The maximum quantity of a prescription that can be dispensed and covered each month at a retail pharmacy is a 30-day supply or 100 tablets (whichever is less).

- You will have to pay 20% of the cost of a prescription (whether generic, preferred brand, non-preferred brand and/or specialty drugs) when the HEP rules are met.
- You will have to pay 30% of the cost of a prescription (whether generic, preferred brand, non-preferred brand and/or specialty drugs) when the HEP rules are not met.

Home Delivery Pharmacy Benefits

The quantity of a prescription dispensed by the home delivery pharmacy is a three-month (90-day) supply.

- You will have to pay 20% of the cost of a prescription (whether generic, preferred brand, non-preferred brand and/or specialty drugs) when the HEP rules are met.
- You will have to pay 30% of the cost of a prescription (whether generic, preferred brand, non-preferred brand and/or specialty drugs) when the HEP rules are not met.

If you are taking a maintenance prescription drug (for example, a drug used regularly to treat conditions like arthritis, asthma, diabetes, or high cholesterol), you will most likely save money if you use the home delivery program. At a retail pharmacy, you can only receive up to a 30-day supply (or 100 tablets, whichever is less). However, the home delivery program allows you to receive three times the supply (a 90-day supply) at one time. To get started with home delivery, you can call 1-833-203-1739 or the phone number on the back of your Anthem ID Card, which currently is (833) 267-2133.

Exclusive Specialty Pharmacy

Specialty drugs are provided by IngenioRx through the IngenioRx specialty pharmacy. This allows for highly trained pharmacists and nurses to provide personal care and guidance regarding specialty drugs that often require special storage or extra support. You can contact the IngenioRx specialty pharmacy specialty care team at 833-255-0645 (Toll Free) with any questions.

Pre-certification

Pre-certification may be required for certain prescription drugs that are administered to you by a medical provider in a medical setting to help make sure proper use and guidelines for prescription drugs are follows. For a list of prescription drugs that need pre-certification, please call the phone number on the back of your Anthem ID Card.

Prior Authorization

Certain prescription drugs that you receive at a retail pharmacy or through home delivery may require prior authorization to determine if the prescription drugs should be covered. You or your

provider can get the list of prescription drugs that require prior authorization by calling the phone number on the back of your Anthem ID Card.

Exclusions

In addition to excluding any services not set forth in this SPD, no benefits are payable under the Fund's prescription drug benefit, which include but are not limited to:

- Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.
- Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a covered service under this Plan for non-Investigational treatments.
- Compound drugs, unless all of the ingredients are approved by the Food and Drug Administration ("FDA") as designated in the "FDA's Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations", require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
- Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Charges for delivery of prescription drugs.
- Drugs not on the Anthem prescription drug list (a formulary). You can get a copy of the list by calling Anthem or visiting their website at www.anthem.com. If you or your Physician believes you need a certain prescription drug not on the list, please contact Anthem.
- Drugs which are over any quantity or age limits set by the Plan or Anthem.
- Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original prescription order.
- Drugs prescribed by a provider that does not have the necessary qualifications, registrations and/or certifications, as determined by Anthem.
- Drugs that do not need a prescription by federal law (including drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- Services prescribed, ordered, referred by or given by a member of your immediate family, including your Spouse, Child, brother, sister, parent, in-law, or self.
- Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
- Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
- Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).
- Refills of lost or stolen drugs.
- Drugs not approved by the FDA or that are illegal under federal law (even if legal under applicable state law).

- Services the Plan concludes are not Medically Necessary. This includes services that do not meet Anthem's medical policy, clinical coverage, or benefit policy guidelines.
- Nutritional and/or dietary supplements, except as described in this SPD or that must be covered by law. This exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written prescription or from a licensed pharmacist.
- Off label use, unless the Plan must cover the use by law, or if Anthem, acting in its capacity as the Fund's Prescription Benefits Manager, approves it.
- Drugs for onychomycosis (toenail fungus) except when the Plan allows it to treat individuals who are immuno-compromised or diabetic.
- Certain prescription drugs may not be covered if an Eligible Individual could use a clinically equivalent drug, unless required by law. "Clinically equivalent" means drugs that, for most Eligible Individuals, will give similar results for a disease or condition. If there are any questions about whether a certain drug is covered and which drugs fall into this group, please call the number on the back of your Anthem Identification Card, or visit Anthem's website at www.anthem.com. If an Eligible Individual or his or her Physician believes the Eligible Individual needs to use a different prescription drug, please have the Physician or a pharmacist get in touch with Anthem. Anthem will cover the other prescription drug only if it agrees that the other prescription drug is Medically Necessary and appropriate over the clinically equivalent drug. Anthem will review benefits for the prescription drug from time to time to make sure the drug is still Medically Necessary.
- Drugs with over the counter equivalents and any drugs, devices or products that are therapeutically comparable to an over the counter drug, device, or product may not be covered, even if written as a prescription. This includes prescription legend drugs when any version or strength becomes available over the counter, unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that prescription drug to be considered Medically Necessary, the Physician must substantiate to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative. This exclusion does not apply to over-the-counter products that must be covered as a preventive care benefit under federal law with a prescription.
- Any drug, drug regimen, treatment, or supply that is furnished, ordered or prescribed by a provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies.
- Hypodermic syringes except when given for use with insulin and other covered self-injectable drugs and medicine.

HEARING CARE BENEFITS

Active Members and their Eligible Dependents are generally covered for services to evaluate hearing and, if necessary, obtaining hearing aids. Please note that Retired Members (both in the Retirees Ages 58-65 Plan and the Medicare Eligible Retirees Plan) are NOT eligible for hearing benefits through the Fund.

The hearing services MUST be received at the University of Connecticut Speech and Hearing Clinic (Hearing Clinic) in Storrs, Connecticut, unless an Active Member's primary residence is outside of Connecticut, in which case a limited exception for hearing aid coverage for such Active Member only applies and is discussed below. The phone number for the Hearing Clinic is 860-486-2629.

Medical Evaluation

A medical evaluation by a Physician is required prior to the actual fitting of a hearing aid (instrument or appliance). This evaluation is necessary to assure that there isn't a medical condition which would prevent the use of a hearing aid or which would be aggravated by the use of a hearing aid. The medical evaluation can be provided by a Physician of your choice or you can request that the Hearing Clinic provide a list of Physicians in your area. You will be responsible for arranging this appointment. The claim for charges incurred for the Physician visit will be processed in accordance with the provisions of the Fund. We encourage you to use a network provider, as the charges will be subject to the Schedule of Benefits starting on page 9.

Hearing Evaluation

If an Active Member and/or their Eligible Dependent would like a hearing evaluation, contact the Fund Office to verify eligibility. Those individuals that are eligible may receive a hearing evaluation, paid at 100% by the Fund, once every four years. After eligibility has been established and confirmed, the Fund Office can assist in scheduling an appointment with the Hearing Clinic located in Storrs, Connecticut. At the Hearing Clinic, you will be given a series of tests by an audiologist who is licensed by the State of Connecticut Department of Public Health and certified by the American Speech-Language-Hearing Association.

Hearing Aids

An extensive selection of hearing aids and appliances is available through the Hearing Clinic. The hearing aid(s), if prescribed, will be supplied by the Hearing Clinic. Once every four years, the Fund covers 50% of the cost of the contracted rate of the hearing aid(s), 100% of the charges related to fitting fees associated with the hearing aid(s), and 50% of the charges related to hearing aid(s) repair. Covered charges for hearing aid(s) include the full range of hearing appliances, including any necessary accessories, such as ear molds and an initial supply of batteries, provided the hearing aid(s) are deemed appropriate for the individual with the hearing loss by an audiologist

at the Hearing Clinic. This benefit also includes all of the follow-up sessions for the individual with the hearing loss to adjust to the hearing appliance at the Hearing Clinic.

The Fund will not replace lost, stolen, or damaged hearing aid(s) or appliances under any circumstances. Hearing appliances, however, do have warranties. The typical warranty is for one (1) year, although that can vary based on the aid or appliance selected. The warranty will be explained to you by the staff at the Hearing Clinic and is part of the program the Fund arranges with the Hearing Clinic and the manufacturers of the hearing aid(s).

Note for Out-of-State Active Members: If you are an Active Member whose primary residence is outside of Connecticut, the Fund will cover 50% of the reasonable cost of your Medically Necessary hearing aid(s), not to exceed $1,000 for one hearing aid or $2,000 for two hearing aids, once every four years. This exception does NOT apply to the Spouse or Eligible Dependent Children of the Active Member whose primary residence is outside of Connecticut.

WEEKLY DISABILITY BENEFITS

Subject to the various rules and exclusions in this section if, while an Active Member covered under the Fund, you become disabled, you may be eligible to receive the weekly disability benefits discussed below for a limited period of time. The weekly disability benefit is currently $500 per week for a maximum of 26 weeks in any period of 24 consecutive months. The weekly disability benefit is NOT available to Retired Members (both in the Retirees Ages 58-65 Plan and the Medicare Eligible Retirees Plan) and any Eligible Dependents.

To be eligible for weekly disability benefits, an Active Member must meet all of the following requirements:

1. The Illness or Injury resulting in your disability must have occurred while you were an Active Member;
2. You must be unable to perform your regular duties of your occupation and you cannot be working in other employment (subject to the Light Duty Exception below);
3. You must be under the continuous care of a Physician legally licensed to practice medicine during your period of disability;
4. Your Physician must certify the dates, and extent, of the disability on the Fund's standard claim form;
5. You cannot be receiving: (a) unemployment compensation, (b) Workers' Compensation Benefits, (c) compensation under a salary continuation plan sponsored by an employer, (d) Connecticut Paid Family and Medical Leave Act benefits due to your own serious health condition (subject to a limited exception below*), or (e) retirement benefits on a periodic installment or monthly basis from any source (including our Iron Workers' Locals No. 15 and 424 Annuity and/or Pension Plans);
6. Except as provided below, the disability must not result from or be caused directly or indirectly, wholly or partly, by intentional self-destruction or self-inflicted injury; and
7. The disability must not result from or be caused directly or indirectly, wholly or partly, by participation in the commission of a felony.

Light Duty Exception: If an Active Member is released for light duty work but remains unable to perform all of the duties of Covered Employment, as authorized by his or her Physician, the Active Member is still eligible for weekly disability benefits from the Fund, unless he or she actually performs work which a Contributing Employer is obligated to contribute to the Fund.

Connecticut Paid Family and Medical Leave Act Exception*: The Fund acknowledges that if you experience a "serious health condition," you may elect to apply for benefits from the Connecticut Paid Leave Authority or "Authority" (for further information, visit their website at: https://www.ctpaidleave.org). Effective on and after January 1, 2022, the Authority is responsible for determining whether you are eligible for Connecticut Paid Family and Medical Leave Act (CT PFMLA) benefits based on your own serious health condition. Please keep in mind that the eligibility requirements of our Fund and the CT PFMLA are different. *Assuming you are otherwise eligible for weekly disability benefits under Fund rules*, the Trustees permit you to receive a maximum of two (2) weeks of weekly disability benefits while the Authority determines your eligibility for, and/or commences paying you, CT PFMLA benefits based on your own serious

health condition. During that two week period, if the Authority determines that you are not eligible for CT PFMLA benefits, your Fund weekly disability benefits may then continue subject to all of the Fund's normal rules. However, if you are eligible for CT PFMLA benefits and receive more than two weeks of those benefits, then your Fund weekly disability benefits will cease at such time. In that situation, once your CT PFMLA benefits are exhausted or otherwise end, your Fund weekly disability benefits may then be continued, but you must at that time provide acceptable proof of your continuing disability and all other Fund eligibility rules must be met.

Assuming you are eligible for weekly disability benefits as outlined above, and subject to coordination with CT PFMLA benefit for your own serious health condition, with this weekly benefit from the Fund will commence on the first (1st) day of disability due to Injury or on the eighth (8th) day of disability due to an Illness. No weekly disability benefits are payable with regard to the first seven consecutive days of disability due to Illness. Weekly disability benefits can generally continue for a maximum of 26 weeks for any one continuous period of disability, and more details are provided below. Please be aware that in no event will weekly disability benefits be paid for more than 26 weeks in any 24 consecutive month period, and for clarity the 26 week limit also includes the 2 week exception outlined above for CT PFMLA benefits. These weekly disability benefits will be paid directly to the eligible Active Member, and are paid from Fund assets (not through an insurance company). Please note that an Active Member's admittance to an inpatient mental health or substance abuse facility is a disability due to Illness, and a disability due to a mental health or substance abuse issue will be disregarded for purposes of the exclusion for intentional self-destruction or self-inflicted injury.

The Fund's Board of Trustees reserves the right, as a condition of continued receipt of weekly disability benefits, to require you to provide updated disability reports and/or medical proof of your disability.

Eligibility for Weekly Disability Benefits

Only those Active Members who are covered by the Fund are eligible for weekly disability benefits. Weekly disability benefits are not available under COBRA, the Retirees Ages 58-65 Plan, and the Medicare Eligible Retirees Plan. Also, weekly disability benefits are not available to Eligible Dependents.

Successive Disabilities and Returning to Work

The Fund pays weekly disability benefits based on "one continuous period of disability." Here is how the Fund administers this rule in determining payment of weekly disability benefits:

- Separate periods of disability, *resulting from the same or related cause(s)*, will be deemed one period of disability, unless separated by your return to Covered Employment for at least ten (10) consecutive full 8 hour days.

  EXAMPLE 1: Assume you hurt your back while exercising, qualify for weekly disability benefits, and you receive 5 weeks of weekly disability benefits. You then return to work in Covered Employment, work for five (5) consecutive days, and then hurt your back again in a household accident. As you did not work in Covered Employment for at least

10 consecutive days, under this example you could only receive up to 21 additional weeks of weekly disability benefits (as 26 weeks less 5 weeks already received equals up to 21 remaining weeks).

EXAMPLE 2: The facts are the same as in Example 1, except that you returned to work in Covered Employment and worked for fifteen (15) consecutive full 8 hour days before you hurt your back again in the household accident. Here, because you had worked for at least ten (10) consecutive full 8 hour days, you would be eligible to receive up to the full 26 weeks of weekly disability benefits for this household accident, subject to a seven (7) day waiting period.

Under *both* examples, the Fund's limit of no more than 26 weeks of such benefits in any 24 month consecutive period will apply.

- Separate periods of disability *resulting from unrelated causes* will be deemed one (1) period of disability, unless separated by your return to active Covered Employment for at least one (1) full 8 hour day.

  EXAMPLE: You are cutting down a tree in your yard, break your arm, qualify for weekly disability benefits, and you receive 8 weeks of disability income benefits. You then return to work with your Contributing Employer, and after a few months you break your ankle while playing softball. Assuming you were otherwise eligible, you could receive up to another 26 weeks of weekly disability benefits due to your broken ankle as this is a new "period of disability" under this Fund rule, subject to a seven (7) day waiting period and the limit of no more than 26 weeks in any 24 month consecutive period.

Other Limitations and Exclusions

In addition to the rules above, weekly disability benefits will NOT be paid for:

- Any day you are not under the care of a Physician. It is understood that no disability will be considered to have started, until you have been treated personally by a Physician;
- Any day you are performing work of any kind, anywhere, for compensation, profit or other remuneration;
- Any day you are released by your Physician to engage in work of any kind (subject to the Light Duty Exception);
- Those days for which you are receiving any Workers' Compensation benefits, unemployment compensation benefits, Connecticut Paid Family and Medical Leave Act benefits due to your own serious health condition (subject to the 2-week exception noted earlier), and/or you are receiving any retirement benefits from any source;
- A disability due to accidental bodily injuries arising out of or in the course of your employment; or
- A disability that results from an act of war, whether declared or undeclared, or cause during service in the armed forces of any country.

Repayment Obligation

In all circumstances, if you receive any type of compensation or benefit listed above (whether under automobile insurance, Workers' Compensation, unemployment compensation, Connecticut Paid Family and Medical Leave Act due to your own serious health condition (subject to the 2-week exception noted earlier), pension or other(s)) and weekly disability benefits for the same time period, you are liable and required to refund any weekly disability payments you received to the Fund. In addition, the Fund's "Third Party Liability and Right of Reimbursement" rules which start on page 96 of this SPD will apply.

Taxation

While the Fund does not provide tax advice, weekly disability benefits received from the Fund under this section are considered taxable income, the Fund reports such benefits to you via the issuance of an IRS Form W-2 (even though the Fund is not your employer, the Fund has a duty to report these payments to the IRS) and you should report them on your federal, state or any other applicable income tax returns. The Fund Office will arrange to have all applicable taxes withheld from your weekly disability payments. Also, effective January 1, 2021, if you are a resident of Connecticut, the Fund is required to withhold 0.5% from such weekly disability payments pursuant to the Connecticut Paid Family and Medical Leave Act.

UTILIZATION AND CASE MANAGEMENT – MEDICAL/SURGICAL

Anthem performs utilization and case management services on behalf of the Fund for applicable medical and surgical benefits for Active Members, Retired Members in the 58-65 Plan, and their Eligible Dependents.

Utilization Management

Before receiving certain medical/surgical services under the Fund, Anthem must conduct a Utilization Review to ensure that the services are Medically Necessary and not Experimental/Investigational. Utilization Review also ensures that the use of treatment, level of care, and setting or place of service is proper. A service must be Medically Necessary to be covered by the Fund. When level of care, setting or place of service is reviewed, services that can be safely given in a lower level of care or lower cost setting / place of care, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting / place of care. This means that a request for a service may be denied because it is not Medically Necessary for the service to be provided where it is being requested. When this happens the service can be requested again in another place and will be reviewed again for Medical Necessity. If you have any questions on the Utilization Review process, please call Anthem's Member Services at 833-899-7070.

There are several different types of Utilization Review, such as:

- Pre-service review – a review of a service, treatment or admission for a benefit coverage determination which is done before the service or treatment begins or admission date.
- Pre-certification – a required pre-service review for a benefit coverage determination for a service or treatment. Certain services require pre-certification in order for an Eligible Individual to get benefits.
- Continued Stay/Concurrent Review – a review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.
- Post-Service Review – a review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided.

Pre-certification

Typically, in-network providers know which services need pre-certification and will get any pre-certification on your behalf when needed. However, if you use an out-of-network provider, then you are responsible for calling Anthem's Member Services at 833-899-7070 and obtaining pre-certification when it is required.

If you are admitted to the hospital as a result of a medical emergency or are treated in the emergency room, then you, a responsible family member, the attending Physician or the hospital must contact Anthem's Member Services at 833-899-7070 no later than 48 hours after admission. Emergency hospitalization means a confinement required as the result of an unforeseen medical, mental health or substance use disorder treatment to prevent loss of life or permanent damage to

the organs or systems of the body. A hospital admission or surgery made or performed for you or your Physician's convenience is not a medical emergency.

Please remember that all treatment decisions rest with you and your Physician. You should follow whatever course of treatment that you and your Physician(s) believe to be the most appropriate, even if any proposed surgery or treatment is not certified as Medically Necessary or is Experimental/Investigational; *but remember* that the Fund will not pay benefits for any surgery or treatment that is not Medically Necessary or which is Experimental/Investigational.

Case Management

The Fund, through Anthem, also provides case management services to provide and/or help coordinate services for Active Members, Retired Members in the 58-65 Plan, and/or their Eligible Dependents with health care needs due to serious, complex, and/or chronic health conditions. These programs provide certain services, coordinate benefits and/or education to such individuals who agree to take part in them to help meet their health care needs. These programs are confidential and voluntary and are made available at no extra cost! If you are an Eligible Individual who has been diagnosed with a serious, complex, and/or chronic health conditions, please call Anthem's Member Services at 833-899-7070 to see if you are eligible for these case management services.

UTILIZATION AND CASE MANAGEMENT – BEHAVIORAL HEALTH AND SUBSTANCE ABUSE – EMPLOYEE ASSISTANCE PROGRAM

The Fund currently contracts with Tri-State EAP Services, Inc. to provide Active Members, Retired Members in the Retirees Ages 58 to 65 Plan, and their Eligible Dependents with utilization and case management services for behavioral health and substance abuse benefits, which is known as the Fund's Employee Assistance Program (EAP). The EAP is designed to provide confidential, prompt, professional assistance to those who need help resolving problems that can affect personal and work life, including but not limited to:

- Depression/Anxiety
- Stress/Job Stress
- Parenting Concerns
- Alcohol/Drug Issues
- Marital Issues
- Anger Management
- Grief/Trauma
- Financial and Legal Issues
- Behavioral Health Concerns
- Mental Illness
- Health Concerns
- Crisis Situations
- Gambling Problems

The EAP offers unlimited, telephonic access to the EAP dedicated staff 24 hours a day and anything that is discussed with a counselor will be kept confidential. The EAP can be reached by calling (845) 228-8303 or emailing: TriStateEAP@outlook.com or visiting https://www.tristateeap.com/.

When an individual contacts the EAP, a trained professional will help identify and evaluate the problem and, if necessary, refer that individual to the best and most appropriate resource. If the EAP recommends inpatient or outpatient treatment, it will be subject to all of the rules of the Fund, including the requirement that the individual must be eligible for coverage.

Remember, you or your Physician must contact the EAP at (845) 228-8303 or email: TriStateEAP@outlook.com BEFORE being admitted to a mental health or substance abuse facility if it is not an emergency. The EAP will review the treatment or service to be sure that it is Medically Necessary and it is the right level of care of your condition.

If you are admitted to a mental health or substance abuse facility as a result of a medical emergency you, a responsible family member, the attending Physician or the hospital must call the EAP no later than 48 hours after admission. Emergency hospitalization means a confinement required as the result of an unforeseen medical, mental health or substance use disorder treatment to prevent loss of life or permanent damage to the organs or systems of the body.

If you need inpatient care, the EAP will let you know the number of days the Fund will pay for your facility stay and what charges are covered. If your admission is approved, benefits will be paid for the number of days approved by the EAP.

Please remember that all treatment decisions rest with you and your Physician. You should follow whatever course of treatment you and your Physician believe to be the most appropriate, even if the proposed treatment is not certified as Medically Necessary and not payable under Fund rules.

We encourage you to use the EAP during any of life's difficult times by calling (845) 228-8303 or emailing: TriStateEAP@outlook.com or visiting: https://www.tristateeap.com/.

LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

Life Insurance Benefit

A life insurance benefit is available upon the death of an Active Member and/or Retired Member. The life insurance benefit from the Fund is not available upon the death of any Eligible Dependent. The current life insurance benefit is $40,000 for the death of an Active Member and $5,000 for the death of a Retired Member (both in the Retirees Ages 58-65 Plan and the Medicare Eligible Retirees Plan).

In the event of the death of an Active Member or Retired Member from any cause, a life insurance benefit is paid to the named Beneficiary or Beneficiaries in the lump sum amount discussed above and also shown in the Schedule of Benefits on page 9 of this SPD. The Fund's life insurance benefit is provided on a fully insured basis by an insurance company retained by the Board of Trustees, currently ULLICO.

Selecting a Beneficiary for Life Insurance

You can choose any person, or more than one person, to be your Beneficiary(ies) for your life insurance benefits. If you name more than one Beneficiary, you may specify different amounts to be paid to each. Otherwise, your beneficiaries will receive equal shares of your life insurance benefit in the event of your death. To designate your Beneficiary(ies), fill out a Beneficiary Form provided by the Fund Office, sign and date it, and return it to the Fund Office.

You can also change your Beneficiary(ies) at any time by contacting the Fund Office to request a new Beneficiary Form. The change does not become effective unless the new Beneficiary Form is received at the Fund Office prior to your death. Remember, you must sign and date the new Beneficiary Form. The Beneficiary(ies) listed on the last properly completed Beneficiary Form received by the Fund Office before your death will receive your life insurance benefit. Please know that the Fund **will not** accept any Beneficiary Form filed after your death. If your Beneficiary predeceases you, such Beneficiary's interest will automatically terminate. If there is a court order that requires you to name a specific Beneficiary, such order will only be recognized if it is on file at the Fund Office at the time of your death.

Receiving the Life Insurance Benefit

In order for your Beneficiary(ies) to receive the life insurance benefit, he/she/they must notify the Fund Office of your death, provide a certified original copy of your death certificate, and completely fill out and submit all application forms. If you designate a Beneficiary who is a minor (under age 18) at the time of your death, that Beneficiary cannot receive a life insurance payment until he or she reaches age 18. Certain exceptions may apply if the minor has a legal guardian or other court-appointed representative. Contact the Fund Office for more information.

Termination of Fund Coverage and Converting to an Individual Life Insurance Policy

If your Fund coverage is terminated for any reason other than your death, the life insurance (as well as any AD&D benefits for former Active Members, discussed below) provided through the Fund are also terminated. However, you will have the opportunity to convert your previous life insurance coverage under the Fund's group life insurance policy to an individual life insurance policy. This is called a conversion right. You must notify the life insurance company, currently ULLICO, *immediately* because your rights to convert the policy end 31 days after your coverage under the Plan terminates. If the conversion right is properly elected in a timely manner, it is your responsibility to pay the full cost of the life insurance coverage directly to the insurance company (currently ULLICO) in a timely manner. **This is the only notice you will receive about this conversion right, and the Fund has no obligation to give you any further notice of this conversion right**. Contact ULLICO at 202-682-0900 or 800-431-5425 (toll free) or https://www.ullico.com/lh/contacts for further information on your conversion rights.

Non-assignment of Life Insurance and AD&D Benefit

You may **not** assign your life insurance or AD&D benefits. This means you may not give or transfer your life insurance or AD&D benefits offered through this Plan to any other person or entity.

Accidental Death and Dismemberment Benefit (AD&D)

Accidental Death and Dismemberment benefits, or AD&D benefits, are payable with respect to Active Members only. AD&D benefits are not available for the Injury or death of an Eligible Dependent or a Retired Member (both in the Retirees Ages 58-65 Plan and the Medicare Eligible Retirees Plan). The insurance company retained by the Board of Trustees (currently, ULLICO) must receive written proof that the loss occurred as a result of an accidental bodily injury and independently of all other causes and occurrences, within ninety (90) days after the date of the Injury. AD&D benefits are paid directly to Active Members for an Injury, and to Active Member's designated Beneficiary(ies) in the case of loss of life. The Active Member may be required to undergo an independent medical examination to determine if he/she is eligible for AD&D benefits with the Fund. The AD&D benefit provided by the Fund is a separate insurance policy from, and any benefits under it which are payable to an Active Member or his/her Beneficiary(ies) would be payable in addition to, the Life Insurance Benefit described above. Contact the AD&D insurance company, currently ULLICO, for a list of the AD&D benefits that are provided by the Fund.

Amount of AD&D Benefits

If an Active Member has loss of a hand, foot, eye, or life, as the result of an accident, a payment to either the Active Member or their Beneficiary might be available under the Fund's AD&D Benefit. If an Active Member suffers more than one loss in any one accident, payment will be made only for that loss for which the largest amount is payable. Please contact the Fund Office or ULLICO for the specific amount and schedule of the Fund's AD&D benefits.

For purposes of this AD&D benefit, an "accident" is an unplanned, unforeseen and unexpected event or happening causing an Injury or death that is not due to any misconduct on the part of the injured party.

Selecting a Beneficiary for AD&D

An Active Member can choose any person, or more than one person, to be his or her Beneficiary(ies) for the AD&D benefits. If you name more than one Beneficiary, you may specify different amounts to be paid to each. Otherwise, your Beneficiaries will receive equal shares of your AD&D benefit in the event of your death. To designate your Beneficiary(ies), fill out a Beneficiary Form from the Fund Office, sign and date it and return it to the Fund Office.

You can also change your Beneficiary(ies) at any time by contacting the Fund Office to request a new Beneficiary Form. The change does not become effective unless the new Beneficiary Form is received at the Fund Office prior to your death. Remember you must sign and date the new Beneficiary Form. The Beneficiary(ies) listed on the last properly completed form received by the Fund Office before your death will receive your AD&D benefit. Please know that the Fund **will not** accept any Beneficiary Form filed after your death. If your Beneficiary predeceases you, such Beneficiary's interest will automatically terminate. If there is a court order that requires you to name a specific Beneficiary, such order will only be recognized if it is on file at the Fund Office at the time of your death.

Filing a Claim for AD&D

You or your Beneficiary should contact the Fund Office to file a claim for AD&D benefits within the required ninety (90) days after the date of the Injury or death. Provide proof of the date of the accident, the date of dismemberment or death, and the cause of the Injury or death. Certain other rules and exclusions for AD&D benefits apply.

WORKERS' COMPENSATION BENEFITS

Medical expenses covered by the Fund are for services and supplies received for the treatment of **non-occupational** bodily Injuries and Illnesses. If you incur a work-related Injury or Illness (one which arises out of or in connection with your employment), your claim for any medical expenses arising out of or in connection with that Injury or Illness must be submitted through your Employer for Workers' Compensation coverage. No benefits are payable by the Fund for such medical expenses unless the Workers' Compensation Commissioner determined that the underlying Injury or Illness is not compensable. Plan provisions will apply in all circumstances where Workers' Compensation insurance is required, including individuals that are self-employed.

However, if you have been notified that your Employer is contesting liability for your Workers' Compensation claim and the Fund has received a formal notice to contest liability from your Employer or its Workers' Compensation insurance carrier, the Fund may, at its sole discretion, pay hospital and/or medical expenses connected to a claimed work-related Injury or Illness, pending a formal ruling of the Workers' Compensation Commissioner. In any event, before payment for medical expenses arising out of or in connection with a claimed Workers' Compensation Injury will be advanced by the Fund, you will be required to sign a reimbursement agreement and consent to lien. In order for the Fund to consider exercising its discretion to advance payment for hospital or medical expenses connected to a claimed Workers' Compensation Injury, the Notice to Contest Liability must challenge liability for the underlying Illness or Injury, and not just for particular hospital or medical expenses that are contested by your Employer or its Workers' Compensation insurance carrier for one reason or another. In other words, the Fund will not advance payment for hospital or medical expenses connected to a work-related Injury or Illness simply because your Employer or its Workers' Compensation carrier has contested certain specific hospital or medical expenses.

Although charges relating to an occupational Injury or Illness must be submitted to Workers' Compensation, Life Insurance and other health benefits will continue for you and your Eligible Dependents for charges incurred due to non-occupational accidental bodily Injuries or Illnesses, as long as you maintain eligibility under applicable Fund rules.

Where a claim for Workers' Compensation is settled by stipulation or agreement, you cannot claim benefits for the same disability from the Fund. If benefits are paid by the Fund in error, you must reimburse the Fund for any payments to you or your Eligible Dependents or providers, and all costs of collection, including attorney's fees and court costs. Failure to reimburse the Fund in full for all claims and benefits paid by the Fund determined to be work related will be pursued legally by the Fund to recover all benefits paid that were work related along with all legal and court costs. In addition, any amounts considered an overpayment by the Fund will be used as an offset against future claim and benefit payments.

LIMITATIONS AND EXCLUSIONS

In this section you will find a review of items that are not covered by the Plan. Excluded items will not be covered even if the service, treatment, prescription drug, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as covered services. This section is not meant to be a complete list of all the items that are excluded by the Plan.

1. Acts of war, disasters, or nuclear accidents – In the event of a major disaster, epidemic, war, or other event beyond anyone's control, Anthem will make a good faith effort to provide the Fund's Eligible Individuals with covered services. Anthem and the Fund will not be responsible for any delay or failure to provide services due to lack of available facilities or staff. Benefits will not be provided for any Illness or Injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, participation in a riot or civil disobedience.
2. Administrative charges, such as charges to complete claim forms; charges to get medical records or reports; or membership, administrative, or access fees charged by Physicians or other providers. Examples include, but are not limited to, fees for educational brochures or calling an Eligible Individual to provide test results.
3. Aids for non-verbal communication devices and computers to assist in communication and speech, except for speech aid devices and tracheo-esophageal voice devices approved by Anthem.
4. Alternative/Complementary medicine services or supplies given by a provider for alternative or complementary medicine. This includes, but is not limited to:
    - Acupressure,
    - Hypnosis,
    - Aroma therapy,
    - Massage and massage therapy, unless provided during physical therapy, occupational therapy, speech therapy, or manipulative treatment,
    - Reiki therapy,
    - Herbal, vitamin or dietary products or therapies,
    - Naturopathic services, unless a covered service under this Plan,
    - Thermography,
    - Orthomolecular therapy,
    - Contact reflex analysis,
    - Bioenergial synchronization technique (BEST),
    - Iridology-study of the iris,
    - Auditory integration therapy (AIT),
    - Colonic irrigation,
    - Magnetic innervation therapy,
    - Electromagnetic therapy,
    - Neurofeedback / Biofeedback.
5. Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family are not covered.

6. Applied behavioral treatment (including, but not limited to, applied behavior analysis and intensive behavior interventions) for all indications unless otherwise required by law.
7. Autopsies and post-mortem testing.
8. Charges prior to becoming an Eligible Individual under the Plan or after a person's Plan coverage as an Eligible Individual end.
9. Services an Eligible Individual receives from Physicians that are not licensed by law to provide covered services. Examples include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.
10. Charges over the Maximum Allowed Amount for covered services.
11. Charges for services not supported by medical records.
12. Services, supplies, or treatment related to or, for problems directly related to a service that is not covered by this Plan. The phrase "directly related" means that the care took place as a direct result of the non-covered service and would not have taken place without the non-covered service.
13. Treatments, services, prescription drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change or improve how an Eligible Individual looks or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of an Eligible Individual's skin or to change the size, shape or look of facial or body features (such as an individual's nose, eyes, ears, cheeks, chin, chest or breasts). This specific exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy as required under Federal law, specifically the Women's Health and Cancer Rights Act.
14. Training programs, tests or care required, ordered or sponsored by any court or governmental agency, including but not limited to the Department of Motor Vehicles, unless Medically Necessary or otherwise required by law.
15. Treatment of an Injury or Illness that results from a crime an Eligible Individual committed, or tried to commit. This specific exclusion does not apply if: during the time of the crime or attempted crime the Eligible Individual had an elevated blood alcohol content or was under the influence of an intoxicating liquor or any drug or both; or the Eligible Individual's involvement in the crime was solely the result of a medical or mental condition; or where the Eligible Individual was the victim of a crime, including domestic violence.
16. Custodial care, unless otherwise required by Federal or State law, convalescent care or rest cures. This specific exclusion does not apply to hospice services.
17. Oral appliances utilized to reduce or eliminate snoring, or for the prevention of snoring.
18. Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.
19. Services provided in an emergency room for conditions that do not meet the definition of an emergency as determined by Anthem. This includes, but is not limited to, suture removal in an emergency room.
20. Experimental or Investigational service; treatment; procedure; facility; equipment; drugs; devices; or supplies. Any services associated with, or as follow-up to any of the above is not a covered service.
21. Eye exercises orthoptics and vision therapy.

22. Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
23. Services prescribed, ordered, referred by or given by a member of an Eligible Individual's immediate family, including such individual's Spouse, Child, brother, sister, parent, in-law, or self.
24. Routine foot care unless Medically Necessary. This specific exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to: cleaning and soaking the feet, applying skin creams to care for skin tone, other services that are given when there is not an Illness, Injury or symptom involving the foot.
25. Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic Illness affecting the lower limbs, such as severe diabetes.
26. Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
27. Services an Eligible Individual would not have to pay for if the individual didn't have this Plan. This includes, but is not limited to, government programs, services during a jail or prison sentence, and services from free clinics.
28. Gene therapy, as well as any drugs, procedures, health care services related to such therapy, that introduce or are related to the introduction of genetic material into an Eligible Individual intended to replace or correct faulty or missing genetic material.
29. Growth Hormone Treatment – Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
30. Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Physician. This specific exclusion also applies to health spas.
31. Home Care – Services given by registered nurses and other health workers who are not employees of, or working under, an approved arrangement with a home health care provider. Food, housing, homemaker services and home delivered meals.
32. Services rendered by hospital resident doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of hospitals, labs or other institutions, and charges included in other duplicate billings.
33. Medical and surgical treatment of excessive sweating (hyperhidrosis).
34. Infertility consultations, diagnosis, treatment, surgery or other procedures, or any related drugs, which are not expressly specified in this SPD.
35. Rehabilitative treatment given when no further gains or improvement are clear or likely to occur, unless required under state or federal law. Maintenance therapy includes care that helps an Eligible Individual keep his or her current level of function and prevents loss of that function, but does not result in any change for the better. This specific exclusion does not apply to "Habilitative Services."
36. Medical Equipment, Devices, and/or Supplies which are:
    - Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.

- Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or Injury.
- Non-Medically Necessary enhancements to standard equipment and devices.
- Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in an Eligible Individual's specific situation. Reimbursement, if any, will be based on the Maximum Allowable Amount for a standard item that is a covered service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a covered service is the responsibility of the Eligible Individual.
- Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices.

37. Charges for which benefits are payable under Medicare, including but not limited to Parts A and/or B, or any other government or governmental agency.
38. Charges for missed or cancelled appointments.
39. Services the Fund and/or Anthem concludes are not Medically Necessary. This includes services that do not meet Anthem's medical policy, clinical coverage, or benefit policy guidelines.
40. Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this SPD.
41. Personal Care, Convenience, and Mobile/Wearable Devices:
    - Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
    - First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
    - Home work-out or therapy equipment, including treadmills and home gyms,
    - Pools, whirlpools, spas, or hydrotherapy equipment.
    - Hypo-allergenic pillows, mattresses, or waterbeds,
    - Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails),
    - Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.
42. Private duty nursing services given in a hospital or skilled nursing facility. Private duty nursing services are a covered service only when given as part of the "Home Care Services" benefit.
43. Prosthetics for sports or cosmetic purposes. This specific exclusion includes wigs and scalp hair prosthetics.
44. Any reduction in benefits, including penalties, are not considered a cost-share and do not apply to an Eligible Individual's Out-of-Pocket Limit. Any reduction in benefits or penalties imposed on an Eligible Individual by another group health plan, insurer or other carrier are not reimbursable as a covered service under this Plan.
45. Residential accommodations to treat medical or behavioral health conditions, except when provided in a hospital, hospice, skilled nursing facility, or residential treatment

center. This specific exclusion includes procedures, equipment, services, supplies or charges for the following: Domiciliary care provided in a residential institution, treatment center, halfway house, or school because an Eligible Individual's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included. Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution. Services or care provided or billed by a school, custodial care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.

46. Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Preventive Care" benefit.
47. Any service, drug, drug regimen, treatment, or supply, furnished, ordered, or prescribed by a provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies. This specific exclusion does not apply to Emergency Care.
48. Services rendered by providers located outside the United States, unless the services are for emergency care, urgent care and emergency ambulance.
49. Evaluation, treatment, and procedures and drugs related to and performance of sex-change operations including follow-up treatment, care and counseling, unless the Eligible Individual has been diagnosed with gender dysphoria and all Medically Necessary criteria are met as determined by Anthem in accordance with generally accepted medical standards.
50. Stand-by charges of a Physician or other provider.
51. Services to reverse an elective sterilization.
52. Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
53. Temporomandibular Joint Treatment (TMJ) – Surgical and non-surgical services or supplies for the treatment of temporomandibular and craniomandibular disorders. This includes surgery, medical care, diagnostic services, physical therapy, fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).
54. Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
55. Weight Loss Programs, whether or not under medical supervision, unless listed as covered in this SPD. This specific exclusion includes, but is not limited to, commercial weight loss programs (as examples, Weight Watchers, Jenny Craig, and LA Weight Loss) and fasting programs.
56. Bariatric surgery – This specific exclusion includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries

lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgeries that reduce stomach size), or gastric banding procedures.

57. Wilderness or other outdoor camps and/or programs/therapies.

COORDINATION OF BENEFITS

This section describes the circumstances when you or your Eligible Dependents are covered under more than one group benefit plan or other health insurer. The Fund's Coordination of Benefits (COB) provision coordinates the benefits payable by this Fund with similar benefits payable under other plans, but excluding Weekly Disability Benefits, Life and Accidental Death and Dismemberment Benefits. Under the COB provision, if you or your Eligible Dependents are also covered under any other group plan, insurer or other program (including Medicare or some other government program such as Medicaid or Workers' Compensation), the total payment received for any one person from all such programs may not amount to more than 100% of the allowable expense. If the Fund has made payment of any amount that is in excess of that, the Fund has the right to recover the excess amount from any party that has received the overpayment. Many families that have more than one family member working outside the home are often covered by more than one medical plan. If this is the case with you or your family, you must let the Fund Office know about all of your coverages as soon as possible.

It is the Fund's intention to follow the COB rules adopted by the National Association of Insurance Commissioners (NAIC). To the extent the rules listed below do not cover a specific situation and the NAIC rules do, those NAIC rules will control.

Definitions of Terms Used in This Section

ALLOWABLE EXPENSES: any necessary Reasonable and Customary expenses actually charged for medical services, treatment or supplies covered by one of the plan(s) under which you or your Eligible Dependents are covered, including covered expenses under this Fund. In determining the allowable expenses, the Fund will also consider any PPO discounts or negotiated fees that apply.

PLAN: For this purpose, the term "plan" refers to any of the following which provide full or partial health benefits for services on an insured or self-funded basis:

- Employer sponsored group, blanket, or franchise insurance;
- Any commercial insurer group plan, group practice, and any other group HMO, POS, PPO or prepayment plans;
- Union welfare plans, employer organization plans, or labor-management trustee plans;
- Governmental programs or coverages required or provided by law. However, a "plan" does not include any governmental program coverage which is not allowed by law to coordinate;
- Medicare, Title XVII of the Social Security Act of 1965, as amended, to the extent permitted by law.

The term "plan" will apply separately:

- To each policy, contract, agreement, or other plan of benefits or services; and
- To that part of such policy, contract, agreements, or plan which reserves the right to consider the benefits or services of other plans in determining its benefits and to that part which does not.

PRIMARY PLAN: if a plan is considered "primary," it is responsible for paying benefits first in accordance with its benefits provisions. Covered services are provided or covered without considering the other plan's benefits.

SECONDARY PLAN: if a plan is considered "secondary" it is responsible for paying benefits, if any remain, after the Primary Plan has paid its share.

WHICH PLAN PAYS FIRST – ORDER OF BENEFIT DETERMINATION RULES:

- If you or your Eligible Dependent is covered by another group plan that does not contain a COB provision, the other plan will always be the Primary Plan and pay first.

- If a person is an Active Member/Retiree under one plan and an Eligible Dependent under another plan, the plan covering the person as an Active Member/Retiree will be the Primary Plan, and the plan covering the person as an Eligible Dependent will be the Secondary Plan.

- If a person is an active employee or an Eligible Dependent under one plan and a Retiree under another plan, the plan covering the person as the active employee or Eligible Dependent will be the Primary Plan, and the plan covering the person as a Retiree will be the Secondary Plan.

- If a person works for two or more employers and has coverage under two or more plans, the plan that has covered the person for the longest period of time will be the Primary Plan and the plan which has covered the person for the second longest period of time will be the Secondary Plan. Coverage on a tertiary basis, or other basis, will be determined in the same manner.

- Dependent Child/Parents Not Separated or Divorced: When this Fund (as a "plan") and another plan cover the same child as a dependent of different parents, unless there is a court decree stating otherwise, the plan of the parent whose birthday falls earlier in a year is the Primary Plan and the plan of the parent whose birthday falls later in that year is the Secondary Plan. If both parents have the same birthday, the plan which covered the particular parent longer is the Primary Plan and the plan which covers the other parent for the shorter period of time is the Secondary Plan. *Only the month and day of the parent's birthday are considered, and not the year in which the individual was born*. This is known as the "birthday rule."

- Dependent Child/Separated or Divorced Parents:

    - When the parents are separated or divorced, and the parent with legal custody of the child has not remarried, the plan of the parent with custody is the Primary Plan and the plan of the parent without custody is the Secondary Plan;

    - When the parents are divorced, and the parent with legal custody of the child has remarried, the plan of the remarried parent with custody is the Primary Plan, the plan of the step-parent (Spouse of custodial parent) is the Secondary Plan, and the plan of the natural parent that does not have custody is last.

- If the terms of a court order state that one of the parents is financially responsible for the health care expenses of the child, and this Fund is aware of that court order, then the two bullets above will not apply and the plan of the parent with financial responsibility will be the Primary Plan, the plan of the other natural parent will be the Secondary Plan, and the plan of any step-parent will be last. If the parent with financial responsibility has no health care coverage for the dependent child's health care expense, but that parent's Spouse does, that parent's Spouse's plan is the Primary Plan.

- If the court order states that both parents are responsible for providing health care coverage for the dependent child or the court order provides for joint custody without specifying which parent has the responsibility, and the Fund is aware of the court order, the birthday rule described above applies.

- Coverage as a Dependent Child and Also as a Spouse:

  - If a dependent child has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a Spouse's plan, then the plan that covered the person for the longer period of time is the Primary Plan and the plan that covered the person for the shorter period of time is the Secondary Plan.

  - In the event the dependent child's coverage under the Spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule.

- Dependent Child Also Covered by Employer: If a dependent child has coverage through his or her own employer and also under either or both parents' plans, then the plan that covers the person *other than* as a dependent, for example as an employee, member, subscriber, policyholder or retiree, is the Primary Plan and the plan that covers the person as a dependent is the Secondary Plan.

- Medicare: If you and/or your Eligible Dependents are covered by this Fund and by Medicare, and you remain eligible for Active Member coverage, your health care coverage will continue to provide the same benefits and this Fund will be the Primary Plan and Medicare will be the Secondary Plan.

- COBRA: If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, or retiree or covering the person as a dependent of an employee, member, or retiree is the Primary Plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the Secondary Plan.

- Military Insurance Coverage: If you and/or your Eligible Dependents are covered by this Fund and Military Insurance, Military Insurance will be the Primary Plan and this Fund will be the Secondary Plan.

- Other Coverage Provided by State or Federal Law. If you and/or your Eligible Dependents are covered by this Fund and any other coverage provided by any other state or federal law, the coverage provided by any other state or federal law will be the Primary Plan and this Fund will be the Secondary Plan.

How Much This Plan Pays When It Is Secondary

When this Plan pays second, it will pay the same benefits that it would have paid had it paid first, less whatever payments were actually made by the plan (or plans) that were Primary. In addition, when this Plan pays second, it will never pay more in benefits than it would have paid for each claim as it is submitted had it been the plan that paid first. This has the effect of maintaining this Plan's Deductibles, Coinsurance, Copayments, and exclusion provisions. As a result, when this Plan pays second, you may not receive the equivalent of 100% of the total cost of the covered health care services.

Administration of COB

To administer COB, the Plan reserves the right to:

1. Exchange information with other plans involved in paying claims;
2. Require that you, any of your Eligible Dependents or your health care provider(s) or other plan furnish any necessary information;
3. Reimburse any plan that made payments this Plan should have made; or
4. Recover any overpayment from your hospital, Physician, Dentist, other health care provider, other insurance company, you or your Eligible Dependent(s).

If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount that the Fund Office or its designee determines to be proper under this provision. Any amounts so paid will be considered benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply these COB provisions.

Other Important COB Provisions

Under the Fund's COB provisions, an Eligible Dependent also covered under another plan which includes programs such as a Utilization Review Program, Hospital Pre-Admission Certification and Continued Stay Review Process and Mandatory Second Surgical Opinion Benefits, will not receive any payment or compensation from this Fund for reductions in benefits paid by the other plan, because of the failure of your Eligible Dependent to utilize the other plan's mandatory programs.

For example, if the other plan requires that your Eligible Dependent pre-certify a scheduled surgery or hospital stay, and your Eligible Dependent fails to do this which results in a reduction of benefits

or no benefits being paid by the other plan, the Fund will not reimburse you or your Eligible Dependent for what the other plan failed to pay. These reductions or penalties may be, for example, flat dollar reductions or a lesser percentage of benefits otherwise payable. In addition, if your Eligible Dependents are covered under an HMO or PPO which is considered the Primary Plan, they must utilize the facilities listed in their plan before the Fund will consider secondary payment.

Coordination with Motor Vehicle Insurance

If you or your Eligible Dependent are involved in an automobile accident and you have, or are required by state law to have, basic reparation coverage, your insurance carrier will be liable for lost wages, medical, surgical, hospital and related charges.

When you or your Eligible Dependent are in an accident, the Fund (if the Primary Plan), will pay the charges and expenses under the applicable provisions of this SPD, including but not limited to the COB provisions. Regardless of whether this Fund is primary or secondary, you, your Eligible Dependent (if an adult) and any attorney you have hired or are working with, may be required to sign a Reimbursement Agreement before any claims relating to the accident will be paid. The Reimbursement Agreement permits the Fund to receive reimbursement for expenses paid by the Fund that you recover through litigation or settlement with another party or insurance provider or other source. See pages 96-98 for further details regarding the Fund's Right of Reimbursement.

A Common COB Question – HUSKY Health Insurance Coverage

One question which the Fund Office has received is whether an Active Member can "unenroll" or "drop" one or more of his or her Eligible Dependent(s) under the Fund's rules and then enroll such Eligible Dependent(s) under Connecticut's HUSKY Health insurance coverage. The simple answer to this question is no. This is because the Fund is structured in a way that if an Active Member is eligible for Fund coverage, then his or her children who qualify as "Eligible Dependents" under the Plan are also *automatically* eligible for Fund coverage. Under federal law, including the Affordable Care Act, because our Fund offers coverage to such children (as Eligible Dependents), it is required by the ACA to make coverage available until: (A) the Active Member loses his or her coverage, (B) the end of the month in which the Child reaches age 26 (subject to an extension due to disability), or (C) the Child engages in Non-Covered Employment. Simply having HUSKY Health insurance coverage *available* to a Child is not an event that triggers the loss of Fund coverage. In addition, HUSKY Health insurance coverage is a payor of "last resort," meaning if the HUSKY program ever determined that Fund coverage was available, the Active Member and/or the Fund could face potential liability.

COBRA CONTINUATION COVERAGE

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (commonly known as "COBRA"). COBRA is not free, the Fund charges an applicable monthly premium as permitted by law and individuals on COBRA must be sure the Fund receives the applicable monthly premium in full and on time. For additional information about your rights and obligations under the Fund and under federal law, you should contact the Fund Office.

WHAT IS COBRA?

COBRA is a temporary continuation of Fund coverage on a self-pay basis when coverage would otherwise end because of a life event known as a "qualifying event." The Fund currently has two different COBRA Plans you can choose between. COBRA Plan 1 coverage includes hospital, medical, dental, prescription drug, vision, hearing aid, life insurance and accidental death and dismemberment (AD&D) insurance. COBRA Plan 2 coverage only includes hospital, medical and prescription drug. Please note that neither COBRA plan includes weekly disability benefits. Also, if benefits under the COBRA Plan you elect (whether Plan 1 or Plan 2) are changed during your period of COBRA coverage, your benefits will also change and the amount you pay each month may be adjusted accordingly.

There may be instances that would cause you to lose coverage which are not "qualifying events," such as a Termination for Cause. In that type of instance, you would not be entitled to COBRA. Specific qualifying events are listed below. After a qualifying event, COBRA must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who is covered by the Plan on the day before a qualifying event occurred that caused him or her to lose coverage under the Fund. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including special enrollment rights.

If you are an Active Member, you will become a qualified beneficiary if you lose Fund coverage because one of the following qualifying events happens (as applicable):

- A reduction in your hours of employment; or
- Termination of your employment (including retirement) other than a Termination for Cause.

If you are the Spouse of an Active Member, you will become a qualified beneficiary if you lose your Fund coverage because any of the following qualifying events happen (as applicable):

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment terminates (including retirement) other than a Termination for Cause;
- Your Spouse becomes enrolled in Medicare (Part A, Part B, or both); or

- You become divorced or legally separated from your Spouse.

Dependent children of an Active Member will become qualified beneficiaries if they lose Fund coverage because any of the following qualifying events happen (as applicable):

- The Active Member-parent dies;
- The Active Member-parent's hours of employment are reduced;
- The Active Member-parent's employment terminates (including retirement) other than a Termination for Cause;
- The Active Member-parent becomes enrolled in Medicare (Part A, Part B, or both);
- The divorce or legal separation of the Active Member and Spouse; or
- The child ceases to be eligible for coverage under the Fund as a Child.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA?

Yes. If you are an Active Member who is otherwise losing Fund coverage because of a reduction of hours, one possible option for you may be the Fund's "self-payment" option which is discussed earlier in this SPD starting on page 18. In addition, instead of enrolling in COBRA, there may be other more affordable coverage options for you and your family through a Marketplace, Medicare, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Additionally, you may apply for and, if eligible, enroll in Medicaid at any time. If you're eligible for Medicare, consider signing up during its special enrollment period to avoid a coverage gap when your COBRA coverage ends and a late enrollment penalty. You should compare your other coverage options with COBRA and choose the coverage that is best for you.

When you lose "job-based" health coverage (due to the end of employment or a reduction in hours of employment), it is important that you choose carefully between COBRA and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option until the next available open enrollment period.

IF I ELECT COBRA, HOW LONG WILL IT LAST?

Once the Fund Office determines or receives notice that a qualifying event has occurred, COBRA will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA. Former participants may elect COBRA on behalf of their Spouses, and parents may elect COBRA on behalf of their children.

In the case of a loss of coverage due to the involuntary end of employment or a reduction in hours of employment, coverage generally may be continued for up to a total of 18 months. When the qualifying event is the end of employment or reduction in hours, and the Active Member became entitled to Medicare less than 18 months before the qualifying event, COBRA coverage for the Active Member's Eligible Dependents can last until 36 months after the date the Active Member becomes entitled to Medicare.

In the case of losses of coverage due to an Active Member's death, divorce or court-ordered legal separation, or a dependent child ceasing to be an Eligible Dependent under the terms of the Plan, coverage may be continued for up to a total of 36 months.

Please be aware that COBRA will be terminated before the end of the maximum period if:

- any required monthly COBRA premium is not paid in full and on time,
- you again satisfy the Plan's normal eligibility provisions and reestablish Plan coverage,
- a qualified beneficiary becomes covered, after electing COBRA, under another group health plan,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA,
- the Plan is terminated,
- the individual engages in conduct that constitutes a Termination for Cause, or
- in the case of extended COBRA coverage due to disability, the Social Security Administration makes a final determination that the individual is no longer disabled.

Once COBRA coverage is terminated, it cannot be reinstated. If the Trustees amend, reduce, or terminate any part of the Plan's benefits, COBRA will only provide benefits still offered under the Plan.

After COBRA ends, the Fund offers certain limited "Self-Pay" extensions to: (A) eligible former Active Members who are not retired, (B) eligible former Active Members who are retired under the Iron Workers' Locals No. 15 and 424 Pension Fund but are younger than age 58, and (C) widows or widowers of: (i) an individual who dies while on the job in Covered Employment and covered by the Fund as an Active Member, or (ii) an individual who dies while covered by either of the Fund's retiree programs. Further details are provided on these Self-Pay extensions starting on page 81.

HOW CAN YOU EXTEND THE LENGTH OF COBRA BEYOND 18 MONTHS?

If you elect COBRA due to the end of employment or a reduction in hours, an extension of the 18-month maximum period of coverage may be available if a qualified beneficiary is disabled. You must notify the Fund Office of a disability or a second qualifying event in order to extend the period of COBRA. Failure to provide timely notice of a disability will eliminate the right to extend the period of COBRA.

For example, if a participant becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA for his Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the participant's hours of employment, COBRA generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA can be extended:

Disability

An 11-month extension of coverage (after the initial 18-month period) may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started within the first 60 days of COBRA and must last at least until the end of the 18-month period of COBRA. You must notify the Plan within 60 days after the notice was received by a qualified beneficiary and before the end of the initial 18-month period. Each qualified beneficiary who has elected COBRA, and any child born to, adopted by or placed with the covered Member for legal adoption during the initial 18-month period, will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to Spouses and dependent children who elect COBRA if a second qualifying event occurs during the first 18 months of COBRA. The maximum amount of COBRA available when a second qualifying event occurs is 36 months from the date of the first qualifying event. Such second qualifying events may include the death of a Member, divorce or separation from the Member, or a dependent child's ceasing to be eligible for coverage as an Eligible Dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your COBRA.

For much more information about extending the length of COBRA, you are encouraged to visit the following website: https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/an-employees-guide-to-health-benefits-under-cobra.pdf.

THE COST OF COBRA

Any individual who is eligible and elects COBRA will be required to pay the "applicable monthly premium." In accordance with applicable federal law, the maximum amount that may be charged is 102% of the cost of coverage for Members and their Eligible Dependents for the first 18 or 36 months, as applicable, and no more than 150% of the cost of coverage for the additional 11 months allowed for disabled individuals. Note that our Plan provides a "subsidy" for certain individuals who are eligible to elect COBRA, meaning that the Plan may charge ***less*** than the full 102% or 150% charge, as applicable, that it could otherwise assess. Please be aware that the monthly costs of COBRA continuation coverage under the Plan may be increased, even if your benefits stay the same, but not more than once every 12 months except in unusual circumstances. In the event that the cost of COBRA coverage changes, you will receive a notice of the revised cost.

HOW CAN YOU ELECT COBRA?

To elect COBRA, you must complete the Fund's "COBRA Election Form" according to the directions on the Form and furnish it to the Fund Office in a timely manner, subject to any extensions permitted by law. Subject to any such extensions, the Fund Office must receive your properly completed Election Form within 60 days after you receive the information packet or, if

your current coverage would terminate after you receive the information packet, within 60 days after the date specified in the Fund's cover letter regarding when your coverage would end. If you elect not to continue coverage, you may still change your mind by sending the Fund a signed COBRA Election Form within the original 60-day period.

Please note that the Plan is not always aware of specific "qualifying events," *especially* in instances of divorce or legal separation. If a divorce or legal separation occurs, it is the responsibility of the Eligible Individual (or a related third party, such as an attorney) to notify the Plan of the divorce or legal separation within sixty (60) days of the relevant court order or decree. Otherwise, the Plan does not need to offer or provide COBRA under the law.

Each qualified beneficiary has a separate right to elect COBRA. For example, a Spouse may elect COBRA even if the Active Member does not. COBRA may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect COBRA on behalf of any eligible dependent children. The Active Member or the Active Member's Spouse can elect COBRA on behalf of all of the qualified beneficiaries.

If you elect COBRA and subsequently add a dependent (by marriage, birth, adoption, or placement for adoption) during your coverage period, that new dependent can also be covered for the remainder of the coverage period. Any qualified beneficiary can add a new spouse or child to his or her COBRA; however, the newly added family members will only have the rights of that qualified beneficiary. Subject to any applicable extension mandated under federal law, you must notify the Fund Office of the addition of any new dependent within 30 days of the marriage, birth, adoption, or placement for adoption.

If, while you are enrolled in COBRA, your Spouse or dependent loses coverage under another group health plan, you may enroll the Spouse or dependent for coverage for the balance of the period of COBRA, but must do so within 30 days after the termination of the other coverage. When any additional individuals are added to COBRA under the rules above, please be aware that you (or they) are required to pay any applicable increase in the COBRA monthly premium.

WHEN AND HOW MUST PAYMENT FOR COBRA BE MADE?

Here are the applicable Fund rules and deadlines:

First payment for COBRA

If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA not later than 45 days after the date of your election (this is the date the Election Notice is post-marked, if mailed) and no benefits will be paid, or covered service provided, until your payment is received. If you do not make your first payment for COBRA in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

You are responsible for making sure that the amount of your first payment is correct. You may contact the Fund Office at (203) 238-1204 to confirm the correct amount of your first payment.

Payments for COBRA after the first payment

After you make your first payment for COBRA, you will be required to make timely monthly payments for each subsequent month of your COBRA coverage. Under the Plan, each monthly payment for COBRA is due on the *1st day of each month* for such month. If you make a monthly payment on or before the first day of the month to which it applies, your coverage under the Plan will continue for that month without any break.

Please note that the Plan does NOT send periodic notices or "coupons" regarding your monthly COBRA premium payments, although it may send you a reminder notice if such a monthly payment is late. But even if you do not receive any reminder notice the Plan may send, it is still your responsibility to make monthly payments on time if you wish your COBRA coverage to continue.

Grace periods

Although monthly COBRA payments are due on the 1st day of each month, you will be given a grace period until the last day of that month to make full payment. Your COBRA will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment in full later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

Example: Assume you are an iron worker covered by the Fund and you lose eligibility on October 31, 2021 due to a reduction in hours, despite the fact that you are able, available and seeking to work in the union iron working trade in Connecticut. You elect to continue medical, prescription drug, dental, vision and dental benefits for you and your eligible dependents (through COBRA Plan 1) at the subsidized rate of $750 monthly (as of the printing of this SPD, which can change in the future), and you provide your Election Form to the Fund Office on November 20, 2021. You include a check for $750 with your Election Form for the month of November. On December 1, 2021, you send another check (also in the amount of $750) to the Fund Office for the month of December. You have preserved COBRA coverage for both the months of November and December. Future monthly payments are due on the first day of the month for which COBRA coverage is to be extended.

If you fail to make a monthly payment before the end of the grace period for that month, you (and any other eligible dependents) will lose all rights to COBRA under the Plan. Remember: You cannot reinstate your COBRA once it is terminated.

IF YOU HAVE QUESTIONS

Questions concerning your COBRA rights should be addressed to the Fund Office. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. For more information about health insurance options available through the Health Insurance Marketplace or Connecticut's Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov or www.accesshealthct.com.

FUND COVERAGE OPTIONS AFTER COBRA ENDS

DOES THE FUND OFFER ANY ADDITIONAL COVERAGE OPTIONS *AFTER* COBRA ENDS?

Yes! The Fund currently offers three (3) limited "Self-Pay" extensions described below to eligible individuals after COBRA ends. These extensions are separate and distinct from the self-payment rule outlined for continuing eligibility in the Active Plan which is contained on page 18. ***The general eligibility rules and other important conditions of Fund coverage (see subsection D) are outlined below, and please be aware that the specific rules of the Plan document will govern in any situation***. In addition, the Fund's Board of Trustees has the full authority and discretion to amend, modify and/or terminate any one, any combination, or all of these Self-Pay extensions at any time.

A. Self-Pay Extension for former Active Members who are not retired.

Individuals who: (i) are former Active Members, (ii) did not lose Fund eligibility due to a Termination for Cause, (iii) are younger than age 65, (iv) are able, available and seeking work in Covered Employment in Connecticut, and (v) are not retired under the Iron Workers' Locals No. 15 and 424 Pension Fund are eligible for a Self-Pay extension *solely for themselves* after their normal COBRA ends.

An extension granted under this provision is limited to a single period of up to 18 months, and the extension cannot run beyond the date the individual would otherwise be eligible for coverage under the Retirees Ages 58-65 Plan or the Medicare Eligible Retirees Plan. A request for such an extension must be made to the Fund Office before his or her COBRA period expires, and Fund coverage can continue on a month-to-month basis *provided that* all required monthly premiums under this Self-Pay extension are remitted to the Fund Office on a timely basis.

B. Self-Pay Extension for Retired Members.

Individuals who: (i) are former Active Members, (ii) did not lose Fund eligibility due to a Termination for Cause, (iii) are younger than age 58, and (iv) are Pensioners retired and actually receiving an Early Retirement, Disability or a Service (including a Rule of 85 or a Rule of 89) Pension under the Iron Workers' Locals No. 15 and 424 Pension Fund (Pension Fund) are eligible for a Self-Pay extension for themselves and any of their Eligible Dependents as to benefits available to Retired Members and their Eligible Dependents either before, or after, their normal COBRA ends. Further, a Pensioner must be covered under the terms of the Active Plan (which may include COBRA) up to the date their Pension Fund benefits begin to qualify for this Self-Pay extension.

An extension granted under this provision is limited for up to 18 months, *and more than one extension may be granted*. But in all circumstances, any such extension may not extend beyond the date the eligible individual attains age 58, whether or not such individual would otherwise be eligible for coverage under the Retirees Ages 58-65 Plan or the Medicare Eligible Retirees Plan.

A request for such an extension must be made to the Fund Office before his or her Active Plan coverage ends, his or her COBRA period expires, or a previous extension ends, as applicable. Fund coverage can continue on a month-to-month basis *provided that* all required monthly premiums under this Self-Pay extension are remitted to the Fund Office on a timely basis, and Eligible Dependents are not permitted to request an extension on their own.

C. Self-Pay Extension for Widows and Widowers.

The Fund has two specific extensions here, one for "Active widows" (or widowers) whose Spouse dies while on the job for a Contributing Employer and while an Active Member in the Plan, and a second for "Retiree widows" (or widowers) whose Spouse dies while covered under either the Retirees Ages 58-65 Plan or the Medicare Eligible Retirees Plan.

The rules for an Active widow electing this Self-Pay extension on a month-to-month basis for himself or herself, along with any of his or her Eligible Dependents, after COBRA ends are discussed starting on page 81 of this SPD. Fund coverage can continue on a month-to-month basis *provided that* all required monthly premiums under this Self-Pay extension are remitted to the Fund Office on a timely basis, and Eligible Dependents are not permitted to request an extension on their own.

A Retiree widow must submit a request for such a Self-Pay extension to the Fund Office prior to the expiration of his or her COBRA. Fund coverage can continue on a month-to-month basis for solely the Retiree widow (subject to applicable laws governing special enrollment rights), *provided that* all required monthly premiums under this Self-Pay extension are remitted to the Fund Office on a timely basis.

D. Conditions of coverage under ALL Self-Pay extensions.

Any individual who is on a Self-Pay extension who engages in conduct that constitutes a "Termination for Cause" **will immediately lose his or her Fund coverage under such Self-Pay extension and it may not be reinstated**. Note that if the individual who experiences a Termination for Cause is also covering his or her Eligible Dependent(s), then those Eligible Dependent(s) will lose Fund coverage as well.

The Fund also provides generous subsidies to individuals who qualify for these Self-Pay extensions, *meaning that the Fund normally does not charge the individual the actual "true" cost of that coverage*. The subsidy can be lost in two specific circumstances:

- ✓ the individual works in the "Construction Industry," OR
- ✓ the individual exceeds the Fund's "Income Limitation."

Here are the relevant details:

Working in the Construction Industry Restriction

The "Construction Industry" is broadly defined to include any work (i.e., employment, consulting, contract work, etc.) which involves the building, upgrading, maintenance and/or repair of structures. The term covers, but is not limited to:

- ✓ the union iron working trade or craft, and
- ✓ the building construction industry (all work which involves the construction of residential, farm, industrial, commercial, or other buildings and related structures), and
- ✓ the heavy construction industry (such as highways and streets, sewers, railroads, irrigation projects, marine construction, etc.), and
- ✓ the specialty trade construction (such as painting, electrical work, air conditioning work, masonry, plumbing, carpentry, etc.), and
- ✓ acting as an officer, director, owner, supervisor, superintendent, safety officer, estimator or other similar capacity: (i) on a self-employed basis in any category noted above, or (ii) for a corporation or other business entity which performs work in any category noted above.

So, if you are on *any* Self-Pay extension and decide to engage in work in the Construction Industry at any time, here is what will happen:

A. Coverage under the Self-Pay extension can continue for you and any Eligible Dependents (to the extent applicable), *but*

B. Commencing with the first day of the month in which you engage in work in the Construction Industry, you will no longer qualify for the Fund's subsidized monthly rate and you must pay the Fund's unsubsidized monthly rate.

EXAMPLE: You are unmarried and age 55, you retire under the terms of the Pension Fund on an Early Retirement Pension, and you qualify for the Self-Pay extension for Retirees as of January 1, 2021. Under your Self-Pay extension you pay the subsidized single rate, and you pay that premium on a timely basis each month. *However, you then decide to work as a safety officer for a signatory iron working company starting July 1, 2021, and you actually engage in such work.* Under this rule, you can continue to utilize your Self-Pay extension and maintain Fund coverage; **however**, you must pay the *unsubsidized* single monthly premium starting July 1, 2021 (and thereafter). The monthly premium figures are reviewed annually by the Fund's Board of Trustees and are subject to adjustment.

Income Limitation

Commencing with the 2020 calendar year, the Fund assesses the unsubsidized monthly cost of individual or family coverage (as applicable) under *any* Self-Pay extension if you and your Spouse (if married) earn $45,000 or more in income as reported on your tax return(s) in the immediately

preceding calendar year, subject to exceptions (1) and (2) noted in the first bullet below. The Fund's Board of Trustees will monitor the Income Limitation dollar figure (the $45,000 threshold amount) on an annual basis, and it may be adjusted in future years in their full and complete discretion.

EXAMPLE: You and your Spouse are covered by the Self-Pay extension for Retirees as of January 1, 2022, and you provide documentation to the Fund Office in late April of 2022 which shows that earnings for you and your Spouse exceeded the Income Limitation during 2021 (which was still set at $45,000). At that point (starting in May of 2022), you would be required to pay the Fund the *unsubsidized* family rate for a period of 12 consecutive months in order to maintain your coverage.

Here are a few other important points to be aware of:

- ✓ The Income Limitation considers the total income of your household during each and every calendar year (i.e., you and your Spouse, if you are married). However, it *will not* include any amounts you or your Spouse, if married, may receive during a calendar year as: (1) a union pensioner (for example, amounts received directly as distributions from the Iron Workers' Locals No. 15 and 424 Annuity and/or Pension Funds, or other union-sponsored benefit funds), and/or (2) taxable income from Social Security.

- ✓ If you and your Spouse, if married, *are below* the Income Limitation for the prior calendar year, then you are able to utilize the Fund's Self-Pay extension at the Fund's subsidized rate for a twelve (12) consecutive month period.

- ✓ If you and your Spouse, if married, *equal or exceed* the Income Limitation for the prior calendar year, then you must pay for your Fund Self-Pay extension at the Fund's unsubsidized rate for a twelve (12) consecutive month period.

Also, in the event that you decided to discontinue your Fund Self-Pay extension because you believe that the unsubsidized rate is too expensive, then the Fund wants you to know that: (1) your Fund coverage will be <u>permanently lost</u> for you and any family members, and (2) you and any other family members or potentially eligible family members can NEVER enroll, or re-enroll, as the case may be, for coverage under any of the Fund's Self-Pay and/or Retirees Programs (which includes BOTH the Retirees Ages 58-65 Plan and the Medicare Eligible Retirees Plan).

Those covered under a Self-Pay extension will be required to provide appropriate evidence of their total income (along with that of their Spouse, if any) for the prior calendar year to the Fund's administrative office in a timely manner. <u>This process will occur each calendar year</u>. You are required to cooperate and to provide the Fund's staff with the information and documentation requested.

CLAIM FILING AND APPEAL PROCEDURES

This Section of the SPD describes the procedures for filing claims for benefits. It also describes the procedures for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

DEFINITIONS OF TERMS USED IN THIS SECTION

Adverse Benefit Determination means any denial, reduction, termination of or failure to provide or make payment for a benefit (either in whole or in part) under the Fund.

Claim means a request for a benefit made by a claimant in accordance with the Fund's reasonable procedures. Casual inquiries about benefits, a request to improve or expand benefits provided under the Fund, or the circumstances under which benefits might be paid according to the terms of the Fund are not considered claims. Nor is a request for a determination of whether an individual is eligible for benefits under the Fund considered to be a claim. However, if a claimant files a claim for specific benefits and the claim is denied because the individual is not eligible for benefits under the Fund, the coverage determination is considered a claim. A request for prior approval of a benefit that does not require prior approval by the Fund is not considered a claim. However, requests for prior approval of a benefit where the Fund does require prior approval are considered claims and should be submitted as Pre-Service claims (or Urgent Claims, if applicable), as described in this SPD.

Concurrent Claim means a Claim that is reconsidered after an initial approval is made, resulting in a reduction, termination or extension of a benefit. An example of this type of Claim would be an inpatient hospital stay originally certified for five (5) days that is reviewed at three (3) days to determine if the full five (5) days' stay is still appropriate. In this situation, a decision to reduce, terminate or extend the hospital stay is made concurrently with the period of hospitalization.

Disability Claim means a Claim that requires a finding of disability as a condition of eligibility.

Post-Service Claim means a Claim for benefits that is not a Pre-Service, Concurrent or Urgent Claim; specifically, a Claim submitted for payment after health services or treatment have been obtained.

Pre-Service Claim means a Claim for a benefit for which the Fund requires approval before health care is obtained, or approval is required in order to receive the maximum benefit provided by the Fund.

Urgent Claim means a Claim for health care or treatment that, if normal pre-service standards were applied, would seriously jeopardize the life or health of the individual or the ability of the individual to regain maximum function or, in the opinion of a physician with knowledge of the individual's medical condition, subject the individual to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

HOW TO FILE A CLAIM

In-Network Benefits – if you use network providers, your Claim for benefits will go directly from the network health care provider (hospital, physician, laboratory, etc.) to the appropriate vendor for processing. Generally, you are not required to file a Claim Form for in-network benefits.

Out-of-Network Benefits – if you use out-of-network providers, you must submit a completed Claim Form and follow the claims procedures outlined in this section of the SPD, as applicable. You can obtain a Claim Form by contacting Anthem. The Claim Form must be signed by you and if there is more than one group insurance plan involved, your Claim must be submitted in accordance with the Coordination of Benefits procedures starting on page 69 of this SPD.

IMPORTANT – As a general rule, claims with In-Network providers will be processed through the Fund's PPO Network without any need for your involvement. However, in situations where Out-of-Network providers are utilized, or claims which could involve the Fund's reimbursement rights, the processing of claims may require additional information from you or an Eligible Dependent of yours. Under Fund rules, if a completed Claim is not provided with all necessary information within twenty-four (24) months from the date services were provided, the Claim will NOT be paid. Any Claims received after twenty-four (24) from the date services were provided will be denied on the basis that it has not been filed in a timely manner. Incomplete Claim Forms and/or missing documents or information may result in your Claim being denied.

Authorized Representatives – an authorized representative may submit a Claim on your behalf if you are unable to do so yourself and you have previously designated the individual to act on your behalf. A form can be obtained from the Fund Office to designate an authorized representative. The Fund will also recognize a court order giving a person authority to submit Claims on your behalf. A health care professional with knowledge of your condition may act as an authorized representative in connection with an Urgent Claim without you having to complete an authorization form.

INITIAL DECISION ON CLAIM

You will be notified of a decision on a Claim no later than the following time frames:

- 72 hours after an Urgent Care Claim is filed, or
- 15 days after a Pre-Service Claim is filed, or
- 30 days after a Post-Service Claim is filed, or
- 45 days after a Claim for Weekly Disability Benefits is filed, or
- 90 days after a Claim for Death or Accidental Death and Dismemberment Benefits, as applicable, is filed, or
- for a Concurrent Care Claim involving Urgent Care that would extend the course of treatment, generally as soon as possible after the Claim is filed, or
- for a Concurrent Care Claim that will reduce or terminate a pre-approved course of treatment, there will be enough time to allow you to appeal and obtain a determination on review before benefits are reduced or terminated.

In the event special circumstances require an extension of time for processing a Claim beyond the time frames above, a decision shall be rendered as soon as possible, but not later than an additional:

- 15 days for Pre-Service Claims, or
- 15 days for Post-Service Claims, or
- 30 days for Claims for Weekly Disability Benefits, or
- 90 days for Claims for Death or Accidental Death and Dismemberment Benefits, as applicable.

If an extension of time is required, you will be notified in writing before the expiration of the initial time period provided, and will be informed of the reason for the delay and the date by which a decision is expected.

NOTICE OF CLAIM DENIAL

If a Claim is partially or wholly denied, you will be provided with written notice of the denial. This written notice will include:

- the reason(s) for the Denial, and
- reference(s) to Fund provision(s) on which the Denial is based, and
- what additional information is necessary for you to complete the Claim and an explanation of why such material or information is necessary, and
- a description of the Fund's Procedures and the time limits applicable to such Procedures (including a description of the expedited review process available for a Denial of Urgent Care Claims, when applicable), and
- a statement of your right to bring a lawsuit under ERISA Section 502(a) after an Adverse Benefit Determination of an appeal of a Claim Denial, and
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Claim Denial, either a copy of the specific internal rule or guideline, or a statement that such internal rule or guideline was relied upon in making the determination and that a copy of such internal rule or guideline is available upon request and free of charge, and
- if the Claim Denial is based upon the lack of being Medically Necessary, being an Experimental Procedure, or similar exclusion, either an explanation of the scientific or clinical judgment for the Claim Denial, or a statement that such explanation will be provided upon request and free of charge.

SPECIAL RULES REGARDING NOTICE OF CLAIM DENIAL FOR DISABILITY BENEFITS

If a Claim is partially or wholly denied which involves the determination of a disability (for example, Weekly Disability Benefits), the applicable Notice of the Claim Denial will comply with Sections 2560.503-1(o) of the Department of Labor Regulations, including but not limited to the requirement to provide notices in a culturally and linguistically appropriate manner. Also, the Notice will include, in addition to the requirements noted above:

- a discussion of the decision, including an explanation of the basis for disagreeing or not with the following: (i) the views presented by the Claimant to the Fund of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Fund in connection with such Claim Denial, without regard to whether the advice was relied upon in making that Claim Denial, and (iii) if applicable, a disability determination regarding the Claimant presented by the Claimant to the Fund made by the Social Security Administration; and
- if the Claim Denial is based on a finding of the lack of being Medically Necessary, being an Experimental Procedure, or similar exclusion, either an explanation of the scientific or clinical judgment for the Claim Denial, applying the terms of the Fund to Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Fund relied upon in making the Claim Denial, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Fund do not exist; and
- a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim. The statement shall be made in accordance with Department of Labor Regulation Section 2560.503-1(m)(8).

APPEAL OF A CLAIM DENIAL

If your Claim has been denied, you may:

- request a review upon written application, and
- receive, upon request and free of charge, reasonable access to and copies of all documents and records relevant to the Claim, and
- submit written comments, documents, records and other information relating to the Claim.

Further, with respect to a denial of disability benefits provided under the Fund, to the extent that the Fund considered, relied upon, or generated any new or additional evidence in connection with the Claim, or utilized any new or additional rationale for the denial of the Claim, such evidence or rationale, as applicable, shall be provided free of charge to you as soon as possible and sufficiently in advance of the date on which the Adverse Benefit Determination is required to be provided in order to give you a reasonable opportunity to respond prior to such date.

If you would like to appeal a Claim Denial for an Urgent Care, Pre-Service, Concurrent Care or Post-Service Claim or a Claim for Weekly Disability Benefits, send a written request for a review of the Denial to the Fund Office no later than 180 days after the date the notice of Denial is received. If you would like to appeal a Claim Denial for Life Insurance or Accidental Death and Dismemberment Benefits send a written request for a review of the Denial to the Fund Office no later than 60 days after the date the notice of Denial is received. An appeal will be considered as "filed" under the Fund when the written request for a review of a Denial is received by the Fund Office.

DECISIONS ON APPEAL

You may appeal a Claim Denial as follows:

- An appeal of a Claim Denial for an Urgent Care, Pre-Service or Concurrent Care Claim shall be made to the Board of Trustees, and such appeal may be decided by the Board of Trustees or, if applicable, a sub-committee consisting of those Trustees appointed by the Board of Trustees. In the event that a sub-committee is designated, each sub-committee member shall be entitled to one vote and a decision shall require a simple majority of affirmative votes. You will be notified of a decision on appeal not later than:

    - 72 hours after an Urgent Care Claim appeal is filed, or
    - 30 days after a Pre-Service Claim appeal is filed, or
    - 30 days after a Concurrent Care Claim appeal is filed.

- The request for an appeal of a Pre-Service or Concurrent Care Claim must be made in writing. The request for an appeal of an Urgent Care Claim may be made orally.

- An appeal of a Claim Denial for a Post-Service Claim, or a Claim for Weekly Disability, Life Insurance or Accidental Death and Dismemberment Benefits shall be decided by the Board of Trustees and the request must be submitted in writing to the Board of Trustees in care of the Fund Office. The appeal will be heard at the next regularly scheduled meeting of the Board of Trustees, unless such request for an appeal is received within 30 days of the meeting, in which case the appeal will be heard at the second regularly scheduled meeting. If special circumstances require a further extension, a decision will be rendered not later than at the third meeting of the Board of Trustees following the receipt of the request. Notification of the Board of Trustees' decision will be provided to you within 5 days of the meeting at which the appeal is decided.

- The Board of Trustees will consider all information submitted in rendering a decision on appeal. No personal appearances by you (or any authorized representative) are permitted with respect to an appeal. If an extension of time is required, you will be notified in writing before the expiration of the initial time period allowed for making the decision, and will be informed of the reason for the delay and the date by which a decision is expected.

NOTICE OF ADVERSE BENEFIT DETERMINATION

The decision on an appeal of a Claim Denial shall be provided in writing and shall include:

- the reason(s) for the decision, and
- reference(s) to the Fund provision(s) on which the decision is based, and
- a statement that you may receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Claim, and
- a statement of your right to bring a lawsuit under ERISA Section 502(a) including, with respect to an Adverse Benefit Determination, a description of the Fund's limitation period,

along with the calendar date on which such limitation period expires for bringing that lawsuit, and

- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either a copy of the specific internal rule or guideline, or a statement that such internal rule or guideline was relied upon in making the Adverse Benefit Determination, and that a copy of the rule will be provided free of charge upon request, and
- if the Adverse Benefit Determination is based upon the lack of being Medically Necessary, being an Experimental Procedure, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request; and
- 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."

SPECIAL RULES REGARDING NOTICE OF ADVERSE BENEFIT DETERMINATION FOR DISABILITY BENEFITS

With respect to the decision on an appeal under this Fund which involves the determination of a disability (for example, Weekly Disability Benefits), the applicable notice will comply with Sections 2560.503-1(o) of the Department of Labor Regulations, including but not limited to the requirement to provide notices in a culturally and linguistically appropriate manner. Also, the Notice will include, in addition to the requirements notice above:

- a discussion of the decision, including an explanation of the basis for disagreeing or not with the following: (i) the views presented by the Claimant to the Fund of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Fund in connection with such Adverse Benefit Determination, without regard to whether the advice was relied upon in making that Adverse Benefit Determination, and (iii) if applicable, a disability determination regarding the Claimant presented by the Claimant to the Fund made by the Social Security Administration; and
- if the Adverse Benefit Determination is based on a finding of the lack of being Medically Necessary, being an Experimental Procedure, or similar exclusion, either an explanation of the scientific or clinical judgment for the Adverse Benefit Determination, or a statement that such explanation will be provided free of charge upon request; and
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Fund relied upon in making the Adverse Benefit Determination, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Fund do not exist.

CLAIM EXTERNAL REVIEW PROCESS

This External Review process is intended to comply with the Affordable Care Act's external review requirements.

If your appeal of a Claim is denied, whether it is a Pre-Service, Post-Service, or Urgent Care Claim, you may request further review by an independent review organization ("IRO") as described below. In the normal course, you may only request external review after you have exhausted the internal review and appeals process described above.

*NOTE: External review is only available for the following types of claim denials***:**

- A denial that involves medical judgment, including but not limited to, those based on the Fund's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or a determination that a treatment is Experimental or Investigational. The IRO will determine whether a denial involves a medical judgment; and
- A denial due to a rescission of coverage (retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

External review is not available for any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Fund. In addition, **external review does not apply to decisions involving Weekly Disability Benefits, Life Insurance or AD&D claims.**

Your request for external review of a denial must be made, in writing, within four (4) months of the date that you receive the denial. Because the Fund's internal review and appeals process generally must be exhausted before external review is available, typically external review of claims will only be available for denials of appeals (and not initial claim denials).

PRELIMINARY REVIEW

Within five (5) business days of the Fund's receipt of your external review request for a claim, the Fund will complete a preliminary review of the request to determine whether it is eligible for external review. Specifically, in order to be eligible for external review, the following factors must be met:

- You are/were covered under the Fund at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Fund at the time the health care item or service was provided;
- The denial does not relate to your failure to meet the requirements for eligibility under the terms of the Fund;
- You have exhausted the Fund's internal claims and appeals process (except, in limited, exceptional circumstances); and
- You have provided all of the information and forms required to process an external review.

NOTICE OF PRELIMINARY REVIEW

Within one (1) business day of completing its preliminary review, the Fund will notify you in writing as to whether your request meets the requirements for external review. Specifically, this notice will inform you:

- If your request is complete and eligible for external review, or
- If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)), or
- If your request is not complete, in which case the notice will describe the information or materials needed to make the request complete, and allow you to perfect the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notice of preliminary review, whichever is later.

REVIEW BY INDEPENDENT REVIEW ORGANIZATION

If the request is complete and eligible, the Fund will assign the request to an Independent Review Organization or "IRO." The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Fund has contracted with more than one IRO, and generally rotates assignment of external reviews among the IROs with which it contracts. Once the claim is assigned to an IRO, the following procedure will apply:

- The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, such information must be submitted within ten (10) business days).

- Within five (5) business days after the assignment to the IRO, the Fund will provide the IRO with the documents and information it considered in making its denial determination.

- If you submit additional information related to your claim, the assigned IRO must, within one (1) business day, forward that information to the Fund. Upon receipt of any such information, the Fund may reconsider its denial that is the subject of the external review. Reconsideration by the Fund will not delay the external review. However, if upon reconsideration, the Fund reverses its denial, it will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the Fund's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Fund to ensure that the IRO decision is not contrary to the terms of the Fund, unless the terms are inconsistent with applicable law. The IRO also must observe the Fund's requirements for benefits, including the Fund's standards for clinical review criteria, medical necessity,

appropriateness, health care setting, level of care, or effectiveness of a covered benefit. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Fund, reports from appropriate health care professionals, appropriate practice guidelines, the Fund's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s), unless such requirements are inconsistent with applicable law.

- The assigned IRO will provide written notice of its final external review decision to you and the Fund within forty-five (45) days after the IRO receives the request for the external review.

    - If the IRO's final external review reverses the Fund's adverse benefit determination, upon the Fund's receipt of the notice of such reversal, the Fund will immediately provide coverage or payment for the reviewed Claim. However, even after providing coverage or payment for the Claim, the Fund may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.
    - If the final external review upholds the Fund's adverse benefit determination, the Fund will continue not to provide coverage or payment for the reviewed Claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

- The assigned IRO's decision notice will contain the following information, unless such information is inconsistent with applicable current law:

    - A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the reason for the previous denial);
    - The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;
    - References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
    - A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
    - A statement that the determination is binding except to the extent that other remedies may be available to you or the Fund under applicable State or Federal law;
    - A statement that judicial review may be available to you; and
    - Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Services Act to assist with external review processes.

Expedited External Review of Claims

You may request an expedited external review if:

- You receive an initial claim denial that involves a medical condition for which the timeframe for completion of a non-expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or

- You receive a denial from an appeal that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive a denial from an appeal that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the Fund will complete a preliminary review of the request to determine whether the requirements for preliminary review set forth above are met. The Fund will immediately notify you as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information described above.

Upon a determination that a request is eligible for expedited external review following the preliminary review, the Fund will assign an IRO. The Fund will expeditiously provide or transmit to the assigned IRO all necessary documents and information that it considered in denying the claim.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo (as if it is new) and is not bound by any decisions or conclusions reached during the Fund's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Fund to ensure that the IRO decision is not contrary to the terms of the Fund, unless the terms are inconsistent with applicable law. The IRO also must observe the Fund's requirements for benefits, including the Fund's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, unless such requirements are inconsistent with applicable law.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Fund.

If, upon external review, the IRO reverses the Fund's denial, upon the Fund's receipt of notice of such reversal, the Fund will immediately provide coverage or payment for the reviewed claim.

However, even after providing coverage or payment for the claim, the Fund may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

If the final external review upholds the Fund's denial, the Fund will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

THIRD PARTY LIABILITY AND RIGHT OF REIMBURSEMENT

The Fund does not cover nor is it liable for any charges or expenses incurred by an Active Member, Retired Member (whether in the Ages 58 to 65 Plan or the Medicare-Eligible Program), his or her Eligible Dependent(s) or a representative, guardian or trustee of such Active Member, Retired Member or Eligible Dependent(s) (hereinafter, collectively "claimant") as a result of an accident, Illness or Injury for which one or more third parties (any person or entity) are or may be liable.

However, subject to the following terms and conditions, the Board of Trustees, at their discretion, may advance payment for some or all of a claimant's expenses after receipt of a properly completed and executed Reimbursement Agreement and Consent to Lien (hereinafter "Reimbursement Agreement"). In addition, acknowledgement of the Agreement must be provided to the Fund Office by the claimant's attorney (if applicable). The Fund's Reimbursement Agreement and any acknowledgement must be executed without any alteration or any other condition.

Where the Fund has made payments for an accident, Illness or Injury, irrespective of whether any reimbursement agreement is completed, signed and returned to the Fund, the Fund will have the right to recover from the claimant the full amount of benefits paid without deductions or adjustments (including for attorney's fees and costs) of any kind if the claimant obtains any settlement, judgment, arbitration or recovery of any sort (referred to as "proceeds") from a third party or from any insurance provider or other source, and even if the claimant is not made whole. It is the claimant's obligation to timely inform the Fund of the filing of a lawsuit (or other legal action) against any third party and to timely inform the Fund about any recovery that is received or could be received, including offers of compromise and/or settlement from an insurance provider. The Fund has a first lien on any such proceeds and must be promptly reimbursed in full within thirty (30) days or the claimant will have additional liability for interest and all costs of collection, including reasonable attorney's fees. The claimant will first reimburse the Fund out of any recovery proceeds before the claimant is entitled to any portion of the recovery and without regard to the extent of the recovery that has been or may be provided to the claimant.

As noted above, the Fund has the right to recover the full amount of benefits paid by the Fund, without deductions or adjustments of any kind and even if the claimant is not made whole. For example, there is no deduction or adjustment for attorney's fees incurred by the claimant in obtaining the settlement, judgment, arbitration or recovery. The Fund's lien is not reduced by any such attorney's fees. Regardless of the sufficiency of any recovery and the proceeds thereof, the Fund is not subject to any state law doctrines, including but not limited to, the "common fund" doctrine, which would purport to require the Fund to reduce its lien by any portion of a claimant's attorney's fees and costs. The Fund is also not subject to the "make whole" doctrine, or any other legal doctrine, argument or theory, which purport to subject the Fund's lien to the claimant's full (or even partial) compensation for all of his or her injuries. Accordingly, even if the amount you owe the Fund exceeds the amount of proceeds recovered from a third-party, you still must pay the Fund back first.

In the event the claimant fails to reimburse the Fund from proceeds received from a third party, or from any insurance provider or other source, the Fund will also have the right to withhold future

benefits equal to the amount otherwise due the Fund, plus interest and the costs of collection, including attorneys' fees.

REIMBURSEMENT AGREEMENT

Every claimant, on whose behalf an advance may be payable, must execute and deliver to the Fund a Reimbursement Agreement in the form provided without alterations. Claimants, and their attorneys (if applicable), must also do whatever is necessary to protect the Fund in obtaining reimbursement and/or its subrogation rights. Each such claimant (or their attorney on their behalf) must promptly notify the Fund Office if he or she makes a claim or brings an action against a third party or if he or she is offered and/or obtains any settlement, judgment, or other recovery from any source.

If a claimant does not execute a Reimbursement Agreement for any reason, it will not waive, compromise, diminish, release or otherwise prejudice any of the Fund's reimbursement rights if the Fund, at its discretion, makes an advance and inadvertently pays benefits in the absence of such a Reimbursement Agreement.

In addition, the Fund's standard administrative procedure is to ascertain the nature of any injury or illness to determine whether a third party could potentially be held liable. Claims relating to such an Injury or Illness will not be paid by the Fund until this determination is made, and any claimant and the claimant's attorney (if applicable) must fully cooperate with the Fund during this process. If the Fund determines that any claim may be the ultimate responsibility of a third party, whether as a result of negligence, intentional tortious conduct or otherwise, the Fund will not process such a claim without: (1) a properly completed and executed Reimbursement Agreement, and (2) in any type of accident or injury involving a motor vehicle, whether the claimant had coverage for medical payments and/or expenses under the claimant's motor vehicle insurance policy (commonly referred to as "Med Pay").

COOPERATION BY ALL CLAIMANTS

By accepting an advance from the Fund for related claim payment, every claimant agrees to do nothing that will waive, compromise, diminish, release or otherwise prejudice the Fund's reimbursement and/or its subrogation rights.

By accepting an advance payment from the Fund for related claims to an accident, illness or injury, every claimant agrees to notify and consult with the Board of Trustees or its Fund Office before:

- Starting any legal action or administrative proceeding against a third party based on any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the claimant's accident, illness or injury that resulted in the Fund's advance payment of claims; or
- Entering into any settlement agreement with that third party or that third party's insurer that may be related to any actions by that third party that may have caused or contributed to the claimant's accident, Illness or Injury that resulted in the Fund's advance for claims related to such accident, Illness or Injury.

By accepting an advance from the Fund for claim payments, every claimant agrees to keep the Board of Trustees, or its Fund Office informed of all material developments with respect to all such claims, actions, or proceedings.

ALL RECOVERED PROCEEDS ARE TO BE APPLIED TO REIMBURSE THE FUND

By accepting an advance payment of claims for an accident, Illness or Injury from the Fund, every claimant agrees to reimburse the Fund for all such advances by applying any and all amounts paid or payable to them by any third party or that third party's insurer or any other source by way of settlement, judgment, arbitration or recovery, or in satisfaction of any judgment or agreement, regardless of whether those proceeds are characterized as being paid on account of the medical expenses for which any advance has been made by the Fund. The Fund will have the right to recover from the claimant the full amount of benefits paid without deductions or adjustments of any kind including attorney's fees. In such event, the Fund must be fully reimbursed within thirty (30) days of the date proceeds are received by the claimant or his attorney, or the claimant will have additional liability for interest and all costs of collection, including reasonable attorney's fees. The Fund may offset future claims/benefits in order to receive the full amount of benefits paid if full reimbursement is not made. If you obtain recovery proceeds from a third-party and spend those proceeds before reimbursing the Fund in the full amount of its lien, the Fund has the right to take legal action against you, including filing a lawsuit against you to recover those amounts.

This Fund is a self-insured employee welfare benefit plan and, therefore, ERISA preempts any state law purporting to restrict the Fund's rights under this provision. Furthermore, any state law directed at insurance companies will not apply to the Fund, since it is self-insured.

OTHER REIMBURSEMENTS; MISTAKE, ETC.

On rare occasions, the Fund may pay benefits to an individual or other entity (such as an estate) which is not otherwise entitled to them. Such benefits may be paid due to a simple mistake or error, due to intentionally misleading information or statements, or due to other causes too numerous to mention. In such a situation, the individual, the individual's estate, or person through whom the individual claimed Fund benefits will be liable to repay all amounts paid by the Fund and all costs of collection, including interest and attorney's fees. The Fund also has the right to deny or offset any future Fund benefits which would otherwise be paid until all amounts have been reimbursed or recovered.

WHEN YOU ARE INJURED ON THE JOB

If you are injured at work, or suffer from a work-related illness, you should be covered by workers' compensation (provided by or through your Contributing Employer) for health care costs and loss of wages. The Fund does not cover any health care costs or disability benefits due to a job-related Injury or one that should be covered by workers' compensation. The Fund will continue to cover you and your Eligible Dependents for other medical claims that are not related to your work-related Injury or Illness, as long as you are eligible for coverage. You should call the Fund Office immediately when you start receiving workers' compensation. Please refer to page 62 for additional information relating to Workers' Compensation.

PATIENT PROTECTION AND AFFORDABLE CARE ACT; OTHER FEDERAL LAWS

We are sure you have heard and read about the federal health care law which was enacted into law in 2010, known as the Patient Protection and Affordable Care Act or "ACA," along with the numerous attempts to repeal and replace that law. As of the printing of this SPD in 2021, the ACA is still in effect and is applicable to the Fund. Outlined below are a few important alterations made to the Fund between 2010 to now, which are due to the ACA:

- The Fund provides dependent coverage for married or unmarried adult children to age 26 for Active Members and those Retirees in the Retirees Ages 55 to 65 Plan.
- The Fund provides you with an annual "Summary of Benefits and Coverage" or SBC, which is a uniform summary of benefits, using standardized definitions and government-approved language.
- The Fund does not impose an annual dollar limit on what the ACA defines as "essential health benefits" and does not impose any pre-existing condition exclusions (i.e., exclusions for a medical condition and/or health problem that existed before the date the individual became eligible under the Fund).
- The Fund is a "non-grandfathered" group health plan under the ACA, which means that the Fund's Eligible Individuals have additional rights as compared to a group health plan which is "grandfathered" under ACA rules.

Connecticut Marketplace. One final ACA point to mention is that you have likely seen or heard the television and radio ads for Connecticut's ACA Health Insurance Exchange or Marketplace, known as Access Health CT. As long as you have Fund coverage, you and any of your eligible dependents will continue to receive your Fund benefits as you normally would and you do not need to access the Marketplace at all. It is also important to mention that when you are eligible for Medicare, you are not eligible to enroll in coverage through the Marketplace. But in the event that you or your family lose coverage through the Fund and are not able (or do not wish) to continue coverage, such as through COBRA or the Fund's various self-pay rules, you may want to consider contacting Access Health CT to explore your other health care options. The applicable website is www.accesshealthct.com, and the telephone number is 1-855-805-HEAL / 1-855-805-4325.

While the Fund complies with multiple laws, here are a few other federal laws we wanted you to know about:

Newborns' and Mothers' Health Protection Act of 1996

The Fund complies with this federal law by not restricting benefits for any hospital stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, this law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours if a cesarean section was

performed). In addition, the Fund does not require that a hospital or physician obtain authorization from the Fund for prescribing a length of stay that does not exceed those time periods.

Women's Health and Cancer Rights Act

The Fund also complies with this federal law. Specifically, in connection with an eligible individual who is receiving Fund benefits for a mastectomy, and who elects (in consultation with their physician) breast reconstruction in connection with the mastectomy, the Fund will treat the following as covered expenses:

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

Coverage of such items are subject to all normal Fund rules (Copayments, Deductibles, etc.).

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Fund is required to protect the confidentiality of your Protected Health Information (PHI) under HIPAA and the rules issued by the U.S. Department of Health and Human Services. PHI includes all individually identifiable health information transmitted or maintained by the Fund. You may request a complete description of your rights under the Fund's privacy policies and procedures (a "Privacy Notice") at the Fund Office, and it will be provided to you free of charge. Please be aware that a copy of the Fund's current Privacy Notice is included at the end of this SPD.

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

The Fund also follows the MHPAEA which prevents the Fund from imposing less favorable benefit limitations on mental health/substance abuse disorder benefits than on medical/surgical benefits. Under the MHPAEA, group health plans offering mental health/substance abuse benefits cannot set day/visit limits on mental health/substance abuse benefits that are lower than any such day or visit limits for medical/surgical benefits. Also, the Fund cannot impose Deductibles, Copayments, Coinsurance, and out of pocket expenses on mental health/substance abuse benefits that are more restrictive than Deductibles, Copayments, Coinsurance and out of pocket expenses applicable to other medical/surgical benefits.

Genetic Information Nondiscrimination Act (GINA)

The Fund complies with this federal law that prohibits discrimination based on genetic information. Under GINA, the Fund cannot request or require an individual to undergo genetic tests, and prohibits the Fund from collecting genetic information (including family medical history) prior to or in connection with enrollment. Genetic information does not include information about the sex or age of any individual.

COVID-19 Testing

As required by various federal laws, including the Coronavirus, Aid, Relief, and Economic Security Act of 2020 (CARES Act), the Fund will cover the full cost of the test and visit (done both in- and out-of-network) for the COVID-19 virus without cost sharing, prior authorization or medical management requirements, from March 18, 2020 through the end of the COVID-19 public health emergency. Please be aware that under guidance issued under the CARES Act, the Fund is not required to cover COVID-19 testing for public health surveillance or employment purposes (i.e., general workplace health and safety). Fund coverage of this test and visit is required to the extent that products or services relate to the furnishing or administration of covered testing, or relate to the evaluation of the individual to determine whether covered testing is needed. All other normal Fund rules continue to apply, including the fact that any Fund payment for the treatment of COVID-19, including but not limited to hospital, transportation and pharmacy services, will be covered in accordance with the terms and conditions set forth in this SPD and will still be subject to applicable cost-sharing, prior authorization and medical management requirements, as may be applicable.

Fund Coverage of the COVID-19 Vaccines

Pursuant to federal law, please be aware that the Fund will cover the cost of the COVID-19 vaccine and any charges for the administration of the COVID-19 vaccine, without any cost sharing to you (i.e., Deductibles, Coinsurance, or Copayments) for in-network providers. During the COVID-19 public health emergency as declared by the federal government, the Fund will also cover the full cost of the COVID-19 vaccine and the administration for out-of-network providers. Please note that when the COVID-19 public health emergency ends, which will be some future date, then normal Fund rules will apply if you receive the COVID-19 vaccine through an out-of-network provider.

FUND INFORMATION

1. Type and Administration of the Fund

The Fund is administered and maintained by a joint Board of Trustees consisting of an equal number of Union representatives and Employer representatives. The Board of Trustees employs staff for the routine administration of the Fund and can be contacted via the Fund Office. The Board of Trustees is governed by the Trust Agreement established and maintained in accordance with a Collective Bargaining Agreement.

2. Name and Address of the Fund

Effective on and after January 1, 2022 the Fund Office will be located at:
Iron Workers' Locals No. 15 and 424 Extended Benefit Fund
162 West Street, Building 2, Suite J
Cromwell, CT 06416

Telephone: (203) 238-1204

Employer Identification Number (assigned by the Internal Revenue Service): 06-6078910

Plan Number: In conjunction with the Employer Identification Number, Plan number is 501.

3. Contributing Employers

You may make a written request to the Fund Office for information as to whether a particular Employer or Employee organization is a Contributing Employer with respect to the Fund and, if so, you may request the address of that Contributing Employer. You may also obtain a complete list of the Employers and Employee organizations sponsoring the Plan upon written request to the Fund Office. Such information is available for examination at the Fund Office.

4. Collective Bargaining Agreement

The Fund is maintained pursuant to Collective Bargaining Agreements with Iron Workers' Locals No. 15 and 424 and participation agreements between the Fund and certain Employers.

Each Collective Bargaining Agreement or participation agreement states the rate of Employer contributions to the Fund (or otherwise references the applicable rate under the Collective Bargaining Agreement) and areas of work for which contributions are payable and certain other terms governing contributions. A copy of the Collective Bargaining Agreement may be obtained upon written request to the Board of Trustees and is available for examination at the Fund Office.

5. The Type of Fund

The Fund generally provides all health benefits (for example, medical benefits, prescription drug benefits, vision and dental benefits, etc.) on a "self-insured" basis to eligible Active Members,

Retired Members, and, as may be applicable, their Eligible Dependents. Specific Fund benefits, including the Life Insurance and Accidental Death and Dismemberment benefits are provided by the Fund on an insured basis. The Fund also has purchased a policy of stop loss insurance to protect it against catastrophic claims. The Fund's Trustees may hire administrative service providers, such as Anthem, Davis Vision and others to process, review and pay your claim for benefits on the Fund's behalf.

6. Source of Contributions to the Fund and Identification of any Organizations through which Benefits are Provided

Contributions to the Fund are made by individual Contributing Employers at the rates established by the applicable Collective Bargaining Agreement or participation agreement. The Fund will also receive COBRA or other permitted self-payments under Fund rules from individuals who have had their Fund coverage terminate, and certain retired individuals covered by the Fund pay a portion of the cost of their coverage, generally through an assignment of retirement benefits paid pursuant to the Iron Workers' Locals No. 15 and 424 Pension Fund. Such contributions and self-payments are received and held in trust by the Trustees. Contact the Fund Office for a listing of the Fund's Contributing Employers.

7. Trust Fund

All assets are held in trust by the Board of Trustees for the purpose of providing benefits to eligible individuals and defraying reasonable administrative expenses. The Fund's assets are managed by professional asset managers selected by the Board of Trustees in conjunction with recommendations from the Fund's investment consultant.

8. Names and Addresses of the Board of Trustees:

UNION TRUSTEES	EMPLOYER TRUSTEES
Mr. Mark J. Buono Iron Workers Local No. 424 15 Bernhard Road North Haven, CT 06473	Richard Fitzgerald Field Operations Manager Blakeslee Prestress, Inc. Rte. 139/McDermott Road P. O. Box 510 Branford, CT 06405
Mr. Trevor W. Danburg Iron Workers Local No. 15 49 Locust Street Hartford, CT 06114	David Hunt (Co-Chairman) Berlin Steel Construction Company P.O. Box 428 76 Depot Street Berlin, CT 06037
Mr. James J. Denning (Co-Chairman) Iron Workers Local No. 15 49 Locust Street Hartford, CT 06114	Lowell Kahn The Hartland Building & Restoration Co. Inc. P.O. Box 614 East Granby, CT 06026

Mr. Joseph D. Sorensen Iron Workers Local No. 424 15 Bernhard Road North Haven, CT 06473	Michael J. O'Sullivan Berlin Steel Construction Company P.O. Box 428 76 Depot Street Berlin, CT 06037

The right is reserved in the Plan for the Board of Trustees, as Plan Administrator, to terminate, suspend, withdraw, amend, or modify the Plan in whole or in part at any time.

9. Name and Address of the Person Designated as Agent for the Service of Legal Process.

If for any reason you wish to seek legal action, you may serve legal process upon:

Fund Manager
Iron Workers' Locals No. 15 and 424 Extended Benefit Fund
162 West Street, Building 2, Suite J
Cromwell, CT 06416

In addition, legal process may be served upon any Board of Trustee member at the addresses listed above.

10. Plan Year

The financial records of the Plan are kept on the basis of a fiscal year, which begins on July 1st and ends on the following June 30th.

11. Appeal Procedure

If an Eligible Individual is denied any benefits under the Fund, in whole or in part, as specified in Section 503 of the Employee Retirement Income Security Act (ERISA), remedies are available and are set forth in the Claim Filing and Appeal Procedures section appearing earlier in this SPD.

12. Procedure for Obtaining Additional Plan Documents

If you wish to inspect or receive copies of additional documents relating to the Plan, you may contact the Fund Office. You may be charged a reasonable fee to cover the copying cost of any materials you wish to receive.

13. Selection of Physicians and Facilities

The Fund utilizes the Anthem provider network for hospital and medical services along with adjudicating claim payments. The Fund does not provide hospital or medical services. Accordingly, the Fund is not responsible for any acts or omissions by hospitals or other facilities, or by physicians, other medical professional or any facility staff member or employee thereof.

14. No Liability for the Practice of Medicine

The Fund, Trustees or any of their designees are not engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided to be delivered to you by any Physician or other provider. Therefore, neither the Fund, Trustee or any of their designees, will have liability whatsoever for any loss or Injury caused to you by any physician or provider by reason of negligence, by failure to provide care or treatment, or otherwise.

STATEMENT OF RIGHTS UNDER ERISA

This statement of your rights under ERISA is required by federal law and regulation. As a participant in the Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (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 Fund Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and CBAs, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Fund Office, copies of documents governing the operation of the Plan, including insurance contracts and CBAs, and copies of the latest annual report (Form 5500 Series) and updated SPDs. The Fund may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Fund Office is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage
You have the right to continue health care coverage for yourself or your Eligible Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Eligible Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

ERISA regulations previously required the Fund to discuss the possibility of exclusionary periods of coverage for preexisting conditions under a group health plan in this section, but based on current law (the Patient Protection and Affordable Care Act), such preexisting condition exclusions are no longer permitted.

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 an employee benefit plan. The people who operate your Plan are referred to as "fiduciaries". They have a duty to act prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within

30 days, you may file suit in a federal court. In such a case, the court may require the Fund Office to provide the materials and pay you up to $110 a day (subject to any applicable U.S. Department of Labor inflationary adjustments) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Fund Office.

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. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a Medical Child Support Order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

However, in all cases including those described in the above paragraph, you must first exhaust your administrative remedies under the Plan before you may file suit in any court.

Assistance with Your Questions

If you have any questions about your Plan (for example, any questions about the processing of your claims, or allowances considered by the Plan, covered expenses, or questions regarding your eligibility), you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Office, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory, or write to the EBSA's Office Assistance:

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

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the EBSA's Toll-Free Employee & Employer Hotline at (866) 444-EBSA (3272) or visit the EBSA website at www.dol.gov/ebsa.

DEFINITIONS

These are some of the terms used in this SPD. PLEASE READ THESE TERMS CAREFULLY. They may help you better understand your benefits.

Active Member or Member means a person eligible for benefits from the Extended Benefit Plan under the Active Member eligibility provisions.

Active Plan means the plan of benefits for Active Members.

Agreement and Declaration of Trust or Trust Agreement means the document entitled "Agreement and Declaration of Trust, Iron Workers' Locals No. 15 and 424 Extended Benefit Plan Trust Fund" under which this Plan is established and governed, and any amendments thereto.

Beneficiary means a person named to receive life insurance benefits and/or accidental death and dismemberment benefits in the event of death under this Fund because of that person's designation for such benefits by an Active Member or, if applicable, a Retired Member on a properly completed and timely submitted form.

Child means, in addition to a biological or lawfully adopted child, any stepchild or foster child of an Active Member or Retired Member. A child is a lawfully adopted "Child" if he or she is legally adopted or lawfully placed with the Active Member or Retired Member, or with the Active Member's Spouse, or a Retired Member's Spouse, as applicable, for legal adoption.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, which is a federal law that established, among other things, the continuation coverage rules for group health plans that are regulated by ERISA.

Coinsurance means the costs of a covered health care service, calculated as a percentage (for example, 20%) of the Maximum Allowed Amount for that service. For example, if the Fund's Maximum Allowed Amount for an office visit is $100 and you've met your Deductible already for the calendar year, a Coinsurance payment of 20% (which you would have to pay) would be $20. The Fund pays the rest of the allowed amount, which would be $80 in this example.

Collective Bargaining Agreement means any written agreement now or hereafter in effect between a Contributing Employer and a Local Union, which describes the terms and conditions of work in the jurisdiction of the Local Union and under which the Contributing Employer is required to make contributions to the Fund, including any extensions or renewals thereof.

Contributing Employer or Employer means any person, firm, corporation, or other entity who or which employs members of a Local Union or other employees and is obligated by a Collective Bargaining Agreement to make contributions to the Fund on behalf of such members or other employees. The term will also include each Local Union and, subject to the approval of the Trustees, any employee benefit fund or other entity that is obligated to contribute on behalf of its employees pursuant to a Participation Agreement with the Fund.

Copayment means the fixed amount you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Covered Employment means employment with a Contributing Employer in a category of work covered by a Collective Bargaining Agreement or Participation Agreement under which the Contributing Employer was or is obligated to make contributions to the Fund on behalf of its Employees.

Deductible means the amount you will owe during a calendar year for covered health care services before the Fund begins to pay anything. An overall Deductible applies to all, or almost all, covered items and services. For example, if your Fund Deductible is $500, the Fund won't pay anything until you've met your $500 Deductible for covered health care services. The Fund has two types of Deductibles - individual and family.

- Individual Deductible: If you are the only person covered by the Fund then the individual Deductible applies.

- Family Deductible: If the Fund covers you and other family members, then both types of Deductibles may apply to you. When a covered iron worker or a covered family member has a health care expense, the money he or she pays towards his or her individual Deductible is also credited towards the family Deductible. There are two ways Fund coverage can apply, at which point the Fund will begin paying towards the covered health care expenses of a specific iron worker / covered family member: (1) The specific iron worker / covered family member has had enough personal health care expenses in the calendar year such that he or she has met the individual Deductible. In this case, the Fund begins paying for this covered iron worker's / family member's covered health care expenses, but not the expenses of other family members (unless it is a service that is covered before the Deductible, such as certain preventive care) OR (2) The iron worker and other covered family members have each paid enough in individual Deductibles in the calendar year that, when considering all of those individual Deductibles together, the family Deductible has been met. In this case, the Fund begins paying the covered health care expenses for all of the Eligible Individuals in the family, even though there may be one or more Eligible Individuals in the family that haven't paid their full individual Deductible.

Dentist means an individual licensed by the state in which the service is provided, to practice the prevention, diagnosis and treatment of diseases, Injuries and malformations of the teeth, gums, jaws and mouth.

Eligible Dependent means a Spouse or Child meeting the Plan's eligibility requirements.

Eligible Individual means an Active Member and/or his or her Eligible Dependents, and a Retired Member and/or his or her Eligible Dependents.

ERISA means the Employee Retirement Income Security Act of 1974, as it may be amended from time to time, and all regulations and rulings issued pursuant thereto.

Experimental or Investigational. A medical procedure will be deemed "experimental" or "investigational":

- If the medical procedure has not received final approval or endorsement of the American Medical Association (AMA), U.S. Food and Drug Administration (FDA), the National Institute of Health (NIH) or other appropriate governmental regulatory body at the time such medical procedure was furnished; or
- If a written informed consent form for the medical procedure being studied has been reviewed and/or has been approved or is required by the treating facility's institutional review board, or other body serving a similar function or if federal law requires such review and approval; or
- If the medical procedure is the subject of a protocol, protocols or clinical trial study, or is otherwise under study in determining its maximum tolerated toxicity dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

Further, a medical procedure may be deemed experimental or investigational based upon:

- Published reports and articles in the authoritative medical, scientific and peer review literature; or
- The written protocol or protocols used by the treating facility or by another facility studying substantially the same medical procedure; or
- The written informed consent used by the treating facility or by another facility studying substantially the same medical procedure.

Notwithstanding the above, a medical procedure will not be considered Experimental or Investigational if such medical procedure has successfully completed a Phase III clinical trial of the FDA for the Illness or Injury being treated, or the diagnosis for which such medical procedure is prescribed. In addition, charges for services and supplies incurred in connection with the routine treatment of an eligible individual in a cancer clinical trial will not be considered Experimental or Investigational. In making determinations of "Experimental or Investigational Procedures," the Trustees may rely on the advice of the Fund's medical and/or dental consultant, or other professionals.

Fund means the Iron Workers' Locals No. 15 and 424 Extended Benefit Fund as established by the Trust Agreement.

Fund Office means the office from which this Plan is administered.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended, which is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.

Illness means any sickness, disorder, or disease that is not employment-related.

Injury means physical damage to you or your Eligible Dependent's body caused by purely accidental means, independent of all other causes. Only Injuries that are not employment-related

are considered for benefits under this Plan, except under the life insurance and accidental death and dismemberment benefits.

Local Union or Union means Local Union No. 15 and/or Local Union No. 424 of the International Association of Bridge, Structural, Ornamental and Reinforcing Iron Workers.

Maximum Allowed Amount means the most the Plan will allow for a covered service.

Medically Necessary means that the services, supplies, treatment and/or confinement are generally recognized in the Physician's profession as effective and essential for treatment of the Injury or Illness for which it is ordered; and that the services are rendered at the appropriate level of care in the most appropriate setting based on diagnosis.

To be considered "Medically Necessary," the care must be based on generally recognized and accepted standards of medical practice in the United States, and it must be the type of care that could not have been omitted without an adverse effect on the patient's condition or the quality of medical care. In addition, services, treatment, supplies or confinement will not be considered "Medically Necessary" if they are "Experimental", or "Investigational", or primarily limited to research in their application to the Injury or Illness; or if primarily for scholastic, educational, vocational or developmental training; or if primarily for the comfort, convenience or administrative ease of the provider or the patient or his or her family or caretaker.

The Fund and/or Anthem reserves the right to review medical care and make a determination as to whether the services, treatment, supplies, confinement, or portion of a confinement, is or is not Medically Necessary. The Fund and/or Anthem may rely on its medical review department or an independent reviewer for this determination. The fact that a Physician or any other health care provider orders or recommends services, treatments, supplies or confinement does not, of itself, make them Medically Necessary.

Medicare means the health insurance program set forth in Parts A and B, Title XVIII of the Social Security Act of 1965, as amended.

Non-Covered Employment means employment in the iron working trade or craft in the United States of America or Canada for an Employer that is not signatory to a Collective Bargaining Agreement (as that term is used in federal labor law) with respect to that work. "Non-Covered Employment" also means acting as an officer, director, or supervisor of, or being an owner of an interest in, such an Employer, and includes any self-employment, whether as a partner, proprietor, or otherwise, in the iron working trade or craft.

Out of Pocket Maximum means the most you have to pay for covered services in a calendar year. After you spend this amount on Deductibles, Copayments, and Coinsurance, the Fund will pay 100% of the costs of covered benefits. Please be aware that the out of pocket maximum does not include anything you spend for services that the Fund does not cover, including amounts over the Maximum Allowed Amount.

- Individual Out of Pocket Maximum: If you are the only person on your plan, then the individual Out-of-Pocket Limit applies.

- Family Out of Pocket Maximum: If your plan includes you and other family members, then both types of Out-of-Pocket Limits may apply to you. When anyone on the plan has a health care expense, the money you pay towards the Out-of-Pocket Limit is credited to both the individual and family Out-of-Pocket Limits. The Out-of-Pocket Limit is considered satisfied for any one member when he or she satisfies his or her individual Out-of-Pocket. The Out-of-Pocket Limit is considered satisfied for the family when the amounts collectively paid by everyone in the family meets the family Out-of-Pocket Limit. Together each family member may contribute to the family Out-of-Pocket Limit, but no family member will contribute more than their individual Out-of-Pocket Limit, and other family members may not need to contribute at all towards the Out-of-Pocket Limit.

Participation Agreement means a written agreement between the Trustees and a Local Union, an employee benefit fund, Contributing Employer or other entity, which sets forth the terms under which the Local Union, employee benefit fund, Contributing Employer or other entity is obligated to contribute to the Fund on behalf of its respective employees.

Physician means, with respect to any particular medical care and services, any holder of a validly issued certificate or license authorizing such holder or licensee to perform the particular medical or surgical services.

Plan means the Iron Workers' Locals No. 15 and 424 Extended Benefit Plan, together with any subsequent amendments.

Plan Year means the period of 12 consecutive months beginning on each July 1st of a calendar year and ending on June 30th of the immediately following calendar year.

Protected Health Information or PHI means all individually identifiable health information relating to an Eligible Individual's past, present or future physical or mental health condition or to payment for health care. Under HIPAA, PHI includes information maintained by the Fund in oral, written or electronic form. The Fund safeguards the PHI of individuals in accordance with the requirements of HIPAA.

Reasonable and Customary means the usual charge made by a person, a group, or an entity, which renders or furnishes the services, treatments, or supplies that are covered under this Plan. A charge is considered to be "Reasonable and Customary" if it is shown to be Medically Necessary and it does not exceed the prevailing level of charges being made by other service providers in the geographical area where the service was performed. In determining whether charges are Reasonable and Customary, due consideration will be given to the nature and severity of the condition being treated and any complications or unusual circumstances which require additional time, skill or experience.

Retired Member means an individual eligible for benefits from the Fund under the Retired Member eligibility provisions, which include the Retirees Ages 58 to 65 Plan and the Medicare Advantage Plan described earlier in this SPD.

Spouse means the individual to whom an Active Member or Retired Member is legally married pursuant to the laws of the State of Connecticut (or that is recognized as a valid marriage under Connecticut law if the Active Member or Retired Member was married outside of Connecticut), to the last day of the month in which divorce, dissolution of marriage, annulment or legal separation is obtained. Please be aware that the Fund does not recognize Domestic Partnerships, so-called "Common Law" marriages or other similar relationships.

Termination for Cause means when an Active Member, Retired Member, or Eligible Dependent, including an individual on COBRA Continuation Coverage, loses eligibility for benefits, because he or she: (i) is convicted of a crime against the Fund, another employee benefit fund, a Local Union or any Contributing Employer, or any of their respective officers, directors, trustees, employees or agents; (ii) makes, gives, or causes to be made or given, directly or indirectly, any false or misleading statement which the Trustees determine was made or given knowingly and for the purpose of inducing the Fund to make a person eligible for a benefit that the person would not otherwise have been eligible to receive; or (iii) engages in any Non-Covered Employment.

Trustees or Board of Trustees means the Board of Trustees as established and constituted from time to time under the provisions of the Fund's Agreement and Declaration of Trust.

Workers' Compensation means medical benefits and any other benefit provided to an individual by his employer pursuant to any state or federal law requiring compensation for work-related injuries.

Iron Workers' Locals No. 15 and 424 Extended Benefit Fund

Notice of the Fund's Privacy Practices

2021 Restatement

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

Section 1: Purpose of This Notice and Effective Date

Effective date. This Notice was initially effective as of April 14, 2003. It was then restated effective as of September 23, 2013, to reflect a number of recent changes in a federal law known as the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA). This is the 2021 Restatement and is effective as of November 1, 2021.

This Notice is required by law. The Iron Workers' Locals No. 15 and 424 Extended Benefit Fund (Fund) is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- The Fund's uses and disclosures of Protected Health Information or "PHI," defined in Section 2,
- Your rights to privacy with respect to your PHI,
- The Fund's duties with respect to your PHI,
- Your right to file a complaint with the Fund and with the Secretary of the United States Department of Health and Human Services (HHS), and
- The person or office you should contact for further information about the Fund's privacy practices.

Section 2: Your Protected Health Information

A. Protected Health Information Defined

The term "Protected Health Information" or "PHI" includes all individually identifiable health information relating to your past, present or future physical or mental health condition or to payment for health care. PHI includes information maintained by the Fund in oral, written, or electronic form.

B. When the Fund May Disclose Your PHI

Under the law, the Fund may disclose your PHI without your consent or authorization, and without providing you an opportunity to agree or object, in the following cases:

- ***For treatment, payment or health care operations.*** The Fund and its business associates will use PHI in order to carry out your treatment, the payment of your benefits, or its health care operations:
  - → **Treatment** is the provision, coordination, or management of health care and related services. It also includes consultations and referrals between one or more of your providers.
    - For example, your doctor or hospital may contact the Fund's utilization review company to request required pre-certification of your in-patient hospital stay.
  - → **Payment** includes actions to make coverage determinations and payment (including billing, claims management, reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations).

- For example, the Fund may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Fund. If we contract with third parties to help us with these operations, such as companies that administer health plans or reprice claims to take advantage of discounts (e.g., Anthem), we will also disclose information to them. These third parties are known as "business associates."

→ **Health care operations** includes quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other activities relating to creating or renewing insurance contracts. Please note that if the Fund uses or discloses PHI for underwriting purposes, it is prohibited from using or disclosing PHI that is genetic information of an individual for such purposes. Health care operations also includes disease management, case management, conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

- For example, the Fund may use information about your claims to refer you into a disease management program, to refer your spouse to a well-pregnancy program, or to project future benefit costs or audit the accuracy of its claims processing functions. In no event will the Fund use or disclose any of your genetic information.

- ***Disclosure to the Fund's Trustees.*** The Fund will also disclose PHI to the Board of Trustees of the Fund for purposes related to treatment, payment, and health care operations, and the Board of Trustees has amended the Fund's Trust Agreement to permit this use and disclosure as required by federal law.
  - For example, the Fund may disclose information to the Board of Trustees to allow them to consider or decide an appeal or review a reimbursement matter.
- ***When required by applicable law.*** The Fund will disclose PHI when required to do so by any federal, state or local law.
- ***Public health purposes.*** The Fund will disclose PHI to an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law. In addition, PHI may be disclosed to an appropriate government agency authorized to receive reports of child abuse or neglect.
- ***Domestic violence or abuse situations.*** The Fund will disclose PHI when authorized by law to report to public authorities information about abuse, neglect or domestic violence if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence and the Fund believes the disclosure is necessary to prevent serious harm to you or other potential victims. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless that disclosure would cause a risk of serious harm.
- ***Health oversight activities.*** The Fund will disclose PHI to a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against health care providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to the Departments of Labor or Health and Human Services).
- ***Legal proceedings.*** The Fund will disclose PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request that is accompanied by a court order.
- ***Law enforcement health purposes.*** The Fund will disclose PHI when required for law enforcement purposes (for example, to report certain types of wounds).

- ***Law enforcement emergency purposes.*** The Fund will disclose PHI for certain law enforcement purposes, including:
  → identifying or locating a suspect, fugitive, material witness or missing person, and
  → disclosing information about an individual who is or is suspected to be a victim of a crime.
- ***Determining cause of death and organ donation.*** We may give PHI to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties. We may also disclose PHI for cadaveric organ, eye or tissue donation purposes.
- ***Funeral purposes.*** The Fund may give PHI to funeral directors as necessary to carry out their duties with respect to the decedent.
- ***Research.*** The Fund will disclose PHI for research, provided certain strict conditions are met.
- ***Health or safety threats.*** The Fund will disclose PHI when, consistent with applicable law and standards of ethical conduct, the Fund in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- ***Workers' compensation programs.*** The Fund will disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

C. When the Disclosure of Your PHI Requires Your Written Authorization

Except as otherwise indicated in this Notice, uses and disclosures will be made only with your written authorization subject to your right to revoke your authorization. You may make a written revocation of your authorization on a prospective basis at any time. Here are a few examples:

- ***Disclosure to Other Benefit Funds.*** On certain occasions, the Iron Workers' Locals No. 15 and 424 Pension Fund (Pension Fund) may need to receive information from this Fund, for example if you are determined to be disabled by the Social Security Administration. In those cases, we will request an authorization from you to release such information in order to enable the Pension Fund to process your application for benefits.
- ***Psychotherapy notes*** are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment or medications prescribed to you. Although the Fund does not routinely obtain psychotherapy notes, it must generally obtain your written authorization before the Fund will use or disclose psychotherapy notes about you other than for treatment, payment or health care operations. However, the Fund may use and disclose such notes when needed by the Fund to defend itself against litigation filed by you.
- ***Marketing purposes.*** The Fund will request authorization for any use or disclosure of PHI for marketing, except in situations involving a face to face communication or a promotional gift of nominal value. The Fund is not in the business of marketing PHI, and does not expect to do so in the future.
- ***Sale of PHI.*** The Fund will request authorization for any disclosure of PHI which constitutes a sale of PHI. The Fund is not in the business of selling PHI, and does not expect to do so in the future.

D. Use or Disclosure of Your PHI That Requires You Be Given an Opportunity to Agree or Disagree Before the Use or Release

- Disclosure of your PHI to family members, other relatives and your close personal friends is allowed under federal law if:
  → The information is directly relevant to the family or friend's involvement with your care or payment for that care, and

→ You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

- You should note that under certain circumstances described earlier, federal law allows the use and disclosure of your PHI without your consent, authorization or opportunity to object to such use or disclosure.
- The Fund has never engaged in any type of fundraising activities. In the unlikely event the Fund engages in fundraising in the future, any fundraising communications you receive will contain a description of how to opt out of receiving such communications.

Section 3: Your Individual Privacy Rights

The following discussion is a description of your individual privacy rights. It is important to note that while all requests should be directed to the Fund, the Fund contracts with numerous vendors, also called "business associates," who provide services to the Fund and services and benefits to you on the Fund's behalf. Once the Fund is notified that you choose to invoke any of the individual rights listed below, it will respond or notify the appropriate vendor, as applicable, on your behalf. Because some of your PHI is maintained and used by these business associates to provide or process your benefits, the Fund requires that they administer certain aspects of the individual privacy rights.

To exercise any of the following rights, you must contact the Privacy Official, whose contact information is located in Section 6, to receive the appropriate form which you must complete in full and submit to the Privacy Official.

A. You May Request Restrictions on PHI Uses and Disclosures

You may request the Fund to:

- Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or
- Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Fund, however, is not required to agree to your request.

B. You May Request Confidential Communications

The Fund will accommodate an individual's reasonable request to receive communications of PHI **by alternative means or at alternative locations** where the request includes a statement that disclosure could endanger the individual. You will have to indicate the requested alternative means and/or locations on the form you request from and submit to the Privacy Official.

C. You May Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set" (defined below), as long as the Fund maintains the PHI. However, you do not have a right to inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; or PHI that is subject to law(s) that otherwise prohibits access to PHI. The Fund must provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Fund is unable to comply with the deadline. You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. A reasonable fee may be charged.

Under limited circumstances, access may be denied. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a

description of how you may exercise your review rights and a description of how you may complain to the Fund and the HHS.

The term "designated record set" includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

D. You Have the Right to Amend Your PHI

You have the right to request that the Fund amend your PHI or a record about you in a designated record set for as long as the PHI is maintained by the Fund in the designated record set subject to certain exceptions.

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

E. You Have the Right to Receive an Accounting of the Fund's PHI Disclosures

At your request, the Fund will also provide you with an accounting of certain disclosures by the Fund of your PHI. We do not have to provide you with an accounting of disclosures related to treatment, payment, or health care operations, or disclosures made to you or authorized by you in writing.

The Fund has 60 days to provide the accounting. The Fund is allowed a single 30-day extension if the Fund gives you a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Fund may charge a reasonable, cost-based fee for each subsequent accounting.

F. Your Right to a Paper Copy of this Notice

You have a right to request and receive a paper copy of this Notice at any time, even if you have received the Notice previously or agreed to receive the Notice electronically. Your request to receive a paper copy of the Notice must be made in writing to the Privacy Official, whose contact information is in Section 6.

G. Your Personal Representative

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed and approved Appointment of Personal Representative form which you may obtain from the Privacy Official.

The Fund retains the right to deny access to your PHI to a personal representative in the following situation. If the Fund has a reasonable belief that: (1) you have been or may be subjected to domestic abuse, violence or neglect by such person or treating such person as your personal representative could endanger you, and (2) the Fund, in its exercise of professional judgment, decides that it is not in your best interest to treat the individual as your representative.

The Fund will recognize certain individuals as personal representatives without you having to complete an Appointment of Personal Representative form. For example, absent notice of any restrictions to the contrary, the Fund will automatically consider a spouse to be the personal representative of an individual covered by the Fund. In addition, the Fund will consider a parent, guardian or other person acting *in loco parentis* as the personal representative of an unemancipated minor unless applicable law requires otherwise. A spouse or a minor's parent may act on an individual's behalf, including requesting access to his or her PHI. Spouses and unemancipated minors may, however, request that the Fund restrict access of PHI to family members as described in Section 3, A of this Notice.

If you have any questions about the circumstance under which the Fund will automatically consider an individual to be your personal representative, contact the Privacy Official and ask for a copy of the Fund's Policy and Procedure for the Recognition of Personal Representatives.

Section 4: The Fund's Duties

A. Maintaining Your Privacy; Providing You a Notice of its Privacy Practices

The Fund is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices with respect to PHI. The Fund is now required to notify you of anything that the law defines as a breach of your unsecured PHI, and you have a right to, and will receive, appropriate notifications in the event of any such breach.

This Notice was initially effective on April 14, 2003, restated effective as of September 23, 2013, and is further restated as of November 1, 2021. The Fund is required to comply with the terms of this Notice. However, the Fund reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Fund prior to the effective date of this Notice. If a privacy practice is changed, a revised version of this Notice will be provided to you and to all past and present participants and beneficiaries for whom the Fund still maintains PHI. Any revised Notice of Privacy Practices will be sent by U.S. Mail, and it will be distributed within 60 days of the effective date of any material change to: (1) the uses or disclosures of PHI, (2) your individual rights, (3) the duties of the Fund, or (4) other privacy practices stated in this Notice.

B. Disclosing Only the Minimum Necessary PHI

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

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Uses or disclosures made pursuant to your authorization,
- Disclosures made to the Secretary of the United States Department of Health and Human Services pursuant to its enforcement activities under HIPAA,
- Uses or disclosures required by law, and
- Uses or disclosures required for the Fund's compliance with the HIPAA privacy regulations.

This Notice does not apply to information that has been de-identified. De-identified information is information that:

- Does not identify you, and
- Cannot reasonably be expected to identify you.

In addition, the Fund may use or disclose "summary health information" to the Fund's Board of Trustees for purposes of obtaining cost bids or modifying, amending or terminating the Fund's group health plan. Summary health information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the Fund's Board of Trustees has provided health benefits under the Fund's group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA.

Section 5: Your Right to File a Complaint with the Fund or the Office of Civil Rights

If you believe that your privacy rights have been violated, you may file a written complaint with the Fund in care of the Privacy Official at the address listed in Section 6, immediately below. You may also file a complaint with the Office of Civil Rights for Connecticut's Region, which as of the date this Notice was prepared was:

Region I
Peter Chan, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
Government Center
JFK Federal Building – Room 1875
Boston, MA 02203
PHONE: (800) 368-1019 or (800) 537-7697 (TDD)
FAX: (617) 565-3809

The Fund will not retaliate against you for filing a complaint.

Section 6: If You Need More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the following official at the Fund Office:

Privacy Official
Iron Workers' Locals No. 15 and 424 Extended Benefit Fund
162 West Street, Building 2, Suite J
Cromwell, CT 06416
PHONE: (203) 238-1204
FAX: (203) 639-0815

Section 7: Conclusion

As outlined in Section 1, PHI use and disclosure by the Fund is regulated by HIPAA, as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. You may find these rules at Parts 160 and 164 of Title 45 of the *Code of Federal Regulations*. This Notice attempts to summarize those regulations and notify you of your rights. The regulations will prevail if there is any discrepancy between the information in this Notice and the regulations.