WISCONSIN LABORERS' HEALTH FUND

PLAN DOCUMENT

Restated Effective September 1, 2016

Final – August 2017

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Statement of Grandfathered Status

The Board of Trustees believes that the Plan is a "grandfathered health plan" under the Affordable Care Act, which means that our Plan existed when the health care reform law was signed on March 23, 2010, and that we can preserve certain basic health coverage that was already in effect when the law was passed. However, as with all grandfathered health plans, we must still comply with certain consumer protections in the Affordable Care Act (for example, the elimination of the Plan's lifetime maximums). Consequently, because this Plan is "grandfathered" and not required to adopt other changes required by the Affordable Care Act, this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 866-444-3272 or www.dol.gov/ebsa/healthreform. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

ARTICLE 1 PURPOSE

Section 1.01 Purpose of the Plan

This Plan is adopted by the Trustees of the Wisconsin Laborers' Health Fund under the terms of the Agreement and Declaration of Trust in order to establish provisions that determine the Eligibility of Active Employees and Retired Employees for the benefits provided by the Wisconsin Laborers' Health Fund and to prescribe the amount, extent, conditions, and methods of payment of such benefits.

ARTICLE 2 DEFINITIONS

Section 2.01 Active Employee

A person who meets the requirements of Article 3 based on contributions made by the Employer or by self-contributions.

Section 2.02 Administrative Manager

The Administrative Manager means the person, firm, or corporation as described and defined in Section 5.08 of the Trust Agreement.

Section 2.03 Allowable Charge

Allowable Charge means:

(a) With respect to a network provider, the Allowable Charge is the negotiated fee/rate set forth in the agreement with the participating network health and/or dental provider, facility, or organization and the Plan.

(b) Effective July 1, 2017, with respect to an out-of-network provider, the Allowable Charge will be determined according to the Medicare Allowable Rate, defined at Section 2.28. The Plan will pay sixty-percent 60% of the Allowable Charge unless otherwise specified in the Plan. The Participant is responsible for any amount in excess of the Allowable Charge. A maximum of forty-percent (40%) of the Allowable Charge paid by the Participant will apply to the annual out-of-pocket maximum for out-of-network services.

(c) Prior to July 1, 2017, the Allowable Charge is defined as the amount most consistently charged by a licensed Physician or other professional provider for a given service and refers to a charge that is within the range of usual charges for a given service billed by most Physicians or other professional providers with similar training and experience in a given geographic area.

(d) Under no circumstances shall the Plan pay an Allowable Charge for out-of-network services or supplies that are determined by any provider, facility, or other person or organization other than the Board of Trustees.

Section 2.04 Ambulatory Medical-Surgical Facility

A freestanding ambulatory surgical center or a facility offering ambulatory medical services 24 hours a day, seven days a week, provided such facilities are not part of a Hospital and, further, provided such facilities have been reviewed and approved by the appropriate State Board of Health or similar agency to provide medical treatment.

Section 2.05 Certified Disability

A disability for which an Employee either draws Weekly Accident and Sickness Benefits through the Fund or submits evidence that he is drawing weekly Workers' Compensation benefits.

Section 2.06 Contributing Employer or Employer

A "Contributing Employer" or "Employer" is:

(a) Any person who, or firm, organization, corporation, or member of an organization or association that now or hereafter has a collective bargaining agreement with a local union requiring periodic contributions to the Health Fund.

(b) Any other Employer who, with the consent of the Trustees, shall make like payments or contributions to said Health Fund.

(c) The Union which, for the purpose of making the required contributions into the Trust Fund, shall be considered as the Employer of the Employees of the Union for whom the Union contributes to the Trust Fund.

(d) An Employer that does not meet the requirements of the definition of Employer as stated in subsections (a), (b) and (c) of this Section 2.06, but who is required to make payments or contributions to the Trust Fund:

(1) By any law or ordinance applicable to the State of Wisconsin or to any political subdivision or municipal corporation thereof; or

(2) Pursuant to any written agreement entered into by such Employer with such State or any political subdivision or municipal corporation thereof.

(e) Employers as described in this Section 2.06 shall, by the making of payments to the Trust Fund pursuant to such collective bargaining or other written agreements, be deemed to have accepted and be bound by the Trust Agreement.

Section 2.07 Cosmetic or Reconstructive Surgery

Any surgical procedure performed primarily:

(a) To improve physical appearance, or

(b) To change or restore bodily form without materially correcting a bodily malfunction, or

(c) To prevent or treat a mental or nervous disorder through a change in bodily form.

Section 2.08 Covered Work

Work performed by an Employee for an Employer under a written agreement requiring contributions to the Fund for such work.

Section 2.09 Custodial Care

Care, also known as long-term care, intended primarily to help a disabled person meet basic personal needs when:

(a) There is no plan of active medical treatment to reduce the disability, or

(b) The plan of active medical treatment cannot be reasonably expected to reduce the disability.

Section 2.10 Dentist

The term Dentist means, with respect to any particular dental care and services, any holder of a certificate or license issued by a governmental body authorizing such holder or licensee to perform the particular dental services. For purposes of this definition, Dentist includes oral surgeon.

Section 2.11 Dependent

(a) An individual who is included in at least one of the following categories:

(1) The Employee's or Retired Employee's spouse. If the spouse is also covered as an Employee under the Plan, each will be covered as both an Employee and as the Dependent of the other when coordinating benefits under the requirements of Article 14.

(2) The Employee's or Retired Employee's natural-born child, legally adopted child, child placed for adoption, stepchild, or foster child through the end of the month in which the child reaches age 26.

(3) The Employee's or Retired Employee's unmarried grandchild if the parent of the grandchild meets the definition of an eligible dependent child under the Plan, and if the parent of the grandchild is younger than age 18, and the grandchild has the same principal place of residence as the Employee or Retired Employee for more than one-half of the calendar year, is dependent on the Employee or Retired Employee for more than one-half of his or her support for the calendar year, and is a U.S. citizen or national.

(4) The Employee's or Retired Employee's child for whom the Employee or Retired Employee has legal guardianship if the child is younger than age 26, has the same principal place of residence as the Employee or Retired Employee for more than one-half of the calendar year, is dependent on the Employee or Retired Employee for more than one-half of his or her support for the calendar year, and is a U.S. citizen or national.

(5) The Employee's or Retired Employee's unmarried child who has reached age 26 and who is permanently and totally disabled (as defined in Internal Revenue Code Section 22(e)(3)) at any time during the calendar year, has the same principal place of residence as the Employee or Retired Employee for more than one-half of the calendar year, is dependent on the Employee or Retired Employee for more than one-half of his or her support during the calendar year, and is a U.S. citizen or national; provided such child became so disabled prior to attaining age 26. Such child must be unable to engage in any gainful activity because of a medically determinable physical or mental impairment that is expected to result in death or last for a continuous period of 12 months or more. An Employee or Retired Employee must provide proof of disability satisfactory to the Trustees no later than 31 days prior to the date such child's eligibility for benefits would otherwise cease and from time to time thereafter as requested by the Trustees.

(6) The Employee's or Retired Employee's unmarried grandchild who shares the same principal place of residence, child for whom the Employee or Retired Employee has legal guardianship, or unmarried disabled child who has reached age 26, provided that:

(B) The child's parents are (i) divorced or legally separated under a decree of divorce or separate maintenance; (ii) separated under a written separation agreement; or (iii) live apart at all times during the last six months of the calendar year;

(C) The child's parents provide over one-half of the child's support; and

(D) The child is in the custody of one or both of his or her parents for more than one-half of the calendar year, and is either a qualifying child or qualifying relative of one of the parents.

(7) The Employee's or Retired Employee's unmarried child who is named as an alternate recipient in a Qualified Medical Child Support Order (QMCSO) approved by the Trustees. Procedures for qualifying Medical Child Support Orders are available from the Fund Office to the eligible Participant and each alternate recipient, upon request, at no cost.

(b) A Domestic Partner must qualify as a Dependent under Section 152 of the Internal Revenue Code to avoid imputed income requirements. These requirements are addressed in Section 2.43.

Section 2.12 Diabetes Outpatient Self-Management Education Program

(a) A program of instruction that:

(1) Is provided by a Physician, a registered nurse, a licensed pharmacist, a dietician or other health professional;

(2) Is designed to teach diabetic patients and their families:

(A) To understand the diabetic disease process;

(B) To manage the daily diabetic therapy; and

(C) To avoid frequent hospital confinements and complications; and

(3) Meets any standards by which the state certifies or approves such programs.

(b) It does not include a program that is mainly for the purpose of weight reduction.

Section 2.13 Eligible or Eligibility

Being entitled to the benefits payable under the provisions of the Plan by virtue of having fulfilled the Eligibility requirements contained in Article 3.

Section 2.14 Emergency Care

(a) Emergency Care is medical care and treatment, including neo-natal care, provided after the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain, that are severe enough that the lack of immediate medical attention could reasonably be expected to result in: (1) the patient's health being placed in serious jeopardy; (2) bodily function being seriously impaired; or (3) serious dysfunction of a bodily organ or part.

(b) Emergency Care is dental care and treatment provided after the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain, that are severe enough that the lack of immediate medical attention could reasonably be expected to result in: (1) the patient's health being placed in serious jeopardy; (2) bodily function being seriously impaired; or (3) serious dysfunction of a bodily organ or part; such dental Emergency Care includes only events that require the patient to go to the Emergency Room on week nights, weekends or holidays.

(c) Emergency Care includes immediate mental health and/or substance abuse treatment when lack of the treatment could reasonably be expected to result in the patient harming himself/herself and/or other persons.

(d) All Emergency Care obtained by Participants will be processed as in-network benefits, regardless of the network status of the facility and attending Physician and are subject to coinsurance, the Emergency Room Deductible, and the Calendar Year Deductible as provided in the applicable Schedule of Benefits in Article 5.

Section 2.15 Employee

An Employee is:

(a) Any Employee represented by the Union and working for an Employer as defined herein, and with respect to whose employment an Employer is required to make contributions into the Trust Fund.

(b) An officer or Employee of the Union for whom the Union agrees in writing to contribute to the Trust Fund at the rate fixed for contributions for other Employers.

(c) An Employee of an Employer, as defined in subsection (d) of Section 2.06, on whose behalf such Employer is required to make payments or contributions to the Trust Fund as provided in subsection (d) of Section 2.06 and at the rate fixed for contributions for other Employers.

(d) An Employee of the Trust Fund, with respect to such an Employee, the Trustees shall be deemed to be an Employer within the meaning of the Trust Agreement and shall provide benefits for said Employee out of said Trust Fund, on the same basis as for other Employees.

(e) A person, represented by or under the jurisdiction of the Union, who shall be employed by a governmental unit or agency, and on whose behalf payment of contributions shall be made at the times and at the rate of payment equal to that paid by an Employer, defined in Section 2.06, in accordance with a written agreement, ordinance or resolution, or a person who had been so employed and who is temporarily making self-payments under rules established by the Trustees.

(f) Non-bargained Employees of the Union or Employer, as defined in subsections (a), (b), and (c) of Section 2.06 if:

(1) The Union or Employer has signed a Participation Agreement with the Fund and has applied for welfare coverage for all non-bargained Employees; and

(2) The Employee works 25 or more hours per week.

Such non-bargained Employees are subject to the Eligibility rules outlined in Sections 3.23, 3.24, 3.25 and 3.26.

(g) Alumni Employees employed by the Union or for an Employer that has signed a Participation Agreement with the Fund. All such Alumni Employees must be Employees of Employers who were previously covered by a collective bargaining agreement that provided for contributions to this Fund.

Such Alumni Employees are subject to the Eligibility rules outlined in Sections 3.27, 3.28, and 3.29.

Section 2.16 Expense

(a) The Expense incurred for a covered service or supply that has been ordered or prescribed by a Physician or Surgeon. An Expense is considered incurred on the date the service or supply is received.

(b) Expense does not include any charge:

(1) For a service or supply that is not Medically Necessary, or

(2) That is in excess of the Allowable Charge for a service or supply.

Section 2.17 Experimental or Investigative Treatments and Procedures

(a) A service, procedure, drug, device, or treatment modality for a specific diagnosis is experimental or investigative if:

(1) It has failed to obtain final approval for use of a specific service, procedure, drug, device, or treatment modality for a specific diagnosis from the appropriate governmental regulatory body;

(2) Reliable Evidence does not establish that which is a consensus conclusion among experts recognizing the safety and effectiveness of the specific service, procedure, drug, device or treatment modality on health outcomes for a specific diagnosis;

(3) The drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval;

(4) Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;

(5) Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

(b) Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature, the written protocol or protocols used by the treating facility or the protocols(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

(c) The Trustees shall have authority to determine, in their discretion, whether a service, procedure, drug, device, or treatment modality is experimental or investigative. The fact that a Physician has prescribed, ordered, recommended, or approved the service, procedure, drug, device or treatment does not, in itself, make it eligible for payment.

Section 2.18 Gender and Number

Except as the context may specifically require otherwise, use of the masculine gender shall be understood to include both masculine and feminine genders, use of words in the Plan may include the plural, or the plural may be used in the singular.

Section 2.19 Health Fund or Fund

The entire trust estate of Wisconsin Laborers' Health Fund as it may, from time to time, be constituted, including, but not limited to, policies of insurance, investments, and the income from any and all investments, Employers' contributions and any and all other assets, property or money received by or held by the Trustees for the uses and purposes of this Trust.

Section 2.20 Home Health Care

Home Health Care means the services and supplies defined under a Home Health Care Plan. Home Health Care must replace a needed Hospital stay, must be for the care or treatment of sick or injured persons, and must be furnished:

(a) By a Home Health Care Agency,

(b) In the Eligible Person's home, and

(c) In accordance with the Home Health Care Plan.

Section 2.21 Home Health Care Agency

A Home Health Care Agency means a home health care agency that:

(a) Has been certified under Title XVIII of the Social Security Act, or

(b) In the case of an institution in any state in which state or applicable local law provides for the licensing of institutions of this nature:

(1) Is licensed pursuant to such law; or

(2) Is approved by the agency of the state or locality responsible for licensing institutions of this nature as meeting the standards established for such licensing; and

(c) Is a state-certified rehabilitation agency.

Section 2.22 Home Health Care Plan

(a) A Home Health Care Plan means a program for care and treatment for an Eligible Person that has been established and approved in writing at least every two months by the attending Physician or Surgeon, unless the attending Physician or Surgeon determines:

(1) A longer interval between reviews is sufficient;

(2) The proper treatment of the Injury or Sickness would require confinement as a resident inpatient in a Hospital or Skilled Nursing Facility in the absence of the services and supplies provided as part of the Home Health Care Plan; and

(3) The necessary care and treatment are not available from the Eligible Person's immediate family or other persons residing with the Eligible Person without causing undue hardship.

(b) If the Eligible Person was hospitalized immediately prior to the commencement of Home Health Care, the Home Health Care Plan must also be initially approved by the Physician or Surgeon who was the primary provider of services during the hospitalization.

Section 2.23 Hospice Care Agency

A Hospice Care Agency means a licensed agency or organization that keeps a medical record of each patient that:

(a) Has hospice care available 24 hours a day, seven days a week;

(b) Provides skilled nursing services, medical social services and psychological and dietary counseling primarily in a home setting using a hospice team;

(c) Has a full-time administrator and at least one Physician, one registered nurse (RN), one licensed or certified social worker employed by the agency and one counselor.

(d) Has established policies governing the provision of hospice care.

Section 2.24 Hospice Care Program

(a) A Hospice Care Program means a written plan of hospice care that:

(1) Is established and periodically reviewed by a Physician attending the Terminally Ill Person or family member and appropriate personnel of a Hospice Care Agency.

(2) Is designed to provide palliative and supportive care to Terminally Ill Persons and supportive care to their families.

(3) Includes an assessment of the Terminally Ill Person's or family member's medical and social needs and a description of the care to be rendered to meet those needs.

(b) The Hospice Care Program may provide care and or services in the Terminally Ill Person's or family member's residence, licensed medical facility, or inpatient care in a hospice facility or Hospital.

Section 2.25 Hospital

(a) A place that is licensed as a Hospital (if licensing is required by law), that is operated for the care and treatment of resident inpatients and that has a laboratory, registered graduate nurses always on duty, and an operating room (or 24-hour access to an operating room and laboratory in an affiliated institution) where major surgical operations are performed by a legally qualified Physician or Surgeon. In no event shall a Hospital include a hospital or institution or that part of an institution that is used primarily as a clinic, convalescent home, rest home, nursing home, home for drug addicts or alcoholics, rehabilitation hospital, or inpatient rehabilitation center.

(b) For the purpose of paying benefits for mental or nervous disorders, Hospital also means a place that has accommodations for resident bed patients, facilities for the treatment of mental or nervous disorders, a resident psychiatrist always on duty, and, as a regular practice, charges the patient for the expense of confinement.

(c) For the purpose of paying benefits for the treatment of alcoholism, chemical dependency, or drug addiction (other than for Non-Residential Alcoholism, Chemical Dependency or Drug Addiction Treatment Benefits), Hospital also means a facility that provides a residential treatment program, as licensed by the appropriate State Agency, or Department of Human Services, pursuant to a diagnosis and upon the recommendation of a legally qualified Physician.

Section 2.26 Injury

Injury means a bodily injury that requires treatment by a Physician. It must result in loss independently of sickness and other causes.

Section 2.27 Medically Necessary or Medical Necessity

(a) For purposes of this Plan, to be Medically Necessary, or to be a Medical Necessity, the service or supply must:

(1) Be consistent with the symptoms, diagnosis, or treatment of the Eligible Person's Injury or Sickness;

(2) Be appropriate with regard to accepted standards of good medical practice, and recognized by an established medical society in the United States;

(3) Not be primarily for the patient's convenience or that of the Physician, other licensed health care practitioner, or the facility at which treatment is received;

(4) Not be an "Experimental or Investigative Treatment or Procedure" as defined by this Plan; and

(5) Be given as an inpatient only when the service cannot reasonable be provided on an outpatient basis.

(b) A medical service or supply is not considered Medically Necessary solely because it is ordered or approved by a Physician

Section 2.28 Medicare Allowable Rate

Medicare Allowable Rates are the rates established and periodically updated by the Centers for Medicare and Medicaid Services (CMS) for payment for services and supplies provided to Medicare enrollees. The claims administrator updates its systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate for a particular service, the rate will be based on the same method that CMS uses to set Medicare rates.

Effective July 1, 2017, for purposes of this Plan, all covered expenses obtained at an out-of-network facility will be paid according to the Medicare Allowable Rate. The maximum Allowable Charge payable by the Plan will be 120% of the Medicare Allowable Rate for the geographic area where the service is furnished.

Geographic area is generally defined by the first three digits of the U.S. Postal Service zip codes.

All covered expenses obtained at an out-of-network facility remain subject to all applicable coinsurance, copayments, and other limitations shown in the applicable Schedule of Benefits in Article 5.

Section 2.29 Mental Health Condition or Nervous Condition

A Mental Health Condition or a Nervous Condition is a mental disorder identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Section 2.30 Morbidly Obese, Morbid Obesity

(a) A Body Mass Index (BMI) equal to or greater than:

(1) 40; or

(2) 35 in conjunction with any of the following severe, diagnosed co-morbidities:

(A) Coronary heart disease;

(B) Type 2 diabetes mellitus;

(C) Clinically significant obstructive sleep apnea; and

(D) High blood pressure/hypertension (BP > 140 mmHg systolic and/or 90 mmHg diastolic).

(b) BMI is calculated by dividing an individual's weight (in pounds) by height (in inches) squared and then multiplying by a conversion factor of 703, or by using the Obesity Education Initiative Web site (www.nhlbisupport.com/bmi).

Section 2.31 Oral Surgery

The branch of dentistry concerned with operative procedures in and about the oral cavities and jaws.

Section 2.32 Participant

Any Employee or former Employee of an Employer who is or may become eligible to receive a benefit of any type from this Fund or whose beneficiaries may be eligible to receive such benefit.

Section 2.33 Person

An Active or Retired Employee or a Dependent(s) of an Active or Retired Employee.

Section 2.34 Physician or Surgeon

A person licensed to prescribe and administer all drugs and to perform all surgery or any other licensed practitioner, practicing within the scope of his or her license, performing services that would be payable under the Plan if performed by a Physician or Surgeon, including chiropodists, podiatrists, osteopaths, and certified dieticians. Dentists and oral surgeons are excluded from this definition (See Dentist, Section 2.10).

Section 2.35 Plan or Health Plan

This document, the Wisconsin Laborers' Health Fund, as adopted by the Trustees and as thereafter amended by the Trustees.

Section 2.36 Plan Year

The Plan Year is the fiscal year that runs from September 1 through August. However, benefits are determined on the basis of the calendar year.

Section 2.37 Qualified Medical Child Support Order (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is a court or administrative order, judgment or decree issued by a court of competent jurisdiction or administrative process pursuant to a state domestic relations law or community property law that creates or recognizes the right of an alternate recipient to receive benefits under the employer benefit plan of the child's parent and includes certain information relating to the Participant and the alternate recipient who is generally the child of the Employee recognized in such order.

Section 2.38 Retired Employee

A person who meets the requirements of Section 3.13.

Section 2.39 Self-contributions

Payments made to the Fund by an Active or Retired Employee or Dependent for the purpose of continuation of Eligibility for Plan benefits, subject to the provisions of Article 3.

Section 2.40 Sickness

Sickness means a disease, disorder, or condition that requires treatment by a Physician and includes pregnancy.

Section 2.41 Skilled Nursing Care Confinement

Confinement in a skilled nursing care facility:

(a) Upon a specific recommendation and under the general supervision of a legally qualified Physician or Surgeon,

(b) That must be recertified as Medically Necessary every seven days by the attending Physician or Surgeon,

(c) That must begin within 24 hours after discharge from required Hospital confinement for which room and board benefits are paid, and

(d) For the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the preceding Hospital confinement.

Section 2.42 Skilled Nursing Care Facility

An institution or the part of any institution that operates to provide convalescent or nursing care and:

(a) Is primarily engaged in providing to inpatients:

(1) Skilled Nursing Care and related services for patients who require medical or nursing care, or

(2) Rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(b) Has policies that are developed with the advice of (and with provisions for review of such policies from time to time by) a group of professional personnel, including one or more Physicians or Surgeons and one or more registered professional nurses, to govern the Skilled Nursing Care and related medical or other services it provides;

(c) Has a Physician or Surgeon, a registered professional nurse, or a medical staff responsible for the execution of such policies;

(d) Has a requirement that the health care of every patient be under the supervision of a Physician or Surgeon, and provides for having a Physician or Surgeon available to furnish necessary medical care in case of emergency;

(e) Maintains clinical records on all patients;

(f) Provides 24-hour nursing service that is sufficient to meet nursing needs in accordance with the policies developed as provided in subsection (b) of this Section, and has at least one registered professional nurse employed full time;

(g) Provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

(h) In the case of an institution in any state in which state or applicable local law provides for the licensing of institutions of this nature:

(1) Is licensed pursuant to such law; or

(2) Is approved by the agency of the state or locality responsible for licensing institutions of this nature as meeting the standards established for such licensing; and

(i) Meets any other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof.

Section 2.43 Spouse

Spouse means legal spouse. For purposes of benefits and rights under the Plan, with the exception of differences in tax treatment as required by law, a Domestic Partner of an Employee or a Retiree is treated as a Spouse. Opposite sex domestic partners are only entitled to these benefits and rights if the partnership is established in Dane or Milwaukee counties. For purposes of the Plan:

(a) A Domestic Partner is a person of the same sex or opposite sex (as specified above) and if the following requirements are met:

(1) Both the Employee or Retired Employee and Domestic Partner are of legal age to marry in the State in which the Employee or Retired Employee and Domestic Partner reside;

(2) The Employee or Retired Employee and Domestic Partner are not related to each other by blood to the extent that it would otherwise prohibit them from legally marrying in the State in which they reside;

(3) The Employee or Retired Employee and Domestic Partner have completed the State of Wisconsin, or if applicable, the Dane County Declaration Process for their domestic partnership, or have followed the procedures for registration of their domestic partnership in the State, city or county in which they reside;

(4) Neither the Employee (or Retired Employee) or Domestic Partner is legally married to anyone else or in another domestic partnership;

(5) The Employee or Retired Employee and Domestic Partner complete and the Employee or Retired Employee submits to the Plan as proof of the domestic partnership the State Declaration of Domestic Partnership. In addition, the Employee or Retired Employee must notify the Plan when the domestic partnership relationship ends.

(6) The Employee or Retired Employee agrees to pay the Employee or Retired Employee's portion of the Federal Insurance Contributions Act (FICA) tax or any other employment tax due because of the Plan's provision of benefits to the Domestic Partner.

(b) A Domestic Partner is treated in the same manner as a Spouse under this Plan and has the same rights as a Spouse under the Plan, except that:

(1) For a Domestic Partner who is not a dependent of the Employee or Retired Employee, as defined in Section 152 of the Internal Revenue Code, income will be imputed to the Employee for non-HRA benefits provided to such Domestic Partner; and

(2) A Domestic Partner who is not a dependent of the Employee or Retired Employee, as defined in Section 152 of the Internal Revenue Code, is not considered a spouse for purposes of Article 21, the Health Reimbursement Arrangement (HRA) Plan.

(c) Coverage of a Domestic Partner ends in accordance with Section 3.11(e) and Section 3.14.

(d) The Dependent children of a Domestic Partner shall be treated in the same manner as Dependent children of a Spouse of the Employee or Retired Employee under this Plan and have the same rights as Dependent children of a Spouse under the Plan, except that:

(1) For Dependent children of a Domestic Partner who are not dependents of the Employee or Retired Employee, as defined in Section 152 of the Internal Revenue Code, income will be imputed to the Employee for non-HRA benefits provided to such Dependent children of a Domestic Partner; and

(2) Dependent children of a Domestic Partner who are not dependents of the Employee or Retired Employee, as defined in Section 152 of the Internal Revenue Code, are not considered Dependent children of a spouse for purposes of Article 21, the Health Reimbursement Arrangement (HRA) Plan.

(e) If both spouses or both Domestic Partners are covered under the Plan as Employees or Retired Employees, their Eligible children will be covered as the Dependents of both parents when coordinating benefits under the requirements of Article 14.

Section 2.44 Subrogation/Reimbursement

Subrogation/Reimbursement means the Plan's right (as provided in Section 4.14) to recover Plan benefits from another party or a Person.

Section 2.45 Terminally Ill Person

Terminally Ill Person means a Person whose medical records indicate a life expectancy of six months or less.

Section 2.46 Trustees or Board of Trustees

The Trustees designated in the Trust Agreement, together with their successors designated and appointed in accordance with the terms of the Trust Agreement. The Trustees, collectively, shall be the administrator of this Plan as that term is used in the Employee Retirement Income Security Act (ERISA) of 1974, as amended.

Section 2.47 Uniformed Services

Uniformed Services means the United States Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

Section 2.48 Union

Any Wisconsin local union affiliated with the Laborers International Union of North America and Operative Plasterers' and Cement Masons' International Association Local No. 599, Areas 558 and 138.

ARTICLE 3 ELIGIBILITY

Section 3.01 Eligibility, In General

Employees will become Eligible for benefits if they perform Covered Work and sufficient contributions are made to the Fund in accordance with the provisions of this Article. In addition, in certain instances, Eligibility may be based on self-contributions as specified in this Article 3. Plan benefits are not vested and the Plan may be amended or terminated at any time in accordance with Section 4.17.

Section 3.02 Initial Employee Eligibility

An Employee will become Eligible for benefits on the first day of the first calendar month that follows any twelve-consecutive-calendar-month period in which such Employee has been credited with at least 600 hours of Covered Work. If an Employee has been credited with at least 600 hours of Covered Work in consecutive months prior to the completion of the full twelve-consecutive-calendar-month period, then an Employee will become Eligible on the first day of the first calendar month that follows the date on which the 600 hours of Covered Work are credited.

Section 3.03 Continuation of Employee Eligibility

(a) An Employee who meets the Eligibility requirements of Section 3.02 will continue to be Eligible for at least three calendar months. He will also continue to be Eligible for succeeding three-calendar-month intervals if he has performed the required hours of Covered Work in the Contribution Quarter(s) preceding the applicable Benefit Quarter, as outlined in subsection (b) through (e) below.

(b) An Employee will be Eligible for Plan benefits for the Benefit Quarter starting on January 1 and ending on March 31, if the Employee is credited with:

(1) 345 hours of Covered Work during the three-month period of August, September, and October; or

(2) 690 hours of Covered Work during the six-month period of May through October; or

(3) 1,035 hours of Covered Work during the nine-month period of February through October; or

(4) 1,380 hours of Covered Work during the twelve-month period of November through October.

(c) An Employee will be Eligible for Plan benefits for the Benefit Quarter starting on April 1 and ending on June 30, if the Employee is credited with:

(1) 345 hours of Covered Work during the three-month period of November, December, and January; or

(2) 690 hours of Covered Work during the six-month period of August through January; or

(3) 1,035 hours of Covered work during the nine-month period of May through January; or

(4) 1,380 hours of Covered Work during the twelve-month period of February through January.

(d) An Employee will be Eligible for Plan benefits for the Benefit Quarter starting on July 1 and ending on September 30, if the Employee is credited with:

(1) 345 hours of Covered Work during the three-month period of February, March, and April; or

(2) 690 hours of Covered Work during the six-month period of November through April; or

(3) 1,035 hours of Covered work during the nine-month period of August through April; or

(4) 1,380 hours of Covered Work during the twelve-month period of May through April.

(e) An Employee will be Eligible for Plan benefits for the Benefit Quarter starting on October 1 and ending on December 31, if the Employee is credited with:

(1) 345 hours of Covered Work during the three-month period of May, June, and July; or

(2) 690 hours of Covered Work during the six-month period of February through July; or

(3) 1,035 hours of Covered work during the nine-month period of November through July; or

(4) 1,380 hours of Covered Work during the twelve-month period of August through July.

Section 3.04 Termination of Employee Eligibility

An Employee's Eligibility for Plan benefits will terminate on one of the termination dates as follows:

(a) On December 31, unless the Employee was credited with:

(1) 345 hours of Covered Work during the three-month period of August, September, and October; or

(2) 690 hours of Covered Work during the six-month period of May through October; or

(3) 1,035 hours of Covered Work during the nine-month period of February through October; or

(4) 1,380 hours of Covered Work during the twelve-month period ending on October 31.

(b) On March 31, unless the Employee was credited with:

(1) 345 hours of Covered Work during the three-month period of November, December, and January; or

(2) 690 hours of Covered Work during the six-month period of August through January; or

(3) 1,035 hours of Covered Work during the nine-month period of May through January; or

(4) 1,380 hours of Covered Work during the twelve-month period ending on January 31.

(c) On June 30, unless the Employee was credited with:

(1) 345 hours of Covered Work during the three-month period of February, March, and April;

(2) 690 hours of Covered Work during the six-month period of November through April; or

(3) 1,035 hours of Covered Work during the nine-month period of August through April; or

(4) 1,380 hours of Covered Work during the twelve-month period ending on April 30.

(d) On September 30, unless the Employee was credited with:

(1) 345 hours of Covered Work during the three-month period of May, June, and July; or

(2) 690 hours of Covered Work during the six-month period of February through July; or

(3) 1,035 hours of Covered Work during the nine-month period of November through July; or

(4) 1,380 hours of Covered Work during the twelve-month period ending on July 31.

(e) In any event, on the date the Plan terminates.

Section 3.05 Reinstatement of Employee Eligibility

(a) An Employee whose Eligibility ceases because he has not fulfilled the hours of Covered Work requirements under Section 3.03 may be reinstated as an Eligible Employee if, within twelve consecutive months after the end of the Contribution Quarter prior to termination, he performs Covered Work of 345 hours or more during a period of twelve consecutive months or less. He will be so reinstated on the first day of the first calendar month that follows the period in which he performed the required number of hours of Covered Work.

(b) An Employee whose Eligibility ceases and who does not have the required hours of Covered Work in the twelve consecutive calendar months after the end of the Contribution Quarter prior to termination, may again become Eligible upon meeting the "Initial Employee Eligibility" requirements of Section 3.02.

Section 3.06 Continued Eligibility During Disability Periods

(a) If an Employee, is unable to perform Covered Work because of a disability, the Employee will be credited, for the purpose of maintaining Eligibility, with 30 disability hours for each full week of such disability. In no event will more than 525 hours of such disability hours be credited during any consecutive twelve-month period.

(b) A Certified Disability is one for which the Employee submits medical evidence satisfactory to the Trustees that he is disabled and is drawing Weekly Accident and Sickness benefits through the Fund or submits evidence that he is receiving benefits under the Workers' Compensation Act as a result of an injury or occupational disease incurred while engaged in Covered Work.

(c) For work-related Certified Disabilities, a Certified Disabled Employee's benefits will extend to the normal Eligibility termination date, based on his employment records, as outlined in Sections 3.03 and 3.04. In advance of said normal Eligibility termination date, a Certified Disabled Employee will be notified and afforded an opportunity to continue at his expense certain of his benefits, in accordance with the applicable Schedule of Benefits based on the Plan the Employee has chosen, for a maximum of 20 consecutive quarters by making payments to the Health Fund Office in a

manner and in an amount as from time to time prescribed by the Trustees. Any such payment must be received by the Health Fund Office as stated on the self-payment notice sent out by the Health Fund Office.

Section 3.07 Individual Termination

Coverage for an Eligible Person shall terminate on the earliest of the following dates:

(a) On the date the Plan terminates;

(b) On the date the Employee ceases to be Eligible, pursuant to Sections 3.04 and 3.13;

(c) On the date the Dependent ceases to be an Eligible Dependent;

(d) When an Eligible Person enters the Uniformed Services, in accordance with Section 3.10; or

(e) On the last day of the Benefit Quarter for which self-payments were paid in a timely manner.

Section 3.08 Wisconsin Laborers' Continuation Coverage

(a) If an Employee's Eligibility is due to terminate due to failure to be credited with the required number of hours of Covered Work in a Contribution Quarter(s) as specified in Section 3.04 because he is involuntarily unemployed and, as a result, has not worked the required hours of Covered Work, the Employee may make arrangements with the Health Fund Office to make self-payments to maintain his Eligibility for either the Active Employee Schedule of Benefits provided in Sections 5.01, or for the "Bare Bones" Schedule of Benefits provided in Section 5.02 for a maximum of ten (10) consecutive Benefit Quarters.

(b) The Employee's benefit coverage and that of his Eligible Dependents may be continued for a Benefit Quarter if he contributes to the Fund on his own behalf an amount equal to the difference between the amount the Fund received on his behalf during the Contribution Quarter immediately preceding the Eligibility termination date and the amount the Board of Trustees determines as being necessary to meet the Fund's requirements for the Employee's next Benefit Quarter based on the Plan chosen. The Employee may switch from the Active Employee's Plan to the "Bare Bones" Plan on the first day of any Benefit Quarter, but he may not switch from the "Bare Bones" Plan to the Active Employee's Plan.

(c) The Health Fund Office will attempt to contact the Employee to inform him of the requirements of this special continuation rule. However, it is the Employee's responsibility to keep the Health Fund Office informed of his current address so this contact can be made.

(d) Any such self-payments must be received in full by the Health Fund Office prior to the beginning of the Benefit Quarter. Self-payments received after this deadline will not be accepted and the Employee's Eligibility will terminate as of the first day of the Benefit Quarter for which contributions were due and not paid.

(e) The self-payment rate will be an amount equal to the difference between the amount the Fund received on an Employee's behalf during the Contribution Quarter immediately preceding the Eligibility termination date and the amount the Board of Trustees determines as being necessary to meet the Fund's requirements for the Employee's next Benefit Quarter based on the Plan chosen. In determining the Employee's self-payment, the difference between the actual number of hours of Employer Contributions credited on behalf of the Employee and the required number of hours used to calculate the self-payment will be limited to 300 hours.

(f) Reinstatement to full benefits coverage will be in accordance with Sections 3.02 and 3.05.

(g) An Employee's self-payments must be made for consecutive Benefit Quarters so that there is no break in Eligibility, and Eligibility thus remains continuous. In the event that an Employee's Eligibility terminates because of his failure to make self-payments, he will lose the right to make future self-payments unless he returns to work and subsequently reinstates his Eligibility.

(h) An Employee who is continuing Eligibility under this Section 3.08 will lose all rights to make self-payments in the event he is called to work and refuses or if it is proven that he is working in a job not in the construction industry.

(i) An Employee who is Eligible for Wisconsin Laborers' Continuation Coverage under this Section is also simultaneously eligible for COBRA Continuation Coverage described in Section 3.09. However, if the Employee elects to continue coverage under Wisconsin Laborers' Continuation Coverage under this Section, the Employee must waive COBRA Continuation Coverage. If the Employee elects to continue coverage under COBRA Continuation Coverage, the Employee must waive coverage under this Section 3.08.

(j) An Employee who makes self-payments under this Section 3.08 is not again eligible for COBRA Continuation Coverage until he returns to work and subsequently reinstates his Eligibility in accordance with Sections 3.02 and 3.05.

(k) An Active Employee who retires and maintains his Eligibility for Active Employee benefits due to accumulated hours will only be allowed to make one full self-payment for Active Employee benefits once his accumulated hours run out. After he has made one full self-payment for Active Employee benefits, he will subsequently then only be able to self-pay for Retired Employee benefits.

(l) An Active Employee who retires and subsequently returns to covered employment will be allowed to maintain his eligibility for Active Employee benefits due to accumulated hours and partial self-payments up to the maximum permitted under the Plan, provided he has not elected Retired Employee benefits. Once a full self-payment is required, then Retired Employee benefits must be elected at the end of that Benefit Quarter.

(m) Any time prior to the expiration of his Active Employee benefits, an Employee who has retired and maintains his Eligibility for Active Employee benefits will be allowed to elect Retired Employee benefits. Once an Employee elects Retired Employee benefits he will no longer be eligible for Active Employee benefits unless he returns to work and works the minimum hours required for "Initial Employee Eligibility" pursuant to Section 3.02. If a Retired Employee subsequently loses the Active Employee benefits or fails to meet the minimum required hours to maintain coverage under the Active Employee benefits he will return to the Retired Employee benefits previously elected.

Section 3.09 COBRA Continuation Coverage

(a) An Employee may elect continuation coverage under this Section as required under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). However, if the Employee elects to continue coverage under Wisconsin Laborers' Continuation Coverage under Section 3.08, the Employee must waive COBRA Continuation Coverage. If the Employee elects to continue coverage under COBRA Continuation Coverage, the Employee must waive coverage under Section 3.08. Under COBRA, a Qualified Beneficiary has the right to continue the same health benefits for which he was Eligible at the time of the Qualifying Event, provided he experiences a loss of health coverage due to a Qualifying Event as defined below in Section 3.09(b)(2). Death Benefits, the Accidental Death and Dismemberment Benefit and the Weekly Accident and Sickness Benefit are excluded from COBRA Continuation Coverage.

(b) **Definitions**

(1) **Qualified Beneficiary:** An Employee and/or his Dependents who are covered under the Plan on the day before a Qualifying Event and who would lose such coverage as a result of such Qualifying Event, were it not for the provisions of this Section 3.09.

(2) **Qualifying Event:** Any of the following events that would result in loss of coverage for a Qualified Beneficiary:

(A) An Active Employee loses Eligibility due to a termination of employment or the failure to work the required number of hours in the corresponding Contribution Quarter;

(B) The death of the Employee;

(C) The entitlement (eligibility for and enrollment in) of the Retired Employee to Medicare;

(D) The divorce of the Dependent spouse from the Employee or Retired Employee, or the termination of the domestic partnership by the Employee or Retired Employee and the Employee or Retired Employee's Domestic Partner;

(E) A Dependent child ceases to satisfy the definition of a Dependent under Section 2.11.

(3) **Election Period:** The 60-day period that commences on the later of:

(A) The date the Qualified Beneficiary would otherwise lose coverage under the Plan by reason of the Qualifying Event; or

(B) The date the Qualified Beneficiary receives the notice required by subsection (g) of this Section 3.09.

(c) **Entitlement to COBRA Continuation Coverage**

(1) Each Qualified Beneficiary who would otherwise lose coverage under this Plan as a result of a Qualifying Event shall be entitled to elect, within the Election Period, to continue coverage under the Plan in accordance with the provisions of this Section 3.09.

(2) A Qualified Beneficiary's entitlement to COBRA Continuation Coverage shall not be conditioned upon evidence of insurability.

(3) If, and to the extent, the provisions of this Section 3.09 shall be determined to be inconsistent with any amendment of the applicable laws or the regulations to be promulgated thereunder, the provisions of such law and/or regulations shall supersede the provisions of this Section 3.09.

(d) **Maximum Period of Coverage**

(1) If the Qualifying Event is due to an Active Employee's termination of employment, or the failure of an Active Employee to work the required hours of Covered Work, the maximum period of continuation coverage for such participant and his Eligible Dependents shall be 18 months, commencing from the date of loss of coverage due to the Qualifying Event; provided, however, if a second Qualifying Event occurs within such 18-month period, the maximum period of coverage for his Eligible Dependents is extended to a maximum of 36 months.

(2) For an Employee who terminates employment during the 18 months after his entitlement to Medicare, the maximum period of continuation coverage for Eligible Dependents will not end prior to 36 months after the date the Employee enrolled in Medicare.

(3) For a Qualified Beneficiary who is determined by the Social Security Administration to be disabled within 60 days of COBRA Continuation Coverage, the maximum period of continuation coverage will be extended from 18 to 29 months in total for the disabled person and any covered Dependents and the monthly premium will increase by an amount determined by the Board of Trustees not to exceed 150% of the applicable premium.

(4) If the Qualifying Event is any event other than that described in paragraph (1) of this subsection (d), the maximum period of continuation coverage shall be 36 months, commencing from the date of the Qualifying Event.

(e) **Termination of Coverage**

Continuation coverage shall terminate on the earliest of the following dates:

(1) The last day of the last period for which contributions are made, if the Qualified Beneficiary fails to make any contributions required under subsection (f) of this Section 3.09 on a timely basis;

(2) The date on which the Qualified Beneficiary first becomes, after the date of the election, covered as an Employee or as a Dependent under any other group health plan;

(3) The date on which the Qualified Beneficiary first becomes, after the date of the election, entitled to benefits under Medicare;

(4) The date that is 18, 29 or 36 months, as the case may be, after the date of the Qualifying Event pursuant to the provisions of subsection (d) of this Section 3.09; and

(5) The date on which the Plan is discontinued by the Trustees.

(f) **Contribution Requirement**

Entitlement to COBRA Continuation Coverage under the provisions of this Section shall be conditioned upon payment of monthly contributions in such amounts as shall be established by the Trustees from time to time.

(g) **Notice and Election Requirements**

(1) The Trustees shall provide written notice of the COBRA Continuation Coverage provisions of this Section 3.09 to each participant and Dependent within 90 days of the date his coverage under the Plan commences.

(2) An Employer shall notify the Administrative Manager within 30 days of the Qualifying Events described in Section 3.09(b)(2)(A), (B), or (C). Completion of the employer remittance form will be deemed sufficient notice.

(3) The Employee or other Qualified Beneficiary shall be responsible for notifying the Administrative Manager within 60 days of the Qualifying Events described in Section 3.09(b)(2)(D) and (E). Failure to provide such notice within 60 days will result in loss of eligibility for continuation coverage.

(4) Upon receipt of the notices described in paragraphs (2) and (3) of this subsection (g), the Administrative Manager shall notify each affected Qualified Beneficiary of his right to continuation coverage and provide him with an enrollment form. Notice to a Qualified

Beneficiary who is the spouse or Domestic Partner of the Employee or Retired Employee shall be deemed notice to all other Qualified Beneficiaries residing with the spouse or Domestic Partner at the time notification is made.

(5) Upon receipt of such notice of entitlement to continuation coverage, each Qualified Beneficiary may elect such coverage by completing and returning the enrollment form to the Administrative Manager within the Election Period. Failure to return the enrollment form within the Election Period will result in loss of eligibility for COBRA Continuation Coverage.

Section 3.10 Service in the Uniformed Services

(a) Eligibility for Employees who enter the Uniformed Services for more than 31 days will terminate on the date they are inducted. Such Employees and their Dependents will be eligible for coverage under Section 3.09. Upon release from service in the Uniformed Services, the Employees' Eligibility and that of their Dependents will be reinstated on the day they return to Covered Work, provided such return to Covered Work is within the then current federal guidelines.

(b) If Employees do not return to Covered Work within such federal guidelines, they will be considered a new Employee and be required to satisfy the Eligibility requirements in Section 3.02, "Initial Employee Eligibility."

(c) If an Employee's health benefit coverage ends because of service in the Uniformed Services, the Employee may elect to continue such health benefit coverage for himself or herself and any covered Dependents if required by the Uniformed Services Employment and Reemployment Rights Act (USERRA) until the earlier of:

(1) The end of the period during which he or she is eligible to apply for reemployment in accordance with USERRA; or

(2) 24 consecutive months after coverage ended.

(d) Coverage under USERRA will be administered in the same manner as coverage under COBRA Continuation Coverage, except that coverage may continue for up to a maximum of 24 months, and only the Employee-servicemember may make the election. If the Employee-servicemember chooses not to elect continuation coverage under USERRA, the Dependents of the Employee-servicemember may continue coverage under COBRA, pursuant to Section 3.09.

Section 3.11 Dependent Eligibility

(a) Dependents of Eligible Employees who meet the definition of a Dependent as stated in Section 2.11 and who are not Eligible as an Employee under the Wisconsin Laborers' Health Plan will be Eligible.

(b) Dependent coverage will begin on the date the Employee becomes Eligible or on the date the Employee first acquires the Dependent, whichever is later.

(c) The date a Qualified Medical Child Support Order is determined to be valid in the case of a child named as an alternate recipient.

(d) The ineligibility of one Dependent will not affect the Eligibility of any other Dependent.

(e) Dependent coverage will terminate on the earlier of the date the Eligible Employee's coverage terminates, or the date that the Dependent loses Dependent status because the Dependent no longer meets the definition of Dependent as stated in Section 2.11.

Section 3.12 Continuation of Health Coverage for Dependents of Deceased Eligible Active Employees

(a) In the event of an Active Employee's death while Eligible, Dependent benefits will be extended to the normal termination date, based upon the Employee's employment records, as outlined in Section 3.03.

(b) Continued health coverage for Dependents of a deceased active Employee will end on the earliest of:

(1) The date the surviving spouse remarries or the Domestic Partner marries or enters into a new domestic partnership;

(2) The date the Dependent becomes insured under another group plan; or

(3) The date a Dependent's Eligibility would otherwise terminate.

If the Active Employee has accumulated ten (10) service credits as defined under Article 19, the surviving spouse or surviving Domestic Partner may continue under the Retiree Health Plan as if the member had retired on the day before his death.

(c) Any health benefits becoming payable because of expenses incurred by a Dependent after the date of the Employee's death will be paid to the hospital or provider of the services, when such benefits are assigned. If benefits are not assigned, the Fund will pay at its option to:

(1) The Dependent, or

(2) The Hospital or provider of the services.

Any payment made in good faith will fully discharge the Fund to the extent of the payment.

Section 3.13 Eligibility for Retired Employees

(a) Following retirement, an Employee will become Eligible for Retired Employee benefits on a self-payment basis in accordance with the following provisions:

(1) He must have at least 10 service credits; and

(2) He must have been Eligible for benefits under the Plan immediately prior to retirement or disability; and

(3) He must be receiving:

(A) Pension benefits from the Wisconsin Laborers' Pension Fund (or related pension fund as designated by the Trustees), and

(i) Had been Eligible in each of the four Plan Years prior to retirement or disability for benefits under the Fund's active program; or

(ii) Have 50,000 hours or more of participation in the Wisconsin Laborers' Health Fund prior to retirement or disability for benefits under the Fund's active program;

or

(B) A disability pension from the Wisconsin Laborers' Pension Fund (or related pension fund as designated by the Trustees), or a Social Security Disability Pension.

(4) "Service credits," for purposes of this Plan, are determined by dividing an Employee's total contribution hours from Covered Work under the Wisconsin Laborers' Health Fund by 1,400 (rounded to the nearest 0.10 credit). Service credits are provided for Employer contribution hours only. Hours for which self-payments were made by an Employee do not count toward earning service credits. Service credits earned before a break in service are not used when determining Eligibility for Retiree coverage, and the amount of an Employee's contribution allowance;

(5) The continuous employment of a former Participant by the Laborers International Union of North America that immediately follows covered employment and immediately precedes permanent retirement shall count towards the eligibility requirements outlined in Sections 3.13(a)(2) and (a)(3)(A), and shall not count toward earning service credits under Section 3.13((a)(4); and

(6) He must elect Retiree coverage and waive COBRA coverage.

(b) If an Employee is over age 65 or eligible for Medicare, he must enroll in Medicare Part A and purchase Medicare Part B coverage to be Eligible for Retired Employee benefits. A Retired Employee who enrolls in a Medicare Prescription Drug Plan, other than the Medicare Part D Employee Group Waiver Plan (EGWP) in which the Plan participates, will lose eligibility for himself/herself (and any covered Dependents) to receive Retired Employee prescription drug benefits; however, the Retired Employee (and his/her covered Dependents) will continue to be eligible to receive Retired Employee medical benefits at the same self-payment amount charged for both prescription drug and medical benefits. A Retired Employee who loses prescription drug benefit coverage due to enrollment in a Medicare Prescription Drug Plan, other than the Medicare Part D Employee Group Waiver Plan (EGWP) in which the Plan participates, will have a "one-time" opportunity to have Retired Employee prescription drug benefit coverage reinstated for himself/herself (and any eligible Dependents) if he/she disenrolls from or otherwise loses Medicare Prescription Drug coverage, other than the Medicare Part D Employee Group Waiver Plan (EGWP) in which the Plan participates. If a Retired Employee who enrolls in a Medicare Prescription Drug Plan, other than the Medicare Part D Employee Group Waiver Plan (EGWP) in which the Plan participates, elects to drop Retired Employee medical benefit coverage at the time his/her prescription drug coverage terminates, he/she will not be eligible to re-enroll in the Plan for Retired Employee prescription drug and medical benefit coverage. However, a Retired Employee who elects to drop medical and prescription drug coverage upon enrollment in a Medicare Prescription Drug Plan, other than the Medicare Part D Employee Group Waiver Plan (EGWP) in which the

Plan participates, can be reinstated into the Plan as an active Employee if he/she otherwise meets the eligibility requirements in Article 3.

(c) A Dependent spouse, Domestic Partner or child may elect to defer coverage following the rules regarding postponement of Retired Employee benefits. If a Retired Employee marries or enters into a domestic partnership after retirement, the new spouse or Domestic Partner may be covered under the special enrollment rules if enrolled within 60 days after the marriage or State Domestic Partner Declaration. If a Retired Employee acquires a Dependent child after retirement, the child may be covered under the special enrollment rules of Section 3.34 if enrolled within 30 or 60 days, as applicable under that Section.

(d) The Trustees will from time to time determine the benefits to be provided to Retirees, and to the surviving spouse, surviving Domestic Partner or surviving covered Dependent children of a deceased participant or Retired Employee, which benefits will not necessarily be the same as those benefits provided to the actively employed and which may be discontinued or modified at any time. The amount of self-payment will also be determined by the Trustees from time to time and may not necessarily be the same as the self-payment amount for Active Employees. A Retiree Contribution Allowance is provided at Article 19.

(e) An Employee who meets the above requirements for Retired Employee benefits will become Eligible along with his Dependents on the first day of the month following the month Active Employee benefits are terminated, or the first day of the month following the month his application for Retired Employee benefits is approved, whichever is earlier. If a Retired Employee returns to performing Covered Work, he will be Eligible again for Active Employee benefits upon satisfying the "Initial Employee Eligibility" requirement described in Section 3.02. In no event can an Employee be Eligible for both Active and Retired Employee benefits at the same time.

(f) An Employee will lose all rights to self-pay for Retired Employee benefits if it is proven that he is working for an Employer in the construction industry who is not required to make contributions to the Fund.

(g) If an Employee retires and subsequently returns to work, the Retired Employee will be allowed to continue active benefits if the Retired Employee works sufficient hours for active benefits. If the Retired Employee does not work sufficient hours for active benefits, the Retired Employee may make partial self-payments up to the maximum allowed, provided the Retired Employee has not elected Retired Employee benefits. After one full self-payment for active benefits, the Retired

Employee must elect retiree coverage, or the Retired Employee may elect retiree coverage any time before making the one full self-payment for active benefits.

After a Retired Employee elects retiree coverage, the Retired Employee is not eligible for active benefits unless the Retired Employee returns to work and works the required number of hours to meet the initial eligibility requirements. Subsequently, if the Retired Employee does not work enough hours to maintain active coverage, the Retired Employee will be eligible to return to the retiree benefits previously elected.

(h) Coverage under the Retiree Plan (see Section 5.03) must be continuous. If coverage terminates for non-payment, it cannot be reinstated. However, effective December 1, 2005, Retired Employees, spouses of Retired Employees, and surviving spouses of Retired Employees, and effective April 1, 2013 Domestic Partners of Retired Employees and surviving Domestic Partners of Retired Employees, who become eligible for the Retiree Plan and who have health coverage under another employer group health plan, will be given a one-time opportunity to postpone or suspend retiree coverage under the Wisconsin Laborers' Health Fund until such time as they are no longer covered under another employer's group health plan, as provided in Sections 3.13(i), (j) and (k) below. After coverage under the employer group health plan ends, the Retired Employee, spouse or Domestic Partner of a Retired Employee or the surviving spouse or Domestic Partner of a Retired Employee may resume coverage under the Retiree Plan.

(i) On or after December 1, 2005, Retired Employees, spouses of Retired Employees and surviving spouses of Retired Employees and, effective April 1, 2013 Domestic Partners of Retired Employees and surviving Domestic Partners of Retired Employees, may postpone or suspend Retiree coverage and later enroll if they did not initially enroll in the Retiree Plan when first Eligible to do so or they may re-enroll if they suspended Retiree coverage and then choose to resume such coverage at a later date. This option to postpone or suspend Retiree coverage may be exercised only once per lifetime. Such persons must:

(1) File a written notice delaying coverage under the Retiree Plan to the Fund Office within the 60 days following the date they first become eligible for coverage under the Retiree Plan under the Wisconsin Laborers' Health Fund; and

(2) Provide proof that they have coverage through another employer health plan, which is approved by the Fund Office.

Once the notice and evidence of employer group health plan coverage have been approved by the Fund Office, then coverage under this Plan will be suspended on the first day of the month following the Plan's receipt and approval of the person's written notice to suspend coverage and proof.

(3) On or after June 1, 2011, this option to postpone Retiree Coverage may also be exercised at any time after an Employee's Retirement but prior to Eligibility to enroll in the Retiree Plan. In the event of such an election, all accumulated eligibility under the Active Plan shall be permanently forfeited and shall be unavailable to continue coverage under the Active Plan at a later time. Persons exercising this option must:

(A) File a written notice waiving coverage under the Active Plan and delaying coverage under the Retiree Plan to the Administrative Manager;

(B) Provide proof that they have coverage through another employer health plan, which is approved by the Fund Office; and

(C) Acknowledge in writing that any and all accumulated eligibility is permanently forfeited.

(j) Retiree coverage that has been postponed or suspended will be resumed under the Wisconsin Laborers' Health Fund if:

(1) A written application is filed by the Retired Employee, spouse or Domestic Partner of a Retired Employee, or the surviving spouse or surviving Domestic Partner of a Retired Employee, as applicable, and is received by the Fund Office within the 60 days following termination of coverage under the other employer's group health plan;

(2) Proof is provided to the Fund Office that the Retired Employee, spouse or Domestic Partner of a Retired Employee, or the surviving spouse or surviving Domestic Partner of a Retired Employee had been continuously covered by the other employer's group health plan since the date such person elected to postpone or suspend Retiree Plan coverage under the Wisconsin Laborers' Health Fund; and

(3) Required self-payments are made to maintain coverage.

(k) The decision to postpone or suspend coverage and reserve the right to enroll for coverage at a later date is a one-time only option. If an election is made to postpone a Retired Employee's, spouse or Domestic Partner's, or surviving spouse or surviving Domestic Partner's coverage at the time of retirement, another opportunity to suspend coverage will not be granted at a later date. However, effective December 1, 2005, if a Retired Employee, spouse of a Retired Employee, or surviving spouse of a Retired Employee and, effective April 1, 2013 a Domestic Partner of a Retired Employee or surviving Domestic Partner of a Retired Employee, elects not to postpone retiree coverage when initially Eligible, such person(s) may make a one-time election at a later date to suspend such coverage if he or she otherwise meets the requirements of Sections 3.13(i), (j), or (k). Retired Employees, spouses or Domestic Partners of Retired Employees, or surviving spouses or surviving Domestic Partners who enter coverage under the Retiree Plan after postponing or suspending coverage must remain continuously covered under the Retiree Plan and will not be given a second opportunity to defer coverage. Thereafter, if such coverage terminates for any reason, it may not be reinstated.

Section 3.14 Termination of Eligibility for Retired Employees and Dependents Covered under the Retiree Plan

(a) Benefits for a Retired Employee and his Dependents will terminate on the last day of the month preceding any month for which the required self-payments have not been made by the Retired Employee to the Health Fund Office.

(b) Dependent coverage will terminate on the earlier of the date the Eligible Retiree's coverage terminates, the date that the Dependent loses Dependent status because the Dependent no longer meets the definition of Dependent as stated in Section 2.11, or otherwise in accordance with the rules in this Section.

(c) In addition, a child no longer satisfying the requirements for a Dependent under Section 2.11 has the right to continue Retired Employee benefits in accordance with COBRA Continuation Coverage under Section 3.09 for a maximum of 36 months by making monthly self-payments commencing at the time he loses Dependent status.

(d) Upon the death of an Eligible Retired Employee, coverage for his Dependents will terminate on the last day of the month in which the Eligible Retired Employee died.

(e) The Dependents of a deceased Eligible Retired Employee will be given the opportunity to continue their health benefits by making monthly payments to the Health Fund Office in an amount prescribed by the Trustees. Such benefits will terminate on:

(1) The last day of the last period for which contributions are made if the Dependent fails to make the required contribution; or

(2) The date the surviving spouse remarries or the date the surviving Domestic Partner marries or enters into a new domestic partnership; or

(3) The day coverage would otherwise terminate in accordance with all other Plan provisions relating to termination of Dependent coverage except for the surviving spouse; or

(4) The day the Dependent becomes eligible under another group plan.

(f) Any health benefits becoming payable because of an expense incurred by a Dependent after the date of the Employee's death will be paid to the hospital or provider of the services, when such benefits are assigned. If benefits are not assigned, the Fund will pay at its option to:

(1) The Dependent; or

(2) The Hospital or provider of the services.

Any payment made in good faith will fully discharge the Fund to the extent of the payment.

Section 3.15 Change of Eligibility Rules

(a) In order that the Trustees may carry out their obligation to maintain, within the limits of the funds available to them, a sound and economical program dedicated to providing the maximum benefits for Eligible Employees and their Dependents, the Trustees expressly reserve the right in their sole and broad discretion and without prior notice to Employees, Retired Employees, Contributing Employers, the Union and others affected hereby, to:

(1) Discontinue or modify, in whole or in part, either the amount of any benefit and/or the limitations or conditions pertaining to any benefit; and/or

(2) Alter the method of payment of any benefits; and/or

(3) Amend any other provisions of the Plan; provided, however, no amendment to the Plan shall retroactively reduce benefit entitlement or benefit levels then in effect; and/or

(4) Interpret the provisions of the Plan.

(b) The Trustees shall have broad discretion to determine eligibility for benefits and to interpret Plan language. The decisions of the Trustees shall be accorded judicial deference to the extent that they do not constitute an abuse of discretion.

Section 3.16 Amounts of Coverage

The amounts of benefits to which an Eligible Person covered under the Plan is entitled will be the amounts applicable to that Eligible Person's classification. If there is a change in the schedule or in the amounts of benefits under the Plan, the amounts to which an Eligible Person is entitled will be adjusted to conform to the changed classification or the changed amounts of benefits, effective with the date of such change.

Section 3.17 Employer Contributions for Work Performed Outside the Jurisdiction

The following definitions apply to Sections 3.17, 3.18, 3.19, 3.20, 3.21, and 3.22.

(a) **Participating Employer** means an Employer that is a party to, or subject to, a labor agreement with a Union, which labor agreement requires such Employer to make contributions to this Fund.

(b) **Local Union** means a union as defined in Section 1.2 of the Trust Agreement.

(c) **Out-of-town Welfare Fund** means a health and welfare fund located outside the Territorial Jurisdiction of this Fund.

(d) **Territorial Jurisdiction of this Fund** means, for a particular craft or trade covered by this Fund:

(1) The geographical area covered by the labor agreements entered into with a Local Union of that particular craft or trade; and

(2) Which labor agreements require employers to make contributions to this Fund.

(e) **Sister Local Union** means a labor organization (not a Local Union as defined in the Trust Agreement) affiliated with an international labor organization with which a Local Union is also affiliated.

(f) **Current Contribution Rate** means the hourly rate of contribution to this Fund currently prescribed under the applicable labor agreement in effect with a Local Union.

Section 3.18 Coverage of Employees Working Outside the Territorial Jurisdiction of This Fund for Non-Participating Employers

When an Employee performs work outside the Territorial Jurisdiction of this Fund, this Fund may receive contributions directly from an Out-of-Town Welfare Fund under a ratified reciprocal agreement at the rate established for health contributions in the labor agreement under which the work is performed, and to which the Employer is a party. In the event health fund contributions thus received are at a lesser contribution rate than the Contribution Rate of this Fund, the total contributions received will be credited by this Fund as having been made for the number of contribution hours which such total contributions received represent on the basis of the Current Contribution Rate; and the Employee will only have to pay whatever additional contributions would be necessary (if any) on the basis of the Current Contribution Rate to bring the Employee's credited contribution hours up to those necessary to maintain coverage and Eligibility.

Section 3.19 Coverage of Employees Working for Participating Employers Outside the Territorial Jurisdiction of This Fund

(a) Where an Out-of-Town Welfare Fund has reciprocity arrangements in effect with the Trustees of this Fund pursuant to Section 3.21, the Employee will be covered by this Fund under the reciprocity procedures provided.

(b) If an Out-of-Town Welfare Fund has no reciprocity arrangements in effect with the Trustees of this Fund, the Employee may continue to be covered by this Fund only if he makes self-payments for the duration of his employment with the Participating Employer outside the Territorial Jurisdiction of this Fund.

Section 3.20 Transfer of Contributions for the Benefit of Employees Covered by an Out-of-Town Welfare Fund

If an Employee:

(a) Is eligible for benefits from an Out-of-Town Welfare Fund under a labor agreement with a Sister Local Union; and

(b) Performs work within the Territorial Jurisdiction of this Fund under a labor agreement requiring the payment of contributions to this Fund, then

up to twelve months of contributions for work performed before the Employee's request for transfer is received by this Fund may be transferred to the Out-of-Town Welfare Fund under a ratified reciprocal agreement for the purpose of continuing that Employee's health coverage and Eligibility. Future contributions may be transferred as long as the Employee's written request remains in effect.

Section 3.21 Receipt of Self-Payments from Employees Transferring to a Sister Local Union

In order to permit an Employee to transfer to a Sister Local Union and maintain continuous health benefit coverage, this Fund may receive self-payments from the Employee while an employer (other than a Participating Employer) is making contributions on his behalf to an Out-of-Town Welfare Fund until such time as the Employee becomes (or could become) eligible for benefits from the Out-of-Town Welfare Fund; but in no event will the continuance of benefit coverage for the Employee from this Fund extend beyond the time specified in Section 3.08.

Section 3.22 Recognition of Reciprocal Rights

The provisions of Sections 3.18 and 3.20 may be made applicable and put into effect as to any particular Out-of-Town Welfare Fund's Territorial Jurisdiction by action of the Trustees on condition that, in the considered view of the Trustees, reciprocal rights and privileges are extended by the affected Out-of-Town Welfare Fund.

Section 3.23 Non-Bargained Employees – Initial Eligibility

(a) A non-bargained Employee will become Eligible for benefits on the first of the month after the necessary contributions are made on such Employee's behalf. Employers may cover their non-bargained Employees only if:

(1) The Employer has signed a Collective Bargaining Agreement and Participation Agreement; and

(2) All office staff and other non-bargained Employees who work a minimum of 25 hours per week are covered.

(b) Sole proprietors, partners, or 100% shareholders are not eligible to participate as a non-bargained Employee under the Plan.

(c) The non-bargaining rules will not apply to the Plan if the non-collectively bargained employees constitute more than 5% of the Employees benefiting under the Plan.

(d) The non-bargaining rules must be applied to all Employees on a reasonable and consistent basis for the Plan Year.

Section 3.24 Non-Bargained Employees – Continued Eligibility

A non-bargained Employee who meets the requirements of Section 3.23 will continue to be Eligible if such Employee works at least 25 hours per week for an Employer or the Union and the necessary contribution is made.

Section 3.25 Non-Bargained Employees – Termination of Eligibility

An Eligible Person's coverage will terminate, on the earliest of the following dates:

(a) On the date the Plan terminates;

(b) On the date the Employee ceases to be Eligible pursuant to Section 3.24;

(c) On the date the Employer does not contribute for all non-bargained Employees who work more than 25 hours a week;

(d) On the date the Participation Agreement terminates;

(e) On the date the Dependent ceases to be an Eligible Dependent; or

(f) When the Eligible Person enters the Armed Forces, in accordance with Section 3.10,

unless such Person qualifies for COBRA Continuation Coverage in accordance with Section 3.09.

Section 3.26 Non-Bargained Employees – Eligibility for Retiree Coverage

(a) Non-bargained Employees will only be eligible to self-pay for Retiree Employee benefits if they:

(1) Have been eligible under the Wisconsin Laborers' Health Fund for the four-year period immediately preceding retirement; and

(2) Are receiving Social Security retirement benefits.

(b) Once a non-bargained Employee and his Dependents are Eligible for Retiree coverage, the same rules apply as those that apply to Employees and Dependents covered under a Collective Bargaining Agreement. However, non-bargaining Employees are not Eligible for the Retiree Contribution Allowance under Article 19.

Section 3.27 Alumni Employees – Initial Eligibility

(a) An alumni Employee will become Eligible if the Employer or Union has signed a Participation Agreement with the Fund and the necessary contributions are made on such Employee's behalf. To be an alumni, the Employee and Plan must satisfy the following criteria:

(1) The Employee must have previously participated in the Plan under a Collective Bargaining Agreement that provided for his participation and contributions on his behalf;

(2) The Employee must be currently performing services for:

(A) One or more Employers who are parties to a Collective Bargaining Agreement requiring contributions to the Plan; or

(B) The Union;

(3) The Employee will be treated as an alumni only if the terms of the Plan treat the Employee in a manner that is generally no more favorable than similarly situated Employees who are covered under a Collective Bargaining Agreement;

(4) The alumni rule will not apply to the Plan if the non-collectively bargained employees constitute more than 5% of the Employees benefiting under the Plan; and

(5) The alumni rules must be applied to all Employees on a reasonable and consistent basis for the Plan Year.

(b) Former bargaining unit Employees who become owners or stockholders who meet the criteria listed above may participate as alumni under the Plan. Sole proprietors, partners, or 100% shareholders are not eligible to participate as alumni under the Plan. Alumni-owners of a firm who initially satisfy the criteria to be alumni will lose their right to participate if the firm subsequently fails to remain a party to a Collective Bargaining Agreement requiring contributions to this Fund for covered work performed anywhere within the Fund's jurisdiction.

Section 3.28 Alumni Employees – Continued Eligibility

An alumni Employee who meets the requirements of Section 3.27 will continue to be Eligible if the necessary contribution is made and the Participation Agreement remains effective.

Section 3.29 Alumni Employees – Termination of Eligibility

An Eligible Alumni Employee's coverage will terminate, on the earliest of the following dates:

(a) On the date the Plan terminates;

(b) On the date the Alumni Employee ceases to be Eligible pursuant to Section 3.03;

(c) On the date the Participation Agreement terminates;

(d) On the date the Alumni Employee's Dependent ceases to be an Eligible Dependent; or

(e) On the date the Alumni Employee enters the Uniformed Services, in accordance with Section 3.10,

unless such Person qualifies for COBRA Continuation Coverage in accordance with Section 3.09.

Section 3.30 Qualified Medical Child Support Orders

(a) Notwithstanding any other provision of this Plan to the contrary, the Plan shall provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order (QMCSO) as defined in ERISA Section 609(a).

(b) Any payment for benefits made by the Plan pursuant to a QMCSO in reimbursement for expenses paid by an alternate recipient's custodial legal guardian shall be made to the alternate recipient or the alternate recipient's parent or legal custodian.

(c) Upon receipt of a QMCSO, the Administrative Manager shall promptly notify the Eligible Employee and each alternate recipient, as that term is defined in ERISA Section 609(a), of the receipt of such Order and the Plan's procedures for determining whether the Order is a QMCSO pursuant to the Plan's procedures, and notify the Eligible Employee and each alternate recipient of the determination.

Section 3.31 Continued Eligibility During Leave of Absence

(a) **Maintenance of Health Benefits**

A Covered Employer must continue to make contributions on behalf of an Eligible Employee while the Eligible Employee is on a Family and Medical Leave Act of 1993 (FMLA) leave. The benefits for an Employee on a FMLA leave are the same as for active Employees.

(b) **Termination of the FMLA Obligation to Maintain Health Care Coverage**

The obligation to maintain health care coverage during a FMLA leave ends on the earliest of:

(1) When an Employee returns to work;

(2) When an Employee informs the Employer that the Employee does not intend to return to work; or

(3) When twelve weeks or FMLA leave ends. However, effective January 28, 2008, twelve weeks may be extended to twenty-six weeks for a spouse, son, daughter, parent, or next of kin to care for a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness incurred in the line of duty while in the armed services.

(c) **Interaction with COBRA**

If the Eligible Employee does not return to work within twelve weeks, he will have a COBRA qualifying event as outlined in Section 3.09.

(d) **Disputes over Eligibility and Coverage**

All disputes over an Eligible Employee's eligibility and coverage under FMLA are between the Employee and Employer. Benefits will be suspended pending resolution of the dispute. The Trustees will have no direct role in resolving such a dispute.

Section 3.32 Eligibility Requirements For New Groups Requesting Immediate Group Eligibility

(a) The following requirements must be met for the types of groups listed below for companies requesting immediate group eligibility in the Wisconsin Laborers' Health Fund:

(1) For construction industry contractors:

(A) Signed Collective Bargaining Agreement.

(B) Proof of current health insurance coverage for at least the four-month period immediately preceding participation in this Fund. Proof consists of copies of premium statements listing each employee covered under the health policy and the canceled check.

(C) Each employee listed on the premium statements above will be granted 115 hours per month for the last three months of the "other" health coverage prior to contributions being made to the Health Fund. These hours are used to determine ongoing eligibility.

(2) For non-job site construction contractors:

(A) Signed Collective Bargaining Agreement.

(B) Proof of current health insurance coverage for at least the four-month period immediately preceding participation in this Fund. Proof consists of copies of premium statements listing each employee covered under the health policy and the canceled check.

(C) Contributions on all hours worked up to a maximum of 2,080 hours per calendar year.

(b) Eligibility begins the first day of the month following the month the agreement is made and contributions are made.

(c) Contributions must begin the month in which the agreement is signed. Contributions made on behalf of each Employee should be for the actual numbers of hours worked, but contributions for a minimum of 160 hours must be received on each Employee's behalf before an Employee's eligibility begins.

(d) The Employee must have 600 hours in contributions made on his behalf before he will be entitled to the Wisconsin Laborers' Continuation Coverage in Section 3.08. However, such Employee will be entitled to COBRA Continuation Coverage under Section 3.09 as of the day he attains eligibility in the Health Fund.

Section 3.33 Eligibility Requirements for Transferees From Other Wisconsin Health Funds

An Employee who was an eligible employee in another certified multiemployer Wisconsin health fund shall become eligible for benefits under this Health Plan when he transfers to this Health Plan ("Transferred Employee") and the following requirements have been met:

(a) The Trustees of this Health Plan determine that such other multiemployer Wisconsin health fund is certified for purposes of determining Eligibility of a Transferred Employee from such other fund to this Health Plan;

(b) The Transferred Employee was eligible under the other certified Wisconsin multiemployer health fund at the time of transfer; and

(c) A Transferred Employee's Eligibility under this Health Plan shall be determined in a manner consistent with the provisions of Section 3.05 hereof, which relate to the reinstatement of Employee Eligibility.

Section 3.34 Special Enrollment and Late Enrollment

(a) Special enrollment is allowed for Active and Retired Employees or Dependents who originally declined coverage if they:

(1) Had other coverage and either they later had a loss of eligibility for such coverage or employer contributions toward such other coverage were terminated; or

(2) Were on continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) under another plan, but their COBRA eligibility has expired.

(b) If an Employee who initially did not enroll later marries or has a birth child or has children placed for adoption or adopts a child, the Employee is entitled to special enrollment, along with the children placed for adoption or adopted child or birth child and spouse if enrollment is requested within 30 days of the marriage, birth, or adoption.

(c) If an Employee who initially did enroll later marries or has a birth child or has children placed for adoption or adopts a child, the child placed for adoption, adopted child or birth child and spouse are entitled to special enrollment if enrollment is requested within 30 days of the marriage, birth, or adoption.

(d) An Employee eligible for special enrollment shall become an eligible Participant on the first (1st) day of the month following receipt of the properly completed application form, subject to administrative approval. A Dependent eligible for special enrollment, including a spouse, birth child, children placed for adoption or adopted child, shall become Eligible for coverage on the date the Dependent is acquired.

(e) An Employee must request enrollment within 30 days after the other coverage ended if that other health coverage was employer-provided health coverage, COBRA continuation coverage that had expired, or other coverage that expired because the Employee reached the lifetime maximum benefit.

(f) An Employee must request enrollment within 60 days after the other coverage ended if the other coverage was under Medicaid or the State Child Health Insurance Program (CHIP), or the Employee or Dependent became eligible to participate in a financial assistance program through Medicaid or CHIP for coverage under the plan.

Section 3.35 Rescission of Coverage

(a) The Plan may rescind a Participant's coverage for fraud, intentional misrepresentation of a material fact, or material omission after the Plan provides the Participant with 30 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 the Participant should not have been covered by the Plan. However, the following situations will not be considered rescissions of coverage and do not require the Plan to give the Participant 30 days advance written notice:

(1) The Plan terminates the Participant's coverage back to the date of the Participant's loss of employment when there is a delay in administrative recordkeeping between the Participant's loss of employment and notification to the Plan of the Participant's termination of employment.

(2) The Plan retroactively terminates the Participant's coverage because of the Participant's failure to timely pay required premiums or contributions for the Participant's coverage.

(3) The Plan retroactively terminates your former spouse's coverage back to the date of your divorce.

(b) For any other unintentional mistakes or errors under which the Participant and the Participant's Dependents were covered by the Plan when they should not have been covered, the Plan will cancel their 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 Plan to give the Participant 30 days advance written notice.

ARTICLE 4 GENERAL PROVISIONS

Section 4.01 Time Limit on Certain Defenses

No misstatement by an Eligible Employee, except a fraudulent or willful misstatement, made in an application for benefits or proof of loss shall be used to deny such benefits if at least two years have elapsed after the loss was incurred or the disability commenced.

Section 4.02 Notice of Claim

(a) Written notice of claim with information sufficient to identify the Eligible Employee or Dependent whose Injury or Sickness is the basis of the claim must be given to the Health Fund Office within 90 days after the occurrence or commencement of the loss for which benefits may be claimed, or as soon thereafter as is reasonably possible.

(b) Network providers will generally file claims for Eligible Persons. If a provider does not file a claim, the Eligible Person must obtain a claim form, complete the claim form, have the provider complete the claim form, or submit a CMS (Centers for Medicare and Medicaid Services) health insurance claim form, or file a HIPAA-compliant electronic claim submission, and submit any necessary claim form to the Fund Office.

Section 4.03 Proof of Loss

Written proof of loss must be furnished to the Health Fund Office (in case of a claim for loss for which the Plan provides any periodic payment for continuing loss) within 90 days after the termination of the period for which the Fund is liable. Periodic payment will be made in case of loss of time during a period of more than two weeks. In the case of a claim for any other loss, proof must be furnished within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and, in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

Section 4.04 Physical and Dental Examination and Autopsy

The Trustees shall have the right and opportunity, at the Fund's expense, to have a Physician or Dentist they designate examine the Eligible Employee or Dependent whose Injury or Sickness is the basis of a claim for Plan benefits, as often as they may reasonably require during the pendency of a claim, and to have made an autopsy in case of death, where it is not forbidden by law.

Section 4.05 Time of Payment of Claim

(a) Benefits payable under the Plan for any loss other than the Weekly Accident and Sickness Benefit will be paid as they accrue, immediately upon receipt by the Health Fund Office of proper written proof of such loss.

(b) Subject to written proof of loss, all Weekly Accident and Sickness Benefits will be paid for up to 19 weeks for any period of Certified Disability.

Section 4.06 Method of Claim Payment

All or a portion of benefits payable under the Plan for Hospital, nursing, medical, or surgical services may, at the Trustees' option (and unless the Employee requests otherwise in writing at the time of filing the proof of loss), be paid directly to the Hospital or person rendering such services.

Section 4.07 Legal Actions

No action at law or in equity, including actions or proceedings before administrative agencies, with respect to a claim concerning a claimant's Eligibility for, or amount of benefits from and under the Fund or Plan, shall be brought to recover from the Plan prior to the time the claimant has exhausted the Plan's claims procedures and exhausted the Plan's appeal opportunities, and in no event later than two years from the date the claim was required to be received by the Fund Office, as specified in Section 4.02 herein.

Section 4.08 Right of Recovery of Overpayments

Overpayments, erroneous payments, or misstatements as to the eligibility or participation of any Employee, or the amount of payments made to an Employee or to his or her Dependents (or to the providers of the Employee or his or her Dependents) may be recovered by the Trustees, including by making deductions or offsets from benefits that may be payable to the Employee or to his or her Dependents from future benefits payable under the Plan, or cause such other adjustment of benefits or payments as will, in the Trustees' sole judgment, result in the Employee or Dependent receiving the proper amount of benefits under the Plan.

Where appropriate, recovery will also be sought from providers, insurance companies or other organizations that have received such payment.

Section 4.09 Change of Beneficiary

The right to a change of beneficiary(ies) is reserved to the Employee without consent of the beneficiary(ies), except as may be required otherwise by law.

Section 4.10 Extension of Benefits

(a) Comprehensive Major Medical Benefits otherwise payable under the Schedule of Benefits will also be paid as specified herein when an Eligible Person, on the date of termination of Eligibility, is under the care of a legally qualified Physician, and is totally disabled by bodily Injury or Sickness so as to be continuously prevented from engaging in any occupation or, in the case of a Dependent spouse, in any employment or household duties or, in the case of any other Dependent, in the normal activities of a person of the same age and gender.

(b) Benefits will be paid for covered charges incurred with respect to the disabling Injury or Sickness that existed on the date of termination of Eligibility in the same manner as if Eligibility had not been terminated; provided, however, notwithstanding anything in the General Provisions to the contrary, no benefits will be paid in any event for charges incurred beyond the earliest of:

(1) 12 months from the date Eligibility terminated;

(2) The date the Eligible Person becomes insured under another group plan; or

(3) The date total disability terminates.

Section 4.11 General Plan Exclusions

Benefits are not provided for the following:

(a) Any Injury, Sickness or dental treatment for which an Eligible Person has received or is entitled to receive benefits under a Workers' Compensation or Occupational Disease law, or which arises out of or in the course of any occupation or employment. This does not apply to Accidental Death and Dismemberment Benefits.

(1) However, the Fund will cover such Expense, subject to the terms and conditions of the Plan if:

(A) The Eligible Person has been denied Workers' Compensation or Occupational Disease benefits; and

(B) The Eligible Person and his/her attorney execute an agreement provided by the Fund stating and agreeing to repay and reimburse the Fund for all benefits paid by the Fund on behalf of the Eligible Person for said injury and out of any recovery proceeds, whether by settlement or otherwise.

(2) Failure by the Eligible Person to comply with the Agreement allows the Fund, at its discretion, to any of the following:

(A) Take a credit against future claims of the Eligible Person up to the amount of the Fund's expenditures on such expense;

(B) Initiate legal proceedings to recover the Fund's expenditures; and

(C) Exercise the Fund's right to reimbursement, including, but not limited to, claims for restitution, unjust enrichment, or a constructive trust over any recovery by the Eligible Person, to the extent of the Fund's expenditures, whether the recovery is paid to, or in the possession of, the Eligible Person, the Eligible Person's attorney, or any other individual or entity.

(b) Any expense incurred after Eligibility terminates, except as provided under the Extension of Benefits provisions in Section 4.10.

(c) Any expense that is in excess of the Allowable Charges.

(d) Any expense or charge for services or supplies not recommended by a Physician or Surgeon, or not Medically Necessary (as defined in the Plan) in treating the Injury or Sickness.

(e) Any expense or charge for services or supplies that are:

(1) Not provided in accordance with generally accepted professional medical standards; or

(2) For Experimental or Investigative Treatments or Procedures as defined in Section 2.17.

(f) Any expense or charge for checkups, routine physical exams, including screenings, or any physical or mental examination, evaluation or treatment, except as provided for in the Comprehensive Major Medical Benefit.

(g) Any physical or mental examination, evaluation, or treatment that is ordered by a court or by a third party or is required for insurance, employment, or special licensing purposes.

(h) Any expense or charge for preventive inoculations, except as specifically provided as a Covered Expense;

(i) Any expense or charge for Custodial Care, or long-term care.

(j) Any loss, expense, or charge that results from cosmetic or reconstructive surgery except:

(1) When such service is incidental to or follows surgery resulting from Injury of the involved part;

(2) When surgery is performed on an Eligible Dependent child because of a congenital disease or anomaly that has resulted in a functional defect, as determined by the attending Physician or Surgeon;

(3) When surgery is performed on an Eligible Person for repair of defects that result from surgery for which benefits are paid under this Plan; or

(4) As required by the Women's Health and Cancer Rights Act of 1998.

(k) Any expense or charge in connection with dental work or surgery (except as provided by the Plan), including:

(1) Treatment involving any tooth structure, alveolar process, abscess or disease of the periodontal or gingival tissue;

(2) Surgery or splinting to adjust dental occlusion; or

(3) Anesthesia or Hospital Expenses for outpatient surgery.

(l) Inpatient or outpatient charges resulting from behavioral problems, conduct disorder, learning disability, and developmental delay unless otherwise specified.

(m) Any loss, expense or charge that results from appetite control or any treatment for obesity, except as specifically provided by the Plan in Section 9.06 and for surgery to treat Morbid Obesity as defined in Section 2.30.

(n) Any expense or charge for routine foot care, orthopedic shoes, orthotics or other supportive devices for the feet (including over-the-counter items), except as provided at Section 9.06(cc).

(o) Any expense or charge for eye exercises or vision training (orthoptics).

(p) Any expense or charge for failure to appear for an appointment as scheduled or for completion of claim forms and obtaining medical records.

(q) Any loss, expense or charge for sex transformation or any treatment related to sexual dysfunction.

(r) Any expense or charge for which an Eligible Person does not have to pay in the absence of these benefits.

(s) Any loss, expense or charge resulting from an Eligible Person's participation in a riot, other than when engaged in, as a part of, or in connection with a labor dispute, or while engaged in the commission of a felony or attempt to commit a felony, except for losses, expenses or charges resulting from domestic violence.

(t) Any loss, expense or charge that results from an act of declared or undeclared war, armed aggression, insurrection or civil war.

(u) Any loss, expense or charge incurred while an Eligible Person is on active duty or in training in the Armed Forces, National Guard or Reserves of any state or country or for which any governmental body or its agencies are liable.

(v) Any expense or charge for the promotion of fertility, including but not limited to:

(1) Reversal of surgical sterilization; and

(2) Any attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization, or embryo transfers.

(w) Any expense or charge for chelation therapy except for acute arsenic, gold, mercury, or lead poisoning.

(x) Any expense or charge for services or supplies that are provided or paid for by the federal government or its agencies, except for:

(1) The U.S. Department of Veterans Affairs, when services are provided to a veteran for a disability that is not service-connected;

(2) A military Hospital or facility, when services are provided to a retiree (or dependent of a retiree) from the armed services; or

(3) A group health plan established by a government for its own civilian employees and their dependents.

(y) Elective abortions, but benefits will be paid for abortions resulting from medical necessity, and for complications arising from abortions.

(z) Supplies or equipment for personal hygiene, comfort or convenience such as air conditioning, humidifier, physical fitness and exercise equipment, home traction unit, tanning bed or water bed.

(aa) Special home construction.

(bb) Speech therapy principally for developmental delay and speech therapy, unless it is required because of a physical impairment caused by a disease or Injury.

(cc) Ambulance service, except as specifically provided in Section 9.06(h).

(dd) Any Hospital expense incurred on a Friday and/or Saturday when the Eligible Person was admitted on that Friday or Saturday as an inpatient in a Hospital, except:

(1) For Emergency Care,

(2) When surgery is performed within one day of such admission, or

(3) For the birth of a baby.

(ee) Any Hospital charge incurred as an inpatient more than one day prior to non-emergency surgery, except when medical evidence is presented and accepted by the Fund that due to unique circumstances more than one day of hospitalization prior to surgery is needed.

(ff) Well child care that is considered routine except for what is specifically provided in Section 9.06(w).

(gg) Any expense incurred for the care or treatment of mental and nervous disorders and alcoholism, chemical and drug dependency, except as specifically provided in Section 9.06(z).

(hh) Any expense for wigs.

(ii) Any expense for radial keratotomy and/or laser surgery to correct vision, except as specifically provided.

(jj) Any expense for a mechanical heart implant, including subsequent medication and maintenance.

(kk) Any expense for swimming and physical fitness programs.

(ll) Any expense for the services of a chiropractor except those covered under Article 10.

(mm) Any expense for nutritional supplements, even if prescribed by a Physician or chiropractor.

(nn) Any expense incurred for non-experimental organ transplants, except as provided under Article 18.

(oo) Any expenditure, charge or Expense arising out of, or incurred in connection with, pregnancy and maternity-related conditions of an otherwise Eligible Person acting as a privately paid surrogate mother, including Expenses and charges incurred by the offspring of such surrogate pregnancy.

(pp) Any Expense for genetic or DNA testing, except for diagnostic genetic testing as provided at Section 9.06(dd).

(qq) Any Expense or charge for prescription drugs, except as provided while in a Hospital or Skilled Nursing Care Facility or under the Prescription Drug Benefit.

(rr) Any Expense for preventive or routine care (including screenings due to family history) unless specifically provided by the Plan.

Section 4.12 Claim Decisions and Notice of Denial of Claim

(a) The time period for making an initial decision on a claim starts as soon as the claim is filed in accordance with the Fund's reasonable filing procedures, regardless of whether the Fund has all of the information necessary to decide the claim. A claim may be filed by an Employee, covered Dependent, an authorized representative, or by a network provider. In the event a claim is filed by a provider, such provider shall not automatically be considered a claimant's authorized representative.

(1) Pre-service claims.

(A) Pre-Service claims (that are not for Urgent Care) will be decided no later than 15 days after receipt by the Fund. A claimant and his/her doctor must be notified

within the 15-day period whether the claim was approved or denied (in whole or in part).

(B) The time for deciding the claim may be extended by up to 15 days due to circumstances beyond the Fund's control (e.g., inability of the medical reviewer to meet a deadline), provided notification of the circumstances requiring the extension and the date the Plan expects to make a determination is given to the claimant before the expiration of the initial 15-day determination period.

(C) If a claim cannot be processed due to insufficient information, the Fund must notify the claimant about what specific information is needed before the expiration of the 15-day initial determination period. Thereafter, the claimant will have 45 days following his/her receipt of the notice to supply the additional information. If the claimant does not provide the information during the 45-day period, the claim will be denied. During the period in which the claimant is permitted to supply additional information, the normal period for making a decision is suspended. The claim decision deadline is suspended until the earlier of 45 days or the date the Fund receives the claimant's response to the request for information. The Fund then has 15 days to make a decision and notify the claimant.

(2) Urgent care claims.

(A) The Fund must decide claims for Urgent Care as soon as possible taking into consideration medical exigencies, but in no event later than 72 hours after receipt of the claim. The Fund will communicate its decision telephonically to the claimant (and his/her doctor). The determination will also be confirmed in writing unless additional information is needed.

(B) If a claim cannot be processed due to insufficient information, the Fund must notify the claimant (and his/her doctor) about what specific information is needed as soon as possible and no later than 24 hours after receipt of the claim. Thereafter, the claimant will have 5 days following his/her receipt of the notice to supply the additional information. If the claimant does not provide the information during the 5-day period, the claim will be denied. Notice of the decision will be provided to the claimant (and his/her doctor) no later than 48 hours after the Fund receives the specific information or the end of the period given for the claimant to provide this information, whichever is earlier.

(3) Concurrent claims.

(A) Claims involving the *termination or reduction* of a benefit must be made as soon as possible, but in any event early enough to allow the claimant to have an *appeal* decided before the benefit is reduced or terminated. Concurrent Claims in this context constitute a request for an appeal of an adverse benefit determination and the Fund shall require any request for such a decision to be made in writing.

(B) Claims that involve the *extension* of an approved Urgent Care treatment must be acted on by the Fund within 24 hours of receipt, taking into account the medical exigencies, provided the Fund receives the claim at least 24 hours before the expiration of an approved treatment. Concurrent Claims involving Urgent Care may be provided orally to the Fund and any determinations communicated by the Fund to the claimant may be oral. Any determinations communicated orally to the claimant shall be confirmed in writing. A request to extend approved treatment that does not involve Urgent Care will be decided according to Pre-Service or Post-Service timeframes, as applicable.

(4) Post-service claims.

(A) Claims for Post-Service treatments or services will be decided within a reasonable period of time but no later than 30 days after receipt by the Fund. A claimant must be notified within the 30-day initial determination period if the claim is denied (in whole or in part).

(B) The time for deciding the claim may be extended by 15 days due to circumstances beyond the Fund's control (e.g., inability of the medical reviewer to meet a deadline), provided notification of the circumstances requiring the extension and the date the Plan expects to make a determination is given to the claimant before the expiration of the initial 30-day determination period.

(C) If a claim cannot be processed due to insufficient information, the Fund must notify the claimant about what information is needed before the expiration of the initial 30-day initial determination period. Thereafter, the claimant will have 45 days after his/her receipt of the notice to supply the additional information. If the claimant does not provide the information during the 45-day period, the claim will be denied. During the period in which the claimant is permitted to supply additional

information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date the Fund receives the claimant's response to the request for information. The Fund then has 15 days to make a decision and notify the claimant.

(5) Weekly Accident and Sickness Benefit claims.

(A) Claims for Weekly Accident and Sickness Benefits will be decided within a reasonable period of time but no later than 45 days after receipt by the Fund. A claimant must be notified within the 45-day initial determination period if the claim is approved or denied (in whole or in part).

(B) The time for deciding the claim may be extended by 30 days due to circumstances beyond the Fund's control (e.g., inability of the medical reviewer to meet a deadline), provided notification of the circumstances requiring the extension and the date the Plan expects to make a determination is given to the claimant before the expiration of the initial 45-day determination period. An additional extension may also be obtained if the Plan provides the claimant with notification of the circumstances requiring the extension and the date the Plan expects to make a determination before the end of the first 30-day extension period. The notice of extension shall specifically explain the standards for eligibility of the benefit, the unresolved issues preventing a decision on the claim, and any additional information that is still needed to process and make a determination on the claim.

(C) If a claim cannot be processed due to insufficient information, the Fund must notify the claimant about what information is needed before the expiration of the initial 45-day initial determination period. Thereafter, the claimant will have 45 days after his/her receipt of the notice to supply the additional information. If the claimant does not provide the information during the 45-day period, the claim will be denied. During the period in which the claimant is permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date the Fund receives the claimant's response to the request for information. The Fund then has 30 days to make a decision and notify the claimant.

(6) Death Benefit and Accidental Death and Dismemberment claims will be decided within 90 days after the Fund receives the claim. If circumstances require an extension of time for processing the claim, the Participant will be notified in writing that an extension is necessary. The notice will state the special circumstances and the date the Fund expects to make a decision. The extension will not be for more than 90 days from the end of the initial 90-day period.

(b) Whenever a claim is denied in part or in whole with respect to Eligibility for, or amount of Plan benefits, the Trustees (or an Administrative Manager acting for the Trustees) shall give written notice to the Employee, the Dependent, Beneficiaries or authorized or legal representatives, as may be appropriate. Such notice will include:

(1) The specific reason or reasons for the denial or other adverse benefit determination;

(2) Reference to the pertinent provisions of the Plan on which the denial is based;

(3) A description of additional material or information, if any, necessary for the claimant to perfect the claim and, where appropriate, an explanation of why such material or information is necessary; and

(4) An explanation of the Fund's Claims Review Procedures and time periods to appeal the claim, plus a statement of the claimant's right to bring a lawsuit under ERISA Section 502(a) following the review of the claim;

(5) A copy of any internal rule, guideline, protocol or other similar criteria that was relied on, if applicable, in making the adverse benefit determination, or a statement that a copy of the rule, guideline, protocol or other similar criteria relied upon is available to the claimant at no cost upon request;

(6) A copy of the scientific or clinical judgment or statement that it is available to the claimant at no cost upon request for medical and weekly accident and sickness claims that are denied due to medical necessity, experimental treatment, or similar exclusion or limit.

(c) A denial of a claim or other adverse benefit determination includes the following:

(1) A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including any such denial, reduction, termination or failure to provide or make a payment that is based on:

(A) A determination of an individual's eligibility to participate in the Plan; or

(B) A determination that a benefit is not a covered benefit;

(2) A reduction in a benefit resulting from the application of any utilization review decision, preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits, or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

(3) Any rescission of coverage, as defined in Section 3.35, whether or not there is an adverse effect on any particular benefit at that time.

Section 4.13 Claims Review Procedure

(a) A claimant may make a written request for review filed with the Trustees within 180 days after the receipt of the notice of denial of a medical or Weekly Accident and Sickness claim wherein the claimant's claim for benefits is denied in whole or in part, or if the claimant is otherwise dissatisfied with a determination of the Trustees with respect to his eligibility for, or amount of, his benefits, or if the claimant has not received such notice of denial of claim within the required time period under Section 4.12(a) after receipt of claimant's claim. A claimant may make a written request for review filed with the Trustees within 90 days after the receipt of the notice of denial of a Death Benefit or Accidental Death and Dismemberment claim that is issued pursuant to Section 4.12. If the claimant has not received such notice of denial of claim, the claimant may make a request for review at the expiration of the timeframes for making a decision outlined in Section 4.12. The request for review must be in writing, and may contain the following:

(1) Request for review of the denial of claim, with an explanation of the reasons for disagreement with the decision on the claim and, if desired, providing supporting documents or additional comments;

(2) Request for an inspection of relevant designated, pertinent documents or files; the claimant has the right to such inspection, without charge;

(3) Request for a copy of any internal rule, guideline, protocol, or other similar criteria on which the denial was based;

(4) Request for a copy of any explanation of the scientific or clinical judgment on which the denial was based, if the denial was based on Medical Necessity, experimental treatment, or similar exclusion or limit; or

(5) Issues and comments, as well as any supplemental material or information that may have been requested in the notice of denial referred to in Section 4.12 or that the claimant may consider desirable or necessary.

(b) If the claim or appeal is denied, in whole or in part, on the basis of a medical judgment, the Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and was not consulted (or is not subordinate to the person who was consulted) in connection with the initial denial of the claim. A claimant has the right to be advised of the identity of any medical or vocational experts consulted on behalf of the Plan in making a determination on the appeal, whether or not the advice was relied on in making the determination. In deciding an appeal of a Medical or Weekly Accident and Sickness disability claim, the Trustees shall not afford deference to the initial adverse decision.

(c) Decisions on appeals of post-service medical claims, Weekly Accident and Sickness disability claims, Death benefit claims, and Accidental Death and Dismemberment claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of the claimant's appeal if the claimant's appeal is received at least 30 days prior to the meeting. If the claimant's appeal is not received within 30 days of the next regularly scheduled meeting, the appeal will be considered at the second regularly scheduled meeting following the Trustees' receipt of the written appeal. In special circumstances, a delay until the third regularly scheduled meeting after the Trustees' receipt of the claimant's written appeal may be necessary. The Plan will notify the claimant in writing in advance of the special circumstances and the date the claim determination will be made if this extension is necessary. Once the appeal has been determined by the Trustees, the Trustees will notify the claimant of the decision on appeal as soon as possible, and no later than five days after the date of the meeting at which the appeal was considered.

(d) Decisions on appeals of urgent, concurrent and pre-service medical claims will be made by the Board of Trustees (or a Committee of the Trustees) within 72 hours of receipt of the claim by the Fund Office for urgent claims, and within 30 days of receipt of the claims by the Fund Office for concurrent and pre-service medical claims.

(e) As part of such written request for review, the claimant shall have the right to request the Board of Trustees to conduct a hearing on the matter. In such event, the claimant (or a duly authorized representative of his choice) will be given the opportunity to appear before the Trustees or before a committee of the Trustees.

(f) With respect to any matter as to which the claimant requests review in accordance with this Section 4.13, the Trustees (or a committee of the Trustees) will act by the vote of a majority of their members present.

(g) The decision of the Trustees or of a committee of the Trustees, on review, will be in writing and will include:

(1) Specific reason or reasons for the decision;

(2) References to pertinent provisions of the Plan on which the decision is based;

(3) A statement that the claimant is entitled to receive reasonable access to and copies of all documents, records and other information relevant to the claim, upon request and free of charge; and

(4) A statement of the claimant's right to bring a civil action under ERISA Section 502(a), following an adverse benefit determination on review.

If an internal rule, guideline or protocol was relied upon by the Fund, then the claimant may receive either a copy of the rule, or a statement that it is available upon request at no charge. If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, then the claimant may receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Fund to the claim, or a statement that it is available upon request at no charge.

(h) The procedures prescribed in Sections 4.12 and 4.13 must be followed and exhausted before the claimant may institute any legal or equitable action (including actions or proceedings before administrative agencies) with respect to a claim concerning Eligibility for, or amount of, benefits from and under the Fund or Plan. Effective for claims filed on or after June 1, 2005, no legal or equitable action (including actions or proceedings before administrative agencies) with respect to a claim concerning a claimant's Eligibility for, or amount of benefits from, and under the Fund or Plan may be commenced later than two (2) years from the date the claim was required to be received by the Fund Office, as specified in Section 4.02 herein.

(i) The Trustees have the sole and absolute discretion to construe and interpret the Plan and any or all of its provisions, rules, regulations, or procedures. The decisions of the Trustees are to be accorded judicial deference in any action at law or administrative proceeding. The Trustees also have the discretion to determine eligibility for benefits under the Plan and Trust, including eligibility for participation, or other benefits available under the Plan. To the extent any such duties are delegated to others, the Trustees retain the right to ultimately decide all appeals, in the Trustees' sole and absolute discretion. Benefits under this Plan will be paid only if the Trustees decide in their discretion that the applicant is entitled to them. Any exercise by the Trustees of their discretionary authority with respect to construction and interpretation of the Plan and Trust or eligibility for benefits will be final and binding.

Section 4.14 Subrogation/Reimbursement – Assignment of Claim Against Third Party

(a) Whenever the Wisconsin Laborers' Health Fund has been or is providing medical, Hospital, dental, vision or disability benefits ("Benefits"), as a result of the occurrence of an injury, sickness or death which results in a possible recovery of indemnity from any party (including an insurer) (hereinafter sometimes called "Loss"), including uninsurance and underinsurance coverage, the Fund may make a claim or maintain an action against such Party.

(b) By virtue of accepting such Benefits as a result of the occurrence of an Injury, Sickness or death, which results in a possible recovery of indemnity from any party (including an insurer) ("Loss"), including uninsurance and underinsurance coverage, the Participant or Dependent recipient, respectively, of such Benefits thereby assigns to the Fund the right to make a claim against such party to the extent of the amount of such Benefits.

(c) A Participant or Dependent must not do anything after the occurrence of a Loss for which the Benefits were provided to prejudice the Fund's right of recovery. A Participant or Dependent shall promptly advise the Administrative Manager of this Fund in writing whenever a claim against any party is made by or on behalf of the Participant or Dependent with respect to any Loss for which Benefits were, or are being, received from the Fund.

(d) The recipient of Benefits has an obligation to provide the Fund or its designee with the names and addresses of all potential parties and their insurers, adjusters, and claim numbers, as well as accident reports and any other information the Fund requests. If the information requested is not provided, the Fund in its discretion may withhold future Benefit obligations pending receipt of the requested information.

(e) The Participant or Dependent recipient of such Benefits, or the Fund, may make a claim against a party, or commence an action against a party, and shall join the other as provided under Section 803.3 of the Wisconsin Statutes or applicable state or federal law. Each shall have an equal voice in the prosecution of such claim or action.

(f) The proceeds from any settlement or judgment in any claim made against a third party shall be allocated as follows:

(1) First, a sum sufficient to fully reimburse the Fund for all Benefits advanced shall be paid to the Fund. No court costs nor attorneys' fees may be deducted from the Fund's recovery without prior expressed written consent of the Fund. This right shall not be defeated by any so-called "Fund Doctrine" or "Common Fund Doctrine," or "Attorneys Fund Doctrine" or any other similar doctrine or theory.

(2) Second, any remainder shall be paid to the Participant or Dependent recipient of Fund Benefits on whose behalf claim is made.

(3) Third, the Fund shall receive a credit, up to the full amount of any remainder paid to the recipient of Benefits pursuant to the prior paragraph (2), to apply against any future Benefit obligations arising out of the injury, sickness, or death that was the subject of the claim that resulted in the settlement or judgment.

(g) The aforesaid allocation of proceeds shall be paid from the first dollar of any proceeds received and shall have priority over competing claims, regardless of whether the total amount of the recovery of the Eligible Person, or those claiming under him, is less than the actual loss suffered, or less than the amount necessary to make the Eligible Person, or those claiming under him, whole. The Fund's rights shall not be defeated or reduced by the application of any so-called "Made-Whole Doctrine," "Garrity Doctrine," "Rimes Doctrine," or any doctrine purporting to defeat the Fund's rights by allocating the proceeds exclusively, or in part, to non-medical expenses or damages.

Furthermore, such allocation shall apply to claims of Dependents or Participants covered by the Fund, regardless of whether such recipient was legally responsible for expenses of treatment.

(h) In the event an Eligible Person makes a recovery in a claim from any party and the proceeds are not allocated in accordance with the prior subsections (f) and (g), the Trustees shall have the right to make a claim for reimbursement, including but not limited to claims for restitution, unjust enrichment, or a constructive trust over any recovery by the Eligible Person, to the extent of the

Fund's expenditures, whether the recovery is paid to, or in the possession of, the Eligible Person, the Eligible Person's attorney, or any other individual or entity, or to take a credit on future Fund obligations to the Eligible Person to the extent of such Benefits. Such credit is not limited to future obligations of the Fund to the actual recipient of such Benefits, but may be taken against any future Fund obligations to the Eligible Employee or any of his Dependents.

Section 4.15 Indemnification

If any benefits have been paid on account of services received by an Eligible Person and thereafter it is established that the charges for said services were not paid by the Eligible Person, or that the Eligible Person was otherwise reimbursed for those expenses, or was entitled to reimbursement for those expenses, then the Trust Fund shall be entitled to a refund of the amount of said benefits paid.

Section 4.16 Right to Make Payment

(a) The Trustees have the right to pay benefits to any other organization or person, as needed, to properly carry out the provisions of the Plan.

(b) The Trustees may pay for or provide services or equipment that they deem to be Medically Necessary, but not otherwise covered by the Plan, if in their sole discretion, they conclude that paying for or providing such services or equipment would be financially beneficial to the Plan. No such payment or providing of services or equipment shall be deemed to be an amendment to the Plan nor establish a precedent, nor shall it obligate such payments or providing of services or equipment in the case of any subsequent claim. The Trustees may, but shall not be required to, delegate to their Administrative Manager the authority to authorize such payments pursuant to written rules of uniform application that they may adopt form time to time.

(c) If any Eligible Person is, in the opinion of the Trustees, legally incapable of giving a valid receipt for any payment due and no guardian has been appointed for that Eligible Person, the Trustees may, at their option, make such payment to the person or persons who, in the opinion of the Trustees, have assumed the care and principal support of such Eligible Person. If the Eligible Person should die before all amounts due and payable have been paid, the Trustees may, at their option, make such payment to the executor, administrator or personal representative of his estate or to the Person's surviving spouse, parent, child or children, or to any other person or persons who, in the Trustees' opinion, are entitled thereto.

(d) The Trustees are authorized to collect from the Employee or Retired Employee the Employee or Retired Employee's share of any Federal Insurance Contributions Act (FICA) tax or any other employment tax due because of the Plan's provision of benefits to Domestic Partners, and to pay it and the Employer's portion of any such tax due because of the Plan's provision of benefits to Domestic Partners in accordance with federal law.

Section 4.17 Amendment and Termination

(a) In order that the Trustees may carry out their obligation to maintain, within the limits of the funds available to them, a sound and economical program dedicated to providing the maximum benefits for Eligible Employees and their Dependents, the Trustees expressly reserve the right in their sole discretion and without prior notice to Employees, Retired Employees, Contributing Employers, the Union and others affected hereby, but upon a non-discriminatory basis, to:

(1) Discontinue or modify, in whole or in part, either the amount of any benefit and/or the limitations or conditions pertaining to any benefit; provided, however, no amendment to the Plan shall retroactively reduce benefit entitlement or benefit levels then in effect; and/or

(2) Alter the method of payment of any benefit; and/or

(3) Amend any other provisions of the Plan; and/or

(4) Interpret the provisions of the Plan.

Any decision of the Trustees or the Trustees' delegate shall be made in the sole and absolute discretion of the Trustees or the delegate, as applicable, and shall be final and binding upon all persons dealing with the Plan or claiming any benefit under the Plan, except to the extent that the decision is determined to be arbitrary or capricious by a court having proper jurisdiction.

(b) Any Plan amendment shall be adopted pursuant to the terms of the Trust Agreement and shall be in writing. The Trustees shall notify Eligible Persons of any amendment in writing.

(c) Upon termination of the Plan, benefits for covered expenses incurred before the termination date will be paid on behalf of Eligible Persons as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets, and benefit payments will be limited to the funds available in the Trust Fund for such purposes. The Trustees will not be liable for the adequacy or inadequacy of such funds. If there are any assets remaining after payment of all Plan liabilities, those assets will be used for purposes determined by the

Trustees according to the Trust Agreement. However, any use of such assets will be made only for the benefit of the Plan Participants who were covered under the Plan at the time of the Plan's termination.

Section 4.18 Prohibition Against Assignment to Providers

(a) An Eligible Person, Participant, or Beneficiary may not assign any right under the Plan or statutory right under applicable law to a provider of services or supplies. The prohibition against assignment of such rights includes, but is not limited to the right:

(1) To receive benefits;

(2) To claim benefits in accordance with the Plan procedures and/or applicable law;

(3) To commence legal action against the Plan, Trustees, Fund, its agents, or employees;

(4) To request Plan documents or other instruments under which the Plan is established or operated;

(5) To request other information that a Participant may be entitled to receive upon written request to a plan administrator; and

(6) To exercise any and all other rights afforded an Eligible Person, Participant, or Beneficiary under the Plan, Restated Trust Agreement, federal law and state law.

(b) This Section 4.18 shall not have the effect of prohibiting the claims administrator or the Trustees from mailing payment of benefits under the Plan to a provider of services or supplies in accordance with Section 4.06.

Section 4.19 Use, Disclosure and Security of Private Medical Information under HIPAA

(a) The Plan will use protected health information (PHI) to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH). Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations. Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Plan Participants' PHI to the Board of Trustees, Wisconsin Laborers' Health Fund, unless the Board

certifies that the Plan Document has been amended to incorporate this Section 4.19 and agrees to abide by this Section 4.19.

(b) "Payment" includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

(1) Determination of eligibility, coverage, and cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim);

(2) Coordination of benefits;

(3) Adjudication of health benefit claims (including appeals and other payment disputes);

(4) Subrogation of health benefit claims;

(5) Establishing employee contributions;

(6) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(7) Billing, collection activities and related health care data processing;

(8) Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to a Person's inquiries about payments;

(9) Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(10) Medical necessity reviews, or reviews of appropriateness of care or justification of charges;

(11) Utilization review, including precertification, preauthorization, concurrent review and retrospective review;

(12) Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security Number, payment history, account number, and name and address of the provider and/or health plan); and

(13) Reimbursement to the Plan.

(c) Health Care Operations include, but are not limited to, the following activities:

(1) Quality assessment;

(2) Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;

(3) Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

(4) Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);

(5) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

(6) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies;

(7) Business management and general administrative activities of the entity, including, but not limited to:

(A) Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;

(B) Customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers;

(C) Resolution of internal grievances; and

(D) Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.

(d) The Plan will use and disclose PHI as required by law and as permitted by authorization of the individual. With an authorization, the Plan will disclose PHI to the pension plan, disability plan, reciprocal benefit plans and Workers' Compensation insurers that are associated with this Plan, for purposes related to administration of these plans.

(e) For purposes of this Section, the Board of Trustees is the Plan Sponsor.

(1) With respect to PHI, the Plan Sponsor agrees to:

(A) Not use or further disclose the Plan Participants' information other than as permitted or required by the Plan Document, as amended, or as required by law;

(B) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides Plan Participants' PHI received from the Plan agree to the same restrictions and conditions of the Plan Document, including this Section 4.19 that apply to the Plan Sponsor with respect to such information;

(C) Not use or disclose the Plan Participants' information for employment-related actions and decisions unless authorized by the individual;

(D) Not use or disclose the Plan Participants' information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual;

(E) Report to the Plan any use or disclosure of the Plan Participants' information that is inconsistent with the uses or disclosures allowed under this Section 4.19 promptly upon learning of such inconsistent use or disclosure;

(F) Make PHI available to the Plan or to the individual, who is the subject of the information in accordance with 45 Code of Federal Regulations § 164.524;

(G) Make Plan Participants' PHI available for amendment and will on notice amend Plan Participants' PHI, in accordance with 45 Code of Federal Regulations § 164.526;

(H) Track disclosures it may make of Plan Participants' PHI that are accountable under 45 Code of Federal Regulations § 164.528 so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528;

(I) Make internal practices, books, and records relating to the use and disclosure of Plan Participants' PHI available to the Plan and to the Secretary of the U.S. Department of Health and Human Services for the purposes of determining the Plan's compliance with 45 Code of Federal Regulations Part 164, Subpart E "Privacy of Individually Identifiable Health Information;

(J) If feasible, return or destroy(and cause its subcontractors and agents to, if feasible, return or destroy) all Plan Participants' PHI, in whatever form or medium, received from the Plan or any health insurance issuer or business associate servicing the Plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow identification of any Participant who is the subject of the PHI, when the Plan Participants' PHI is no longer needed for the plan administration functions for which the disclosure was made. If return or destruction of all Plan Participants' PHI is not feasible, limit (and cause its contractors and agents to limit) further uses and disclosures of any Plan Participants' PHI that cannot feasibly be returned or destroyed to those purposes that make the return or destruction infeasible.

(f) Adequate separation between the Plan and the Plan Sponsor must be maintained. All Trustees serving on the Board may be given access to Plan Participants' PHI received from the Plan or a health insurance issuer or business associate servicing the Plan. All Trustees serving on the Board may receive Plan Participants' PHI relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business. In addition, in accordance with HIPAA, the following employees or classes of employees may also be given access to PHI.

(1) The Administrative Manager;

(2) Staff designated by the Administrative Manager who assist in the administration of the Plan;

The persons described in this subsection (f) may only have access to and use and disclose PHI for administration functions that the Plan Sponsor performs for the Plan.

(g) If the persons described in subsection (f) do not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions. In addition, the Trustees identified in subsection (f) will be subject to disciplinary action and sanctions, including termination of trustee status, for any use or disclosure of Plan Participants' PHI in breach or violation of or noncompliance with the provisions of this Section 4.19.

(h) For purposes of complying with the HIPAA privacy rules, this Plan is a "Hybrid Entity" because it has both health plan and non-health plan functions. The Plan designates that its health care components that are covered by the privacy rules include only health benefits and not other Plan functions or benefits.

(i) The Plan Sponsor will:

(1) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan,

(2) Ensure that the adequate separation between the Plan and Plan Sponsor, specific to electronic PHI, is supported by reasonable and appropriate security measures,

(3) Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and

(4) Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

(5) Provide notification by first-class mail to Plan Participants within 60 calendar days following the discovery of a breach of the Participants' unsecured PHI; provide notification to the Department of Health and Human Services (HHS) following a breach; if the breach involves more than 500 individuals, provide notification to the media.

(j) **Purpose of Disclosure to the Plan Sponsor**

(1) The Plan and any health insurance issuer or business associate servicing the Plan will disclose Plan Participants' PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions for the Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing

regulations (45 C.F.R. Parts 160-64). Any disclosure to and use by the Plan Sponsor of Plan Participants' PHI will be subject to and consistent with the provisions of Sections 4.19(e) and 4.19(f).

(2) Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Plan Participants' PHI to the Plan Sponsor unless the disclosures are explained in the Privacy Practices Notice distributed to the Plan Participants.

(3) Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Plan Participants' PHI to the Plan Sponsor for the purpose of employment related actions or decisions or in connection with any other benefit or employee benefit plan of the Wisconsin Laborers' Health Fund.

(k) **Choice of Law**

As a condition of Plan participation, the Plan Sponsor requires that the privacy rights of Participants and Dependents be governed only by HIPAA and the laws of the State of Wisconsin (but only to the extent such laws are not preempted by the Employee Retirement Income Security Act of 1974), without regard to whether HIPAA incorporates privacy rights granted under the laws of other states and without regard to Wisconsin's choice of law provisions.

(l) With regard to the security of Protected Health Information (PHI), in compliance with the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), the Plan will:

(1) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(2) Ensure that the adequate separation discussed above in Section (d), specific to electronic PHI, is supported by reasonable and appropriate security measures;

(3) Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and

(4) Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

ARTICLE 5 SCHEDULE OF BENEFITS

Section 5.01 Regular Plan for Eligible Active Employees and their Dependents

Benefit amounts stated in percentages denote the percentage of Allowable Charges for Covered Expenses.

SCHEDULE A - DEATH BENEFIT (Active Employee Only)

Death Benefit ..... $ 12,000

SCHEDULE B - ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

(Active Employee Only)

Maximum Benefit ..... $ 12,000
Loss of Life 12,000
Loss of Two Limbs 12,000
Loss of Sight of Both Eyes 12,000
Loss of One Limb and Sight of One Eye 12,000
Loss of One Limb 7,000
Loss of Sight of One Eye 7,000

SCHEDULE C - WEEKLY ACCIDENT AND SICKNESS BENEFIT

(Active Employee Only)

Weekly Benefit ..... $ 300
Maximum Number of Weeks Payable ..... 19 per Period of Certified Disability

Unless otherwise indicated, the following schedules apply to all Eligible Active Employees and their Eligible Dependents. Benefit amounts stated in percentages denote the percentage of Allowable Charges for Covered Expenses.

SCHEDULE D - COMPREHENSIVE MAJOR MEDICAL BENEFIT

	PPO	Non-PPO
Calendar Year Maximum	Unlimited	
Calendar Year Deductible	$300 Per Individual $600 Per Family	

Emergency Room Deductible	$100 Waived if, within a period of 3 consecutive days, the patient is admitted to the hospital as a bed patient for at least 1 day.	
Emergency Care Plan Coinsurance	90%	
Plan Coinsurance	90%	60%
Physician Office Visit Copayment	$15	N/A
Calendar Year Out-of-Pocket Maximum	$4,500 per family	$10,000 per family
	The Out-of-Pocket Maximum does not include the Deductible or Office Visit Copayment.	

Certain Plan benefits are limited, as follows:

Radiologists, Anesthesiologists, Pathologists, and Emergency Room Physician Services:

Covered Expenses Payable by Fund at Network Facility..... 90%

Covered Expenses Payable by Fund at Out-of-Network Facility..... 60%

LiveHealth Online (Medical):

Covered Expenses Payable by Fund 100%

Home Health Care:

Maximum Number of Visits..... 40 every 12 consecutive months

Skilled Nursing Care:

Daily Room Benefit Maximum ..... As established by the local licensing agency

Benefit Period Maximum ..... 60 days per Confinement, concurrent with any other group health coverage

Outpatient Day Rehabilitation Center Services and Supplies:

Benefit Maximum.....30 outpatient visits per lifetime

Hospice Care Program:

Plan Coinsurance..... 100%

Air and Ground Ambulances:

Covered Expenses Payable by Fund..... 90%

Diabetes Education Program: 100%

Mental Health Treatment:

Inpatient Treatment

Covered Expenses Payable by the Fund: 90%

Deductible .....None

Outpatient Treatment

Covered Expenses Payable by the Fund: 100%

Deductible ..... None

LiveHealth Online (Behavioral) (Effective July 1, 2017):

Covered Expenses Payable by the Fund: 100%

Substance Abuse Treatment:

Inpatient Treatment

Covered Expenses Payable by the Fund:

First Occurrence 100%

Second and Subsequent Occurrences 90%

Deductible ..... None

Outpatient Treatment

Covered Expenses Coinsurance Payable by the Fund: 90%

Deductible ..... None

TMJ Benefit:

Covered Expenses Coinsurance Payable by the Fund: 50%

Stop Smoking Assistance Benefit (Only for Members, Spouses and Domestic Partners):

Smoking Cessation Counseling Classes Coinsurance Payable by the Fund 100%

Smoking Cessation Products ..... Covered under the Prescription Drug Program

Orthognathic Surgery:

Coinsurance: 50%

Lifetime Maximum ..... $10,000 per person

Chiropractic Benefit:

Maximums per Individual:

Calendar Year Maximum ..... 26 visits per person

Benefit Amount Per Visit $75

Chiropractic X-Rays 100%

Diagnostic Genetic Testing:

Annual Maximum ..... $2,500 per person

Preventive Care:

In-Network ..... 100%, not subject to the calendar year deductible

Out-of-Network ..... 60%, after the calendar year deductible

Organ Transplant Benefit:

Within the Network of the Plan's Contracted Network Provider:

Transplant Deductible ..... $300 per transplant

Covered Expenses Payable by the Fund:

Coinsurance Until the Out-of-Pocket Maximum is met 90%

Coinsurance After Out-of-Pocket Maximum is met 100%

Out-of-Pocket Maximum per Transplant $10,000*

Organ Procurement Benefit $15,000

Transportation Benefit - Covered Expenses by the Fund 100%**

Mail Order Immunosuppressive Drugs

Co-payment Participant Must Pay:

Per Generic Prescription (90-day supply) $16

Per Formulary Brand Name Prescription (90-day supply) $50

Per Non-Formulary Brand Name Prescription (90-day supply) $80

Retail Immunosuppressive Drugs ..... as determined on a case-by-case basis

Outside the Network of the Plan's Contracted Network Provider ..... No Coverage

* The Out-of-Pocket Maximum includes the Transplant Deductible.

** Transportation, temporary lodging and meal costs for one adult (or two adults if patient is under age 18) when the patient must travel 100 miles or more to receive care.

Prescription Drug Benefit:

Prescription Drug Card Program (30-day supply)

Co-payment by Participant:

Generic Drugs $8

Formulary Brand-Name Drugs* $25

Non-Formulary Brand-Name Drugs* $40

* If a Participant requests a brand-name drug when a generic is available, the Participant must pay the brand-name co-pay plus the difference in cost between the brand-name drug and the generic drug.

Mail Order Program (90-day supply)

Co-payment by Participant:

Generic Drugs $16

Formulary Brand Name Drugs* $50

Non-Formulary Brand Name Drugs* $80

* If a Participant requests a brand-name drug when a generic is available, the Participant must pay the brand-name co-pay plus the difference in cost between the brand-name drug and the generic drug.

Accidental Dental Coverage Coinsurance

When Delta Dental Provider is Used 85%

When Delta Dental Provider is Not Used 70%

Dental Benefit:

	Delta Preferred Option Provider	Non-Delta Preferred Option Provider
Calendar Year Deductible (Does not apply to Preventive and Diagnostic Services	$25 Per Individual $75 Per Family	
Plan Coinsurance for Preventive and Diagnostic Dental Care	100%	
Plan Coinsurance for Other Covered Dental Care and Dental Implants	85%	70%
Orthodontia	50%	
Calendar Year Maximum Benefit for all Dental Care (excluding Orthodontia)	$2,000 Per Individual. This limit does not apply to minor Dependent children under age 19.	
Lifetime Maximum for Orthodontia Dental Care	$2,000 Per Dependent Child. This limit does not apply to minor Dependent children under age 19.	

Vision Benefit:

Maximum Benefit per Individual..... $500 every 2 calendar year period

This limit does not apply to vision examinations for minor Dependent children under age 19.

Hearing Aid Benefit:

Maximum Benefit per Individual.....$2,000 every 5 calendar years

Section 5.02 Bare Bones Plan for Eligible Active Employees and their Dependents

(Optional Reduced Cost Plan for Active Participants in Self-Pay Status and Their Dependents)

COMPREHENSIVE MAJOR MEDICAL BENEFIT

Benefit amounts stated in percentages denote the percentage of Allowable Charges for Covered Expenses.

	PPO	Non-PPO
Calendar Year Maximum	Unlimited	
Calendar Year Deductible	$350 Per Individual $700 Per Family	
Emergency Room Deductible	$100 Waived if, within a period of 3 consecutive days, the patient is admitted to the hospital as a bed patient for at least 1 day.	
Emergency Care Plan Coinsurance	70%	
Physician Office Visit Copayment	$20	N/A
Plan Coinsurance	70%	60%
Calendar Year Out-of-Pocket Maximum	$12,500 per family	$25,000 per family
	The Out-of-Pocket Maximum does not include the Deductible or Office Visit Copayment.	

Certain Plan benefits are limited, as follows:

Radiologists, Anesthesiologists, Pathologists, and Emergency Room Physician Services:

Covered Expenses Payable by Fund at Network Facility..... 70%

Covered Expenses Payable by Fund at Out-of-Network Facility..... 60%

LiveHealth Online (Medical):

Covered Expenses Payable by Fund..... 100%

Home Health Care:

Maximum Number of Visits..... 40 every 12 consecutive months

Skilled Nursing Care:

Daily Room Benefit Maximum ..... As established by the local licensing agency

Benefit Period Maximum ..... 60 days per confinement, concurrent with any other group health coverage

Outpatient Day Rehabilitation Center Services and Supplies:

Benefit Maximum.....30 outpatient visits per lifetime

Air and Ground Ambulances:

Covered Expenses Payable by Fund..... 70%

Diabetes Education Program: 100%

Mental Health Treatment:

Inpatient Treatment

Covered Expenses Payable by the Fund: 75%

Deductible .....None

Outpatient Treatment

Covered Expenses Payable by the Fund: 100%

Deductible .....None

LiveHealth Online (Behavioral) (Effective July 1, 2017):

Covered Expenses Payable by Fund..... 100%

Substance Abuse Treatment:

Inpatient Treatment

Covered Expenses Payable by the Fund:

First Occurrence 100%

Second and Subsequent Occurrences 75%

Deductible.....None

Outpatient Treatment

Covered Expenses Payable by the Fund: 75%

Deductible .....None

Stop Smoking Assistance Benefit (Only for Members, Spouses and Domestic Partners);

Smoking Cessation Counseling Classes Coinsurance Payable by the Fund

In-Network..... 70%, after the calendar year deductible

Out-of-Network ..... 60%, after the calendar year deductible

Smoking Cessation Products .....Covered under the Prescription Drug Program

~~**Routine Mammograms, PAP tests, Routine Prostate Specific Antigen (PSA) Blood Tests for Men Age 50 and Older, and Seasonal Annual Flu Shot:**~~

~~Network Expenses: ..... 70%~~

~~Out-of-Network Expenses: ..... 60%~~

Diagnostic Genetic Testing:

Annual Maximum.....$2,500 per person

Preventive Care:

In-Network ..... 70%, after the calendar year deductible

Out-of-Network ..... 60%, after the calendar year deductible

Organ Transplant Benefit:

Within the Network of the Plan's Contracted Network Provider:

Transplant Deductible .....$300 per transplant

Covered Expenses Payable by the Fund:

Coinsurance Until the Out-of-Pocket Maximum is met 90%

Coinsurance After Out-of-Pocket Maximum is met..... 100%

Out-of-Pocket Maximum per Transplant.....$10,000*

Organ Procurement Benefit $15,000

Transportation Benefit - Covered Expenses by the Fund 100%**

Mail Order Immunosuppressive Drugs

Co-payment Participant Must Pay:

Per Generic Prescription (90-day supply).....$16

Per Formulary Brand Name Prescription (90-day supply) $50

Per Non-Formulary Brand Name Prescription (90-day supply).....$80

Retail Immunosuppressive Drugs..... as determined on a case-by-case basis

Outside the Network of the Plan's Contracted Network Provider..... No Coverage

* The Out-of-Pocket Maximum includes the Transplant Deductible.

** Transportation, temporary lodging and meal costs for one adult (or two adults if patient is under age 18) when the patient must travel 100 miles or more to receive care.

Prescription Drug Benefit

Prescription Drug Card Program

Co-payment by Participant:

Generic Drugs $8

Formulary Brand-Name Drugs*.....$25

Non-Formulary Brand-Name Drugs* $40

* If a Participant requests a brand-name drug when a generic is available, the Participant must pay the brand-name co-pay plus the difference in cost between the brand-name drug and the generic drug.

Mail Order Program

Co-payment by Participant:

Generic Drugs: $16

Formulary Brand Name Drugs* $50

Non-Formulary Brand-Name Drugs* $80

* If a Participant requests a brand-name drug when a generic is available, the Participant must pay the brand-name co-pay plus the difference in cost between the brand-name drug and the generic drug.

Section 5.03 Plan for Retired Employees and their Eligible Dependents

Benefit amounts stated in percentages denote the percentage of Allowable Charges for Covered Expenses.

DEATH BENEFIT

Benefit Amount (Employee Only).....$7,000

COMPREHENSIVE MAJOR MEDICAL BENEFIT

Note: The Plan coordinates benefits with Medicare for Retired Employees and Dependents of Retired Employees who are eligible for Medicare. For eligible covered Expenses, the Health Fund pays 90% of the difference between the Medicare Allowable Expense and the amount paid by Medicare.

	PPO	Non-PPO
Calendar Year Maximum	Unlimited	
Calendar Year Deductible	$300 Per Individual* $600 Per Family*	
Emergency Room Deductible	$100 Waived if, within a period of 3 consecutive days, the patient is admitted to the hospital as a bed patient for at least 1 day.	
Emergency Care Plan Coinsurance	90%	
Plan Coinsurance	90%	60%**
Physician Office Visit Copayment	$15	N/A
Calendar Year Out-of-Pocket Maximum	$4,500 per family	$10,000 per family
	The Out-of-Pocket Maximum does not include the Deductible or Office Visit Copayment.	

* Does not apply to Retired Employees or their Spouses who are eligible for Medicare.

** 90% for retirees and their spouses eligible for Medicare.

Certain Plan benefits are limited, as follows:

Radiologists, Anesthesiologists, Pathologists, and Emergency Room Physician Services:

Covered Expenses Payable by Fund at Network Facility..... 90%

Covered Expenses Payable at Out-of-Network Facility..... 60%

Home Health Care:

Maximum Number of Visits..... 40 every 12 consecutive months

Skilled Nursing Care:

Daily Room Benefit Maximum ..... As established by the local licensing agency

Benefit Period Maximum ..... 60 days per Confinement, concurrent with any other group health coverage

Outpatient Day Rehabilitation Center Services and Supplies:

Benefit Maximum.....30 outpatient visits per lifetime

Hospice Care Program:

Plan Coinsurance..... 100%

Air and Ground Ambulances:

Covered Expenses Payable by Fund..... 90%

Diabetes Education Program:..... 100%

Mental Health Treatment:

Inpatient Treatment

Covered Expenses Payable by the Fund: 90%

Deductible .....None

Outpatient Treatment

Covered Expenses Payable by the Fund: 100%

Deductible .....None

Substance Abuse Treatment:

Inpatient Treatment

Covered Expenses Payable by the Fund:

First Occurrence..... 100%

Second and Subsequent Occurrences..... 90%

Deductible.....None

Outpatient Treatment

Covered Expenses Payable by the Fund: 90%

Deductible .....None

TMJ Benefit:

Covered Expenses Coinsurance Payable by the Fund:..... 50%

Stop Smoking Assistance Benefit (Only for Members, Spouses and Domestic Partners):

Smoking Cessation Counseling Classes Coinsurance Payable by the Fund 100%

Smoking Cessation Products .....Covered under the Prescription Drug Program*

* Coverage for Medicare eligible Retirees covered under the Plan's Medicare Part D Employee Group Waiver Plan (EGWP) is subject to the provisions of that Plan.

Orthognathic Surgery:

Coinsurance 50%

Lifetime Maximum ..... $10,000 per person

Chiropractic Benefit:

Maximums per Individual:

Calendar Year Maximum ..... 26 visits per person

Benefit Amount Per Visit $75

Chiropractic X-Rays 100%

Diagnostic Genetic Testing:

Annual Maximum ..... $2,500 per person

Preventive Care:

In-Network ..... 100%, not subject to the calendar year deductible

Out-of-Network ..... 60%, after the calendar year deductible

Organ Transplant Benefit:

Within the Network of the Plan's Contracted Network Provider:

Transplant Deductible ..... $300 per transplant

Covered Expenses Payable by the Fund:

Coinsurance Until the Out-of-Pocket Maximum is met 90%

Coinsurance After Out-of-Pocket Maximum is met 100%

Out-of-Pocket Maximum per Transplant $10,000*

Organ Procurement Benefit $15,000

Transportation Benefit Covered Expense by the Fund 100%**

* The Out-of-Pocket Maximum includes the Transplant Deductible.

** Transportation, temporary lodging and meal costs for one adult (or two adults if patient is under age 18) when the patient must travel 100 miles or more to receive care.

Mail Order Immunosuppressive Drugs

Co-payment Participant Must Pay:

Per Generic Prescription (90-day supply) $16

Per Formulary Brand Name Prescription (90-day supply) $50

Per Non-Formulary Brand Name Prescription (90-day supply) $80

Retail Immunosuppressive Drugs ..... as determined on a case-by-case basis

Outside the Network of the Plan's Contracted Network Provider ..... No Coverage

Prescription Drug Benefit:

Prescription Drug Card Program (30-day supply)

Co-payment by Participant:

Generic Drugs $8

Formulary Brand-Name Drugs*.....$25

Non-Formulary Brand Name Drugs*.....$40

Mail Order Program (90-day supply)

Co-payment by Participant:

Generic Drugs:.....$16

Formulary Brand Name Drugs *.....$50

Non-Formulary Brand Name Drugs * $80

* If a Participant requests a brand-name drug when a generic is available, the Participant must pay the brand-name co-pay plus the difference in cost between the brand-name drug and the generic drug.

Accidental Dental Coverage Coinsurance

When Delta Dental Provider is Used..... 85%

When Delta Dental Provider is Not Used..... 70%

Vision Benefit:

Maximum Benefit per Individual.... $500 every 2 calendar year period This limit does not apply to vision examinations for minor Dependent children under age 19.

Hearing Aid Benefit

Maximum Benefit per Individual.....$2,000 every 5 calendar years

Optional Dental Benefit If Elected and Paid for by Retired Employee

The Retired Employee Dental Benefit is optional coverage for the Retired Employee and the Retired Employee's Dependents. The Retired Employee Dental Benefit is fully insured and the full cost of this coverage must be paid by the Retired Employee. Delta Dental of Wisconsin provides the benefits under an insurance contract, and Delta Dental makes all decisions on claims and benefits.

Retiree Contribution Allowance, pursuant to Article 19

Retiree Service Credit is multiplied by a factor:

Prior to Medicare Eligibility:..... $42.50 per service credit to a maximum of 30 credits (42,000 hours) and maximum contribution allowance of $1,275.00 per month

After Medicare Eligibility:..... $13.50 per service credit to a maximum of 30 credits (42,000 hours) and maximum contribution allowance of $405.00 per month

The amount of the allowance per service credit and the maximum contribution allowance is established by the Board of Trustees and may be changed at their discretion.

ARTICLE 6 DEATH BENEFIT

Section 6.01 Death Benefit, In General

Upon receipt at the Health Fund Office of written proof of the death of an Eligible Active Employee or Eligible Retired Employee, the Plan will pay the amount of the Death Benefit specified in the Schedule of Benefits in Section 5.01 or 5.03, respectively, in accordance with the provisions of this Article 6.

Section 6.02 Beneficiary

(a) Any sum becoming due by reason of the death of an Eligible Active or Retired Employee is payable to the beneficiary named on the Plan's records in accordance with the Employee's election or as provided in this Article 6.

(b) If more than one beneficiary is named, and the Employee fails to specify the beneficiaries' respective interests, the beneficiaries will share the benefit equally.

(c) If any named beneficiary dies before the Employee, his interest will end and his share will be payable equally to such other named beneficiaries as survive the Employee, unless the Employee has made a written direction to the contrary.

(d) In the event no named beneficiary survives the Employee or if no beneficiary was named by the Employee, the amount payable as a Death Benefit will be distributed as follows:

(1) To the Employee's spouse or Domestic Partner, if living, or if not living; then

(2) To the Employee's children by right of representation (per stirpes and not per capita), or if none survive; then

(3) To the Employee's father and mother, equally if both survive, or all to the survivor of them if only one survives the Employee, or if none survive; then

(4) To the Employee's surviving brothers and sisters, equally, or if none survive; then

(5) To the Employee's estate.

Section 6.03 Change of Beneficiary

An Employee may, from time to time, name a new beneficiary by filing a written designation on a form satisfactory to the Trustees at the Health Fund Office. Such change will be honored upon receipt at the Health Fund Office. When received, the change will take effect as of the date the Employee signed the designation, whether or not the Employee is living when the Health Fund Office receives the designation.

ARTICLE 7 ACCIDENTAL DEATH AND DISMEMBERMENT` BENEFIT

Section 7.01 Accidental Death and Dismemberment Benefits, In General

If an Eligible Active Employee sustains any of the accidental losses outlined in Section 7.02, on or off the job, the Plan will pay the amount of Accidental Death and Dismemberment (AD&D) Benefit shown in Section 5.01, in addition to any other benefits payable under the Plan, except that no payment shall be made for any loss caused wholly or partly, directly or indirectly by:

(a) Bodily or mental infirmity;

(b) Ptomaines;

(c) Bacterial infections, except infections caused by pyogenic organisms that may occur with and through an accidental cut or wound;

(d) Disease or sickness of any kind;

(e) War or any act of war;

(f) Service in any military, naval or air force of any country while such country is engaged in a war, civil war or insurrection; or

(g) Police duty as a member of any military, naval or air organization.

Section 7.02 Schedule of AD&D Benefits

(a) The full amount of the benefit shown in Section 5.01 shall be payable for loss of:

(1) Life;

(2) Two limbs;

(3) Sight of both eyes; or

(4) One limb and sight of one eye.

(b) One-half of the full amount of the benefit shall be payable for loss of:

(1) One limb; or

(2) Sight of one eye.

(c) The loss must occur within 90 days from the date of the accident, except in a circumstance where it cannot be determined that the dismemberment or loss due to an accident was within the 90-day period, but in no event beyond two years.

(d) Loss of limb means irrecoverable loss by severance at or above the wrist joint or the ankle joint. Loss of sight means the total and irrecoverable loss of sight.

(e) If an Eligible Active Employee suffers more than one of the losses described in this Section 7.02 as a result of any one accident, no more than the full amount of the benefit shall be payable.

ARTICLE 8 WEEKLY ACCIDENT AND SICKNESS BENEFIT

Section 8.01 Weekly Accident and Sickness Benefits, In General

Upon receipt at the Health Fund Office of due written proof that an Eligible Active Employee has become totally and continuously disabled as a result of a non-occupational bodily Injury or Sickness and is thereby prevented from working at his regular occupation and requires regular care of a Physician or Surgeon, the Employee will receive a weekly benefit, subject to the provisions of this Article 8 and the Schedule for Eligible Active Employees.

Section 8.02 Weekly Accident and Sickness Benefits Payable

(a) The weekly benefit will be payable in the amount set forth in Section 5.01. This benefit will be payable to the Employee beginning on the first day of disability due to an accidental bodily Injury or the eighth day of disability due to a Sickness, and will continue for up to a maximum of 19 weeks for any one Period of Total Disability. However, benefits will be paid retroactively to the first day of a disability due to a Sickness that extends past the eight-day waiting period. No disability will be considered as beginning more than three days prior to the first visit to a Physician or Surgeon.

(b) During partial weeks of disability, the Employee will be paid a daily rate of one-seventh of the weekly benefit amount set forth in Section 5.01.

(c) Weekly Accident and Sickness Benefits are only payable if the Employee is Eligible for benefits from the Plan when the disability commences.

Section 8.03 Periods of Total Disability Defined

Successive periods of disability shall be considered one Period of Total Disability unless:

(a) The disabilities are due to unrelated causes and begin after the Employee has returned to active, full-time work for at least one full day; or

(b) Before the second disability began, the Employee returned to active, full-time work for at least two continuous weeks or was ready and available for work under the terms of the Collective Bargaining Agreement. Medical evidence must be provided that shows that the Employee was ready and available for work, but unable to find a job, before a new period of disability may be recognized.

Section 8.04 Weekly Accident and Sickness Benefit Exclusions

No benefits are payable under this Article for any of the circumstances described in Section 4.11, “General Plan Exclusions.”

ARTICLE 9 COMPREHENSIVE MAJOR MEDICAL BENEFIT

Section 9.01 Benefits, In General

If an Eligible Person incurs Covered Charges (as defined in Section 9.06) as a result of a non-occupational Injury or Sickness, benefits will be paid at the percentages and up to the maximum amounts shown in the applicable schedule in Article 5.

Section 9.02 Benefits Payable

Benefits are payable at the percentages shown in the applicable schedule in Article 5 for an Eligible Person's Covered Charges in excess of the deductible amount, as described in Section 9.04.

Section 9.03 Out-of-Pocket Maximum

If a family of an Eligible Person, other than a family of Eligible Persons covered under the "Bare Bones" Plan, incurs $4,500 of PPO Provider/$10,000 of Non-PPO Provider Covered Charges (as defined in Section 9.06) during a Calendar Year, excluding copayments, the deductible amount, benefits are payable for 100% of the Eligible Person's Covered Charges in excess of $4,500/$10,000 for the remainder of the Calendar Year. This $4,500/$10,000 amount is called the out-of-pocket maximum. The family of Eligible Persons covered under the "Bare Bones" Plan has a $12,500/$25,000 out-of-pocket maximum and the family is not covered for Hospice Care, listed as item (e) of Section 9.06.

Section 9.04 Calendar Year Deductible

(a) The Comprehensive Major Medical deductible amount for each Calendar Year with respect to each Eligible Active Person, Retired Person not Eligible for Medicare and Persons covered under the "Bare Bones" Plan is shown in the applicable schedule in Article 5. No deductible is required for Retirees or their Spouses or Domestic Partners Eligible for Medicare.

(b) A separate Calendar Year Deductible amount will apply to each Eligible member of the family. The percentage of Covered Charges which the Eligible Person is required to pay may not be used to satisfy the deductible amount.

(c) Benefits will be subject to another Calendar Year Deductible on January 1 of each year. However, Covered Charges incurred during the last 90 days of a Calendar Year will be used to satisfy the deductible amount for that Calendar Year as well as the following Calendar Year.

Section 9.05 Emergency Room Deductible

(a) If an Eligible Person uses the services of an Emergency Room, the Eligible Person must pay the Emergency Room Deductible shown in the applicable Schedule of Benefits in Article 5.

(b) The Emergency Room Deductible will be waived if, within the first three-consecutive-day period, the Eligible Person is admitted to the Hospital as an inpatient for at least one day.

Section 9.06 Medical Benefit Covered Charges

Covered Charges are those Allowable Charges incurred for the following services and supplies that are necessary for treatment of a non-occupational Injury or Sickness, when Medically Necessary, including the following.

(a) Hospital services and supplies for:

(1) Room and board charges up to:

(A) The Hospital's regular daily semi-private rate;

(B) Most common private room rate charged by the Hospital that has only private rooms, unless isolation in a private room is required as the result of a diagnosis made by a Physician or to meet the requirements of the Hospital's public health regulations; and

(C) The Hospital's charges for intensive care unit or coronary care unit.

(2) Drugs, medicines and other Hospital services and supplies, if used while confined as a resident patient.

(3) Outpatient Hospital charges including:

(A) Charges incurred for outpatient surgery;

(B) Emergency Care; and

(C) Laboratory or x-ray examinations and related fees charged by a radiologist or pathologist for diagnosis of an Injury or Sickness which are ordered by a Physician, subject to copayments, coinsurance and deductibles specified in the applicable Schedule of Benefits in Article 5. Such expenses are covered for initial diagnostic

services, even if the treatment for the resulting diagnosis is not covered by the Plan. Genetic testing is not included in this benefit.

(4) This Plan complies with federal law that prohibits restricting benefits for any Hospital length of stay in connection with childbirth for the mother and/or newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section, or requiring a health care provider to obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, the mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours, or 96 hours as applicable.

(b) Surgery and surgical-related services and supplies for:

(1) Surgery and postoperative care performed by a Physician in a Hospital, Physician's office or Ambulatory Medical Surgical Facility. This includes elective sterilization and repair of a dislocation or fracture;

(2) Services performed by an assistant Surgeon when Medically Necessary;

(3) Anesthetics and administration of the anesthetic by a Physician or professional anesthetist; and

(4) Reconstructive breast surgery following a mastectomy, including reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, any necessary prostheses, and surgical bras as a result of a mastectomy, and physical complications at all stages of mastectomy, including lymphedemas.

(c) Home Health Care Charges - Benefits will be payable for expenses incurred for services or supplies set forth in this subsection (c) and the applicable schedule in Article 5:

(1) Part-time home nursing care by or under the supervision of a registered nurse (RN).

(2) Part-time home health aide services that:

(A) Are under the supervision of a registered nurse (RN) or medical social worker; and

(B) Consist solely of caring for the patient.

(3) Physical, respiratory, occupational or speech therapy.

(4) Nutrition counseling provided by or under the supervision of a registered dietician.

(5) Evaluation and development of a necessary plan, by a registered nurse (RN), Physician assistant or medical social worker, for home care when approved or requested by the attending Physician or Surgeon.

(6) Medical supplies prescribed by a Physician or Surgeon and laboratory services by or on behalf of a Hospital, if necessary under the Home Care Plan, to the extent such items would have been covered under the policy had an Eligible Person been Hospital-confined.

(7) For determining the limit of benefits for services in the items above, each visit by a member of a home health care team will be considered as one home health care visit. Up to four consecutive hours in a 24-hour period of home health aide service will be considered as one home health care visit. The maximum number of home health care visits for an Employee or an Eligible Dependent will not exceed 40 visits in any twelve consecutive months. In no event will the aggregate amount payable each week exceed the weekly cost for care had an Employee or an Eligible Dependent been confined in a Skilled Nursing Facility.

(8) Home Health Care benefits will not be payable for:

(A) Home care services not provided by nor planned by a Home Health Care Agency;

(B) Any period during which an Employee or Eligible Dependent is not under the continuing care of a Physician or Surgeon; or

(C) Any Home Health Care charges for which benefits are payable under any other provision of this Plan.

(d) Charges for the services provided by a Skilled Nursing Care Facility up to the daily maximum established by the local licensing agency for up to 60 days per confinement. The confinement must begin within 24 hours after discharge from a Medically Necessary Hospital confinement lasting at least three days and must be:

(1) Upon a specific recommendation and under the general supervision of a legally qualified Physician or Surgeon; and

(2) Recertified as Medically Necessary every seven days by the attending Physician or Surgeon.

(3) Successive periods of confinement will be considered one period of confinement if the Person has been confined in a Skilled Nursing Care Facility during the 60 days preceding the second confinement.

(e) 100% of the following services and supplies (after the Calendar Year Deductible) when provided to a Terminally Ill Person under a Hospice Care Program through a Hospice Care Agency:

(1) Care in the Terminally Ill Person's or family member's home including the following services and equipment:

(A) Physician services;

(B) Physical, respiratory and occupational therapies;

(C) Drugs, medications, and medical supplies when provided under the Hospice Care Program through a Hospice Care Agency;

(D) Private duty nursing services by a registered nurse (RN) or licensed practical nurse (LPN), if certified by a Physician;

(E) Rental of durable medical equipment (DME); and

(F) Oxygen and rental of related equipment.

(2) Outpatient care in a licensed medical facility for:

(A) Physician services;

(B) Laboratory, X-ray and diagnostic testing; and

(C) Ambulance service or alternative types of transportation.

(3) Inpatient care in a Hospital or hospice facility for:

(A) Room and board, which may include overnight visits by family;

(B) Nursing services;

(C) All other related Hospital expenses;

(D) Physician services; and

(E) Ambulance service or alternative types of transportation.

(4) The following additional services provided to the Terminally Ill Person and family members:

(A) Visits by a licensed social worker to evaluate the social, psychological and family problems related to the Terminally Ill Person, and the development of a plan to assist in resolving these problems;

(B) Emotional support services to assist in relieving stress, coping with the anticipated loss, helping families in completing unfinished business, and maintaining the Terminally Ill Person in the most appropriate environment;

(C) Special incidental services for the Terminally Ill Person, such as special dietary requirements, transportation between home and other sites of care; and

(D) Bereavement counseling for the immediate family following the death of the Terminally Ill Patient.

(5) Services under this item (e) are not provided to Eligible Persons covered under the Bare Bones Plan.

(f) Professional services of a Physician, Surgeon or assistant Surgeon. Such professional services include initial diagnostic services ordered by a Physician and performed in the Physician's office, clinic or hospital outpatient department subject to copayments, coinsurance and deductibles, as provided in the applicable Schedule of Benefits in Article 5; such initial diagnostic services are covered, even if the treatment for the resulting diagnosis is not covered by the Plan. Genetic testing is not included in this benefit.

(g) Services of a legally licensed physiotherapist or registered nurse (RN), provided such services are not rendered by a person who ordinarily resides in the Employee's household or is a family member.

(h) The following types of emergency transportation, as provided in the applicable schedule in Article 5:

(1) Local professional ambulance service; or

(2) Professional ambulance service, air ambulance service, a regularly scheduled commercial airline flight or railroad transportation to the nearest Hospital within the United States or Canada that can provide treatment not available in a local Hospital.

(i) Diagnostic X-ray and laboratory service, including initial diagnostic services ordered by a Physician and performed in the Physician's office, clinic or hospital outpatient department subject to copayments, coinsurance and deductibles, as provided in the applicable Schedule of Benefits in Article 5; such initial diagnostic services will be covered, even if the treatment for the resulting diagnosis is not covered by the Plan. Genetic testing is not included in this benefit.

(j) Oxygen and the rental of equipment for its administration.

(k) Blood and blood plasma and its administration.

(l) Radium, radioactive isotopes, and X-ray therapy.

(m) Casts, splints, braces, trusses, and crutches.

(n) Rental (up to the purchase price) of durable medical equipment such as hospital type bed or wheelchairs.

(o) Artificial limbs and eyes to replace natural limbs and eyes. This includes cochlear implants.

(p) Dental services rendered by a Physician, Surgeon or Dentist for treatment within 24 months of an Injury to the jaw or natural teeth, including the initial replacement of such teeth and any necessary dental X-rays. Covered Charges for such dental services shall be payable in accordance with the applicable Schedule of Benefits related to Comprehensive Major Medical Benefits in Article 5 if services are provided by a Physician or Surgeon. However, if a Dentist provides such dental services, the Plan's coinsurance percentage will be payable in accordance with the Accidental Dental Benefit Schedule, only if such services are provided in the applicable Schedule of Benefits. In addition, any dental services rendered by a Physician, Surgeon or Dentist that are Medically Necessary for the treatment of cancer or as a result of related cancer treatment will be Covered Charges under the Plan, but will not be subject to the 24-month limit; however, they will be subject to payment provisions noted in the two preceding sentences.

(q) Purchase of insulin infusion pump, once in any Calendar Year after it has been used for at least 30 days.

(r) Diabetic Outpatient Self-Management Education Program, as shown in the applicable schedule in Article 5.

(s) Medical examination by a licensed otologist or otolaryngologist to determine the medical diagnosis of a hearing problem, but not more than once in any 24-consecutive-month period.

(t) Kidney dialysis treatment including rental or, at the Fund's option, purchase of kidney dialysis equipment, incurred as a Hospital inpatient or outpatient treatment or in home treatment.

(u) Treatment received while traveling outside the United States or Canada, not to exceed the currency rate of exchange and appropriate value of such services as determined solely by the Trustees.

(v) Temporomandibular joint dysfunction (TMJ) as shown in the applicable Schedule of Benefits. TMJ is not covered under the "Bare Bones" plan.

(w) Preventive services as required by the Patient Protection and Affordable Care Act of 2010:

(1) Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations;

(2) Services described in guidelines issued by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC); and

(3) Health Resources and Services Administration (HRSA) guidelines including the American Academy of Pediatrics Bright Futures guidelines.

(4) Preventive services that are identified by the Plan as part of the ACA guidelines will be covered as specified in the Schedule of Benefits with regard to coverage and cost-sharing by the Participant or Dependent. The services will be covered at the specified percentage of the Plan's allowable In-Network or Out-of-Network charge. Well child annual physical examinations recommended in the Bright Futures Recommendations are treated as Preventive Services and paid at the percentage specified in the Schedule of Benefits.

(5) In some cases, federal guidelines are unclear about which preventive benefits must be covered under the ACA. In that case, the Trustees will determine whether a particular benefit is covered under this Preventive Services benefit.

(6) Preventive Services are paid for based on the Plan's payment schedules for the individual services. However, there may be limited situations in which an office visit is payable under the Preventive Services benefit. Out-of-Network office visits are paid as specified in the Schedule of Benefits. The following conditions apply to payment for In-Network office visits under the Preventive Services benefit:

(A) If a preventive item or service is billed separately from an office visit, then the Plan will pay for the office visit as Physician office visit.

(B) If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit:

(i) Is the delivery of such preventive item or service, then the Plan will pay the amount specified in the Schedule of Benefits for preventive services;

(ii) Is not the delivery of such preventive item or service, then the Plan will pay the amount specified in the Schedule of Benefits for a Physician office visit.

(7) The following are Preventive Services limitations and exclusions:

(A) Preventive Services are covered when performed for preventive screening reasons and billed under the appropriate preventive services codes. Service covered for diagnostic reasons and treatment are covered under the applicable plan benefit, not the Preventive Services benefit. A service is covered for diagnostic reasons if the Employee or Dependent had symptoms requiring further diagnosis or abnormalities found on previous preventive or diagnostic studies that required additional examinations, screenings, tests, treatment, or other services.

(B) Services covered under the Preventive Services benefit are not also payable under other portions of the Plan.

(C) The Plan will use reasonable medical management techniques to control costs of the Preventive Services benefit. The Plan will establish treatment, setting, frequency, and medical management standards for specific Preventive Services, which must be satisfied in order to obtain payment under the Preventive Services benefit.

(D) Immunizations are not covered, even if recommended by the CDC, if the recommendation is based on the fact that some other risk factor is present (e.g., on the basis of occupational, lifestyle, or other indications). Travel immunizations (e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus) are not covered.

(E) Examinations, screenings, tests, items or services are not covered when they are investigational or experimental, as determined by the Plan.

(F) Examinations, screenings, tests, items, or services are not covered when they are provided for the following purposes:

(i) When required for education, sports, camp, travel, insurance, marriage, adoption, or other non-medical purposes;

(ii) When related to judicial or administrative proceedings;

(iii) When related to medical research or trials; or

(iv) When required to maintain employment or a license of any kind.

(G) Drugs, medicines, vitamins, and/or supplements that are available over-the-counter, are not covered under the Preventive Services benefit. For example, the following drugs, medicines, vitamins, and supplements are not covered:

(i) Aspirin for any reason, including for prevention, unless prescribed by a Physician;

(ii) Chemoprevention for any indication, including but not limited to breast cancer;

(iii) Supplements, including but not limited to oral fluoride supplements and folic acid supplements, unless prescribed by a Physician; and

(iv) Tobacco cessation products, drugs, or medicine, except as provided under the Stop Smoking Assistance Benefit.

(x) Stop-smoking assistance only for members, spouses and Domestic Partners, as follows:

(1) The Plan will pay the percentage listed in the applicable Schedule of Benefits in Article 5 for a class designed to help a participant stop smoking.

(2) The Plan will cover the cost of smoking cessation products, (nicotine patches, Zyban, etc.) under the Prescription Drug Plan, as provided in the Schedule of Benefits.*

* Coverage for Medicare eligible Retirees covered under the Plan's Medicare Part D Employee Group Waiver Plan (EGWP) is subject to the provisions of that plan.

(y) Orthognathic surgery to correct the position of the jaws in relation to each other. Allowable expenses are paid at the amount provided in the applicable Schedule of Benefits. Orthognathic surgery must be Medically Necessary (causing functional impediment) and not solely for dental conditions. Related hospital services are covered under the Com prehensive Major Medical Benefit. Pre-and Post-Surgical dental or orthodontic treatments are <u>not</u> covered under the Medical Plan. They may be considered under the Dental Benefit.

(z) Inpatient and outpatient mental health and substance abuse treatment, including treatment in Residential Treatment Facilities, up to the maximums shown in the applicable schedule in Article 5.

(1) Definitions Applicable to this Subsection (z):

(A) Residential Treatment Facility means treatment in a non-acute hospital, intermediate inpatient setting with 24-hour level of care that operates 7 days a week, which is a public or private facility licensed or approved by the Wisconsin Department of Health and Social Services, or the applicable state licensing authority, for the treatment of mental and nervous disorders and alcohol, chemical and drug dependency disorders that are unable to be safely and effectively managed in outpatient care. To be payable by this Plan, a facility must be licensed as a Residential Treatment Facility (licensure requirements for this residential level of care may vary by state).

(B) Outpatient Services means nonresidential services provided to an Eligible Person by a program in an Outpatient Treatment Facility licensed and approved by the Wisconsin Department of Health and Social Services, or the applicable state licensing authority.

(C) Outpatient Treatment Facility means a facility that:

(i) Is licensed or approved as such by the Wisconsin Department of Health and Social Services, or the applicable state licensing authority; and

(ii) Provides outpatient services for the prevention and treatment of, but not limited to, mental and nervous disorders and alcohol, chemical and drug dependency.

(D) Occurrence means a continuous period of inpatient treatment in a Hospital. Treatment will be considered a new Occurrence if the Eligible Person is discharged from treatment or voluntarily discontinues treatment and is later readmitted to a Hospital for treatment.

(aa) Surgical treatment of Morbid Obesity, limited to one course of treatment per lifetime, that is Medically Necessary and subject to pre-approval by the Plan. Coverage includes, but is not limited to, gastric restrictive procedures, gastric or intestinal bypass, follow-up surgery to correct a previous gastric surgical procedure and/or any complications due to surgery, and post-surgical counseling. To be covered:

(1) The Eligible Person must be considered Morbidly Obese, as defined by the Plan;

(2) The condition of Morbid Obesity must have existed for at least five years;

(3) The Eligible Person must have participated in a Physician-supervised nutrition and exercise program (including dietician consultation, low calorie diet, increased physical activity, and behavioral modification) documented in the medical record. The program is not a covered expense under the Plan. This Physician-supervised nutrition and exercise program must meet all of the following criteria:

(A) Participation in the program must be supervised and monitored by a Physician working in cooperation with dieticians and/or nutritionists;

(B) The program must be six (6) months or longer in duration;

(C) The Eligible Person must participate in the program within the two-year period before surgery; and

(D) Participation in the program must be documented in the medical record by an attending Physician who does not perform bariatric surgery (a Physician's summary letter is not sufficient documentation).

(bb) Treatment at outpatient rehabilitation ("rehab") hospitals, including day facilities will be covered for up to 30 outpatient visits per lifetime.

(cc) Foot Orthotics, which includes only custom molded foot orthotics that have been prescribed by a Physician and are used to correct bone alignment or to mechanically control the foot. A medical condition must be diagnosed and there must be documentation that conservative treatment has failed prior to the use of orthotics. Replacement foot orthotics may be covered if Medically Necessary and the initial foot orthotics are no longer therapeutic. Custom molded shoes, orthopedic shoes, or other supportive devices for the feet (including over-the counter items) are not included in this benefit.

(dd) Diagnostic genetic testing, as provided in the Schedule of Benefits, provided the:

(1) Eligible individual displays clinical features (symptoms) of the mutation in question;

(2) Test results will directly impact the eligible individual's treatment;

(3) Eligible individual's diagnosis remains uncertain after a history and physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies;

(4) The Plan's administrator confirms the suspected diagnosis and determines that the suspected mutation meets criteria established for the particular genetic test; and

(5) Particular genetic test has not been previously performed on the eligible individual.

(ee) Compression Stockings that are pre-made or custom-made pressure gradient support stockings that have a pressure of 18 mm Hg or more, that require a Physician's prescription, and that require measurements for fitting, up to eight pairs per calendar year.

(ff) Contraceptives, which include devices to prevent pregnancy and related expenses. Birth control pills and devices requiring a prescription are covered under Article 17.

(gg) Charges for member and spouse non-routine physical exams, diagnostic work, colonoscopies, and flexible sigmoidoscopies may also be covered if determined by the Plan to be Medically Necessary due to the medical history of an Eligible Person's immediate family, and in accordance with a

Physician's certification. However, genetic and/or DNA testing is not covered under non-routine exam benefits.

Non-routine benefits are not provided under the "Bare Bones" plan.

(hh) Ambulatory surgical facilities and associated anesthesia for covered dental services that are provided to a covered Person who:

(1) Is a Dependent child age twelve or younger;

(2) Has a medical condition that requires hospitalization or general anesthesia for dental care; or

(3) Is disabled.

Coverage will be subject to the Comprehensive Major Medical Benefits deductible and coinsurance. The procedure must be a covered dental procedure under the Plan's Dental Benefits for the ambulatory surgical facility and associated anesthesia expenses to be covered as medical expenses.

Section 9.07 Biometric Screening Program and Health Management Education Program

The *Get Healthy Screening Program* is part of the Plan for active Regular Plan and Bare Bones Plan members. The benefit is voluntary, confidential, and free of charge.

Participants (Spouses and Domestic Partners) must have a health screening between December 1 and November 30 in a year (dates subject to change as needed) to earn a deductible waiver for the following calendar year. To earn the incentive, Participants (plus Spouse or Domestic Partner) must obtain a basic exam and blood screening through a physician. The physician must complete and fax the information to HMC HealthWorks Medical Checklist.

Effective January 1, 2017, the Plan offers an additional incentive to members (and/or their spouses if married or Domestic Partners) who complete the *Health Management Education Program (HME)* through the *Get Healthy Screening Program* by specified dates announced by the Plan.

If a Participant's (and/or Spouse's if married or Domestic Partner's) biometric health screening results show that the member (and/or Spouse if married or Domestic Partner) is considered out-of-range for certain health-related conditions, the member (and/or spouse or Domestic Partner) will also have an opportunity to

complete the *HME* by a specified date and each earn an additional $100 HRA contribution (a total of up to $200 per household) upon completing the HME unless otherwise specified.

Participants (Spouses and Domestic Partners) who are identified with out-of-range results for one or more conditions (diabetes, back pain, coronary heart failure, high blood pressure, high cholesterol), you (and/or your spouse if married or Domestic Partner) will each have the opportunity to complete the HME, which includes the following steps:

(a) Answer an initial call from an HMC Nurse; and

(b) Engage via telephone on at least 2 calls with an HMC Nurse regarding education and treatment for your condition.

The incentives are not available for COBRA beneficiaries or under the Retiree Plan.

Section 9.08 Online Medical or Behavioral Health Professional Visits (LiveHealth Online)

The Plan provides an online medical and beginning effective July 1, 2017, a behavioral health program in which Participants may consult with board-certified Physicians or licensed Psychologists or Therapists at their convenience. The Participant contacts the Physician, Psychologist or Therapist electronically. LiveHealth online medical and behavioral health sessions are covered at no cost to the Participant, Spouse, Domestic Partner, and Dependent(s) as provided in the applicable Schedule of Benefits in Article V.

LiveHealth Online may not be used for a medical emergency. It can be used for:

(a) **Medical Conditions**

Including but not limited to, common health ailments such as colds, flu, allergies, sinus infections, diarrhea, pinkeye or other eye infections, urinary tract infections, rashes and other such temporary health issues.

(b) **Adult Psychological Issues**

Including but not limited to, stress, anxiety, depression, relationship and family matters, bereavement, panic attacks and stress from coping with a personal or family member illness.

(c) **Adolescent Psychological Issues**

Including but not limited to, attention deficit disorder (ADD), behavior health challenges, difficulty adjusting to life, coping with family members (i.e. divorce of parents, death or other stressors), eating disorders and developmental challenges.

Section 9.09 Maximum Benefit Payment

The maximum benefits payable under this Article for each Eligible Person is stated in the applicable schedule in Article 5 for specific injuries or sicknesses. Benefits are payable only for Expenses incurred while the Employee or Dependent is Eligible under the Plan, including while covered under the Extension of Benefits provision.

Section 9.10 Common Accident Deductible

If an Employee and one or more Dependents or if two or more Dependents, while Eligible under this Article, are injured in the same accident, all Covered Charges incurred as a result of such accident may be combined and only one Calendar Year Deductible amount will be charged, if applicable, against such Covered Charges. This combined Calendar Year Deductible amount will also apply to future reapplication of the Calendar Year Deductible for such common accident; however, nothing herein shall be construed to reduce the maximum payment for each Eligible Person.

Section 9.11 Medical Benefit Exclusions

The Comprehensive Major Medical Benefits do not cover:

(a) Tooth extraction or other dental work or Oral Surgery that involves any tooth or tooth structure, alveolar process, abscess, periodontal disease or disease of the gingival tissue, except as provided in Section 9.06;

(b) Eye refractions or the fitting or cost of eyeglasses or hearing aids;

(c) Nursing expense, except as provided in Section 9.06;

(d) Any medical charges not directly related to the treatment of a Sickness or an Injury except as specifically provided in Section 9.06;

(e) Prescription drugs, except as an inpatient in a Hospital or Skilled Nursing Care Facility, or covered under the Prescription Drug Benefit;

(f) Hearing examinations not performed by a qualified otologist or otolaryngologist, except hearing examinations performed in conjunction with obtaining a hearing aid device through the EPIC Hearing Healthcare network;

(g) Examinations required by an Employer as a condition of employment, or that an Employee is required to provide by virtue of a labor agreement;

(h) Charges for or related to a bone or organ transplant procedure;

(i) Charges for any of the circumstances described in Section 4.11, “General Plan Exclusions;” or

(j) Charges not listed as Covered Expenses.

ARTICLE 10 CHIROPRACTIC BENEFIT

Section 10.01 Chiropractic Benefits, In General

Benefits payable in accordance with this Article 10 will be in lieu of all other Hospital and medical benefits provided by the Fund for chiropractic care. Chiropractic benefits, which include, but are not limited to, services for musculoskeletal treatment, X-rays, physical therapy, and any other covered benefits that are performed, referred, prescribed, or billed by a chiropractor (and/or a chiropractor's office), are subject to the Plan's chiropractic calendar year and per visit maximums, as listed in the applicable schedules in Article 5.

Section 10.02 Chiropractic Benefits Payable

If an Eligible Person, while covered under the Plan, incurs chiropractic care expenses, the Plan will pay benefits as shown in the applicable schedule in Article 5.

Section 10.03 Chiropractic Benefit Exclusions

No benefits are payable under this Article for any of the circumstances described in Section 4.11, "General Plan Exclusions."

ARTICLE 11 DENTAL BENEFIT

Section 11.01 Dental Benefits, In General

Upon receipt of due proof that an Eligible Active Employee or Dependent incurs expenses for dental charges, benefits will be payable subject to the provisions of this Article 11.

Section 11.02 Dental Benefits Payable

(a) Benefits are payable for Covered Dental Charges incurred for dental care or treatment up to the Calendar Year Maximum specified in the applicable schedule in Article 5. The Calendar Year Maximum does not apply to Dependent children under age 19.

(b) Benefits are payable for charges incurred for orthodontia as shown in the applicable schedule in Section 5.01.

Section 11.03 Covered Dental Charges

(a) Covered Dental Charges shall be deemed to have been incurred on the date the dental service or treatment is performed.

(b) Covered Dental Charges are charges incurred for the following:

(1) Coverage A - Routine Oral Exams, including:

(A) Oral examinations including scaling and cleaning of teeth, but not more than one examination or scaling and cleaning in any period of six consecutive months.

(B) Topical application of sodium or stannous fluoride, once in each period of twelve consecutive months, but only for a Dependent child who has not yet attained age 19.

(C) Dental X-rays, if professionally indicated. Bitewing X-rays are limited to once every six months. Full-mouth X-rays are limited to once every twelve months.

(D) Dental sealants, but only for a Dependent child who has not yet attained age 18.

(2) Coverage B - Basic Dental Care, including:

(A) Extractions.

(B) Oral Surgery (including pre-operative and post-operative care) for the:

(i) Excision of a partially or completely unerupted impacted tooth;

(ii) Excision of a tooth root without the extraction of the entire tooth;

(iii) Closed or open reduction of a fracture or dislocation of the jaw; and

(iv) Other incision or excision procedures on the gums and tissues of the mouth when performed in connection with the extraction or repair of teeth.

(C) Amalgam fillings on posterior teeth, synthetic porcelain and plastic fillings on anterior teeth only.

(D) General anesthetics administered in connection with Oral Surgery covered under this Article 11.

(E) Injections of antibiotic drugs by the attending Dentist.

(F) Space maintainers.

(G) Treatment for relief of pain.

(H) Treatment of and surgery for periodontal and other diseases of the gums and tissues of the mouth.

(I) Endodontic treatment, including pupal therapy and root canal therapy.

(3) Coverage C - Restorations and Prosthetics, including:

(A) The initial installation (including adjustments during the six-month period following installation) of full or partial dentures or fixed bridgework.

(B) The replacement or alteration of full or partial dentures or fixed bridgework which is necessary because of Oral Surgery:

(i) Resulting from an accident;

(ii) For repositioning muscle attachments; or

(iii) For removal of a tumor, cyst, torus or redundant tissue when such Oral Surgery occurs after the Eligible Person's effective date under this Article 11 and the replacement or alteration is completed within twelve months of that Oral Surgery.

(C) The replacement of a full denture which is necessary because:

(i) Structural change has occurred within the mouth, if more than five years has elapsed since the existing denture was installed;

(ii) An opposing full denture is installed for the first time; or

(iii) The denture was installed as a temporary denture and the replacement denture is installed within twelve months of when the temporary denture was installed;

(D) Replacement of, or addition of teeth to, an existing partial or full removable denture or fixed bridgework when the existing denture or bridgework was installed more than five years prior to the replacement and the existing denture or bridgework cannot be made serviceable;

(E) The replacement of a crown restoration, provided the original crown was installed more than five years prior to the replacement;

(F) Inlays, gold fillings only if no other material can be used, and crowns, including precision attachments for dentures;

(G) Repair or recementing of crowns, inlays, bridgework or dentures or relining of dentures;

(H) Gold restorations when the teeth cannot be restored with another filling material;

(I) Crowns and jackets when the teeth cannot be restored with a filling material; and

(J) Dental implants, covered in the amount listed in the Schedule of Benefits.

(4) Coverage D - Orthodontics, including all necessary orthodontic treatment by a dentist, for dependent children up to age 26, as provided in the applicable schedule in Article 5. Such necessary orthodontic treatment includes the initial and subsequent, if any, installations of orthodontic appliances. Covered charges for orthodontic care do not become allowable until the services relating to such charges are actually rendered.

Section 11.04 Limitations on Dental Benefits

(a) If a tooth can be restored with amalgam, silicate or plastic, but the Eligible Person selects another type of restoration, the obligation of the Plan will be only to pay the applicable percentage of the fee appropriate to the lowest cost procedure that meets nationally established standards. The balance of the treatment cost will remain the responsibility of the Eligible Person.

(b) If in the construction of a complete or partial denture the Eligible Person and dentist decide on "personalized" restorations or to employ "specialized techniques" as opposed to standard procedures, the Plan will allow the appropriate amount for the standard denture toward such treatment and the Eligible Person will remain responsible for the difference in cost.

(c) If an Eligible Person selects a course of mouth rehabilitation, the obligation of the Plan will be to pay only the applicable percentage of the fees appropriate to those procedures necessary for eliminating oral disease and replacing missing teeth. The balance of the treatment cost, including costs related to appliances or restorations intended to increase vertical dimension or restore the occlusion, will remain the responsibility of the Eligible Person.

Section 11.05 Predetermination of Dental Benefits

(a) For any dental service that will exceed $300, it is recommended that the Eligible Person's Dentist prepare a Treatment Form to be sent to Delta Dental or a dental provider chosen by the Fund. After the proposed treatment plan is approved, the prescribed treatment should be provided, or should begin in the case of orthodontic treatment, as soon as the Eligible Person and Dentist's schedules will permit.

(b) A "Treatment Plan" is a written report showing the proposed recommended treatment of any dental disease, defect or injury, any x-rays needed and the estimated cost of treatment that is prepared by a Dentist as a result of an examination by that Dentist while the Eligible Person is covered under this Article 11.

Section 11.06 Extended Dental Benefits

If coverage terminates while a Person is receiving treatment, Covered Dental Charges will continue to be paid for treatment started while the Person was Eligible if such treatment is completed within 30 days after the termination date. The benefits under this Section are subject to all the conditions and limitations of the Dental Benefit as described in this Article 11.

Section 11.07 Dental Exclusions

(a) No dental expense benefits are payable under this Article 11 for:

(1) Charges made for treatment by anyone other than a Dentist except that scaling or cleaning of teeth and topical fluoride application may be performed by a licensed dental hygienist if treatment is rendered under the supervision and guidance of a Dentist or for X-rays ordered by a Dentist;

(2) X-rays, if not professionally indicated;

(3) Bitewing X-rays, if taken more frequently than once each six months and full mouth X-rays, if taken more frequently than once each twelve months;

(4) Oral examinations including scaling and cleaning of teeth, if performed more than twice each Calendar Year or if not separated by at least six months;

(5) Topical fluoride applications if the Eligible Person is over age 19 or if performed more frequently than once each twelve months;

(6) Prescriptions, including prescriptions for home application of sodium or stannous fluoride;

(7) Oral Surgery, except as provided in Section 11.03;

(8) Expenses incurred after termination of Eligibility, except as provided under Section 11.06;

(9) Services for installation of or treatment related to orthodontic appliances and prosthetic services (including bridges and crowns) that were rendered prior to the Eligible Person's effective date under this Article 11;

(10) Rebasing or relining of a denture:

(i) In less than six months from the date of initial placement; or

(ii) More than one in any two-year period;

(11) Replacement of lost or stolen prosthetics;

(12) Replacement of prosthetics less than one year after the Eligible Person's effective date under this Article 11, except that benefits will be payable for the replacement of a denture if requested as a result of the placement of an opposing denture;

(13) Charges for treatment of temporomandibular joint syndrome (TMJ);

(14) Dental sealants if the Eligible Person is age 18 or over;

(15) Charges for any service for which coverage is not specifically provided under this benefit (including any Hospital charges and/or prescription drug charges);

(16) Any dental expenses for which benefits may be payable under any other Article of this Plan; and

(17) Any of the circumstances described in Section 4.11, "General Plan Exclusions."

Section 11.08 Optional Retired Employee Dental Benefits

(a) Retired Employees and their Dependents may choose to enroll in any of the programs that are offered by Delta Dental Plan of Wisconsin through the Wisconsin Laborers Health Fund when they are eligible for this coverage. The Retired Employee must be receiving health benefits under the Wisconsin Laborers Health Fund to be eligible for these programs. On December 1 of each year the Retired Employee will be given the option to change to a different program, provided he/she is still covered as of November 30. The Retired Employee Dental Benefit is fully insured and the full cost of this coverage must be paid by the member. Delta Dental of Wisconsin provides the benefits under an insurance contract and Delta Dental makes all decisions on claims and benefits.

(b) Effective January 1, 2012, if a Retired Employee and/or the Retired Employee's spouse or the Retired Employee's Domestic Partner, have dental coverage available elsewhere, the Retired Employee and/or the Retired Employee's spouse or Domestic Partner may elect to suspend or postpone coverage under the Plan's Retired Employee Dental Benefits until he or she are no longer eligible for coverage under the other dental plan. Dental coverage that has been postponed or suspended will be resumed under the Plan's Retired Employee Dental Benefits if proof is provided to the Fund Office that the Retired Employee, spouse or Domestic Partner of a Retired Employee, or the surviving spouse or surviving Domestic Partner of a Retired Employee had been

continuously covered by the other employer's group dental plan since the date such person elected to postpone or suspend the Retired Employee Dental Benefits under the Wisconsin Laborers' Health Fund.

This option to suspend or postpone Retired Employee Dental Benefits and to later re-enroll may only be exercised once in a member's lifetime. If the Retired Employee postpones coverage under the Plan's Retired Employee Dental Benefits at the time of retirement, then this option cannot be used again.

ARTICLE 12 VISION CARE BENEFIT

Section 12.01 Vision Care Benefits, In General

If an Eligible Active Employee, Eligible Retired Employee or an Eligible Dependent incurs expenses for vision care, benefits will be payable subject to the provisions of this Article 12.

Section 12.02 Vision Care Benefits Payable

Benefits are payable for Covered Vision Care charges incurred, in an amount equal to 100% of the Allowable Charges, not to exceed the Maximum Allowance stated in the applicable schedule in Article 5.

Section 12.03 Covered Vision Care Charges

(a) Covered Vision Care Charges include:

(1) Complete examination including dilation of pupil and/or relaxing of focusing muscles by drops, refraction for vision and examination for pathology,

(2) New or replacement frames and/or lenses (including contact lenses) furnished by an optician or doctor, including fitting,

(3) Lasik surgery.

(b) An expense is deemed to be incurred on the date on which the services or materials that give rise to the expense are rendered or obtained.

(c) A licensed optometrist, ophthalmologist, or optician must provide services and supplies in order for any Vision Care charges to be considered for coverage by the Plan.

Section 12.04 Vision Care Benefit Exclusions

No payment shall be made under the Plan for expenses incurred for the following:

(a) Sunglasses that are not prescription;

(b) Special procedures, such as orthoptics or vision training and special supplies, and subnormal vision aids;

(c) Medical or surgical treatment of the eyes, except as otherwise provided in Section 12.03(a)(3);

(d) Service or supplies not listed as Covered Vision Care Charges in Section 12.03; or

(e) Any of the circumstances described in Section 4.11, “General Plan Exclusions.”

ARTICLE 13 HEARING AID BENEFIT

Section 13.01 Hearing Aid Benefit, In General

If an Eligible Active Employee, Eligible Retired Employee or an Eligible Dependent incurs expenses for a hearing aid, benefits will be payable subject to the provisions of this Article 13.

Section 13.02 Hearing Aid Benefits Payable

Benefits are payable for Covered Hearing Aid charges in an amount equal to 100% of the Allowable Charges, not to exceed the Maximum Benefit stated in the applicable schedule in Article 5.

Section 13.03 Covered Hearing Aid Charges

(a) Covered Hearing Aid Charges include expenses incurred for a new or replacement hearing aid instrument when hearing loss has been determined by a licensed otologist or an otolaryngologist, unless the hearing aid was obtained through the EPIC Hearing Healthcare network.

(b) If an examination indicates that a school-age Eligible Dependent child requires a new hearing aid more often than once in a five-year period due to, but not limited to, such factors as a prescription change, the Board of Trustees may authorize payment of the benefit.

(c) A hearing aid device replaced without obtaining a new prescription, provided the original device was obtained while covered under the Fund. A valid prescription for the original device must be on file with the Fund Office.

(d) An expense is deemed to be incurred on the date on which the services or materials that give rise to the expense are rendered or obtained.

Section 13.04 Hearing Aid Exclusions

No payment shall be made under the Plan for expenses incurred for the following:

(a) Medical examinations for the prescription or fitting of a hearing aid;

(b) Hearing aids not prescribed by a qualified otologist or otolaryngologist, except as provided in Section 13.03;

(c) Charges by a speech pathologist, or any charges for speech therapy, speech reading or lessons in lip reading;

(d) Charges for the rental or purchase of amplifiers;

(e) Services or supplies not listed as Covered Hearing Aid Charges; or

(f) Any of the circumstances described in Section 4.11, “General Plan Exclusions.”

ARTICLE 14 COORDINATION OF BENEFITS

Section 14.01 In General

The benefits payable to an Eligible Person under this Plan shall be reduced to the extent necessary so that the sum of the benefits payable under the Plan and the benefits payable by an "Other Plan" shall not exceed the total of such "Allowable Expenses." The Eligible Person must provide any necessary information and cooperate with the Administrative Manager so that the coordination of benefits provision can be fully and properly administered.

Section 14.02 Other Plan

(a) "Other Plan" shall mean any plan providing benefits or services for or by reason of dental or medical care or treatment for which benefits or services are provided by:

(1) Group blanket or franchise insurance coverage;

(2) Group Blue Cross or group Blue Shield coverage and other prepayment coverage on a group basis, including Health Maintenance Organizations;

(3) Other arrangements of insured or self-insured group coverage;

(4) Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefits organization plans, or any other arrangement or benefits for individuals of a group;

(5) Any coverage under governmental programs, other than Medicare or Medicaid, and any coverage required as provided by any statute; or

(6) Medical benefit coverage required or available by reason of automobile "no-fault" insurance contracts.

(b) "Other Plan" also includes Dependents' benefits payable under this Plan when a spouse or Domestic Partner is covered both as an Employee and as a Dependent and when a child is covered as a Dependent of more than one Employee.

Section 14.03 Allowable Expense

"Allowable Expense" means any Medically Necessary Charges incurred by an Eligible Person during a Calendar Year and while Eligible under this Plan for dental or medical care and treatment, part or all of which would be covered under any of the plans.

Section 14.04 Order of Benefit Payment

(a) To administer the provisions of this Article, the following order of coordination of benefits shall be used to determine the amount of benefits payable under this Plan and the amounts to be paid by any other plans:

(1) A plan without coordination of benefits shall pay its benefits before a plan that contains coordination of benefits.

(2) A plan that covers a person other than as a Dependent shall pay its benefits before a plan that covers the person as a Dependent.

(3) For claims on behalf of Dependent children whose parents are not divorced or separated or who have a signed joint custody agreement, the plan that covers the parent whose birthday (month and day) falls first in the Calendar Year shall pay first, and plan of the parent whose birthday falls later in the Calendar Year shall pay second. If both parents have the same birthday, the plan covering the parent for the longer period of time shall pay first.

If one parent's plan uses the gender rule and the other parent's plan coordinates benefits as in this subsection (3), the rules of the plan using the gender rule shall determine the order of benefit payment. Under the gender rule, the plan that covers a person as a dependent of a male employee shall pay its benefits before a plan that covers the person as a dependent of a female employee.

(4) For claims on behalf of dependent children whose parents are divorced or separated (including the termination of a domestic partnership), the following rules apply:

(A) If there is a court decree that established financial responsibility for medical expenses, the plan covering the parent who has such financial responsibility shall be primary.

(B) If there is no such court decree and the parent with custody has not remarried or established another domestic partnership, the plan that covers the parent with custody shall be primary.

(C) If there is no such court decree and the parent with custody has remarried or established a domestic partnership, the order of benefit coordination shall be:

(i) The plan of the parent or domestic partner with custody pays first,

(ii) The plan of the step-parent or domestic partner with custody pays second, and

(iii) The plan of the parent or domestic partner without custody pays third.

(5) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in Paragraph (6) applies. 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 in Subsection (a)(3) above to the dependent child's parent(s) and the dependent's spouse.

(6) If none of the above rules applies, the plan that has covered the claimant for the longer period of time shall pay first, except when:

(A) One plan covers the claimant as a laid-off or retired employee (or a dependent of such an employee), and

(B) The other plan includes this same rule for laid-off or retired employees (or is issued in a state that requires this rule by law),

then the plan that covers the claimant as other than a laid-off or retired employee (or as a dependent of such an employee) shall pay first.

(b) Notwithstanding the other provisions contained in Article 14, a special rule will apply if a Participant and/or Dependent have other health plan coverage containing a provision commonly known as a "wrap around" provision, "sub-plan" provision or some similar provision whose purpose is to provide primary coverage only for a small amount of expenses, well below the maximum benefit available under the plan if no other coverage exists (collectively, a "Sub-Plan

Provision"). The effect or intent of a plan with a Sub-Plan Provision is to attempt to transfer the much larger disproportionate amount of secondary coverage to the other health plan with which such plan is coordinating benefits.

In the event this Plan is coordinating benefits with a plan containing a Sub-Plan Provision, two additional rules shall be applied by this Plan. First, the Sub-Plan Provision shall be treated as arbitrary and capricious and a subterfuge and shall be ignored, resulting in coordination of benefits with the plan, sub-plan or similar provision that would apply if the Participant and/or Dependent did not have coverage under this Plan. Second, if the first additional rule described in the previous sentence is found by the Plan or a court of competent jurisdiction to not apply, then the Plan expressly limits its secondary coverage available to the Participant and/or Dependent to the same dollar amount contained in, or calculated under, the Sub-Plan Provision.

The Board of Trustees and its designees have discretion to interpret the Plan and determine whether benefits are payable under the Plan. This discretion shall include, but not be limited to, discretion to interpret the language of other plans and also to determine whether other plans consist of a single plan or multiple plans. The discretion shall also include, but not be limited to, discretion to determine whether a Sub-Plan exists. The Board of Trustees' determination (or the designee's determination) in this regard shall be binding and final for all purposes, including but not limited to all coordination of benefit purposes, and shall not be reversed unless a court of competent jurisdiction determines that such determination is arbitrary and capricious.

Section 14.05 Plan Benefit Limits

If coordination of benefits reduces the benefits payable under more than one policy provision, each benefit will be reduced proportionately. Only the reduced amount will be charged against any benefit limit in the applicable benefit provision.

Section 14.06 Right to Collect and Release Necessary Information

In order to receive benefits, the Eligible Person must give the Administrative Manager any information that is needed to coordinate benefits. With the Person's consent, the Fund may release to or collect from any person or organization any necessary information about the Person, subject to the privacy and security provisions of HIPAA and HITECH.

Section 14.07 Facility of Payment

If benefits that this Plan should have paid are instead paid by another plan, this Plan may reimburse the other plan. Amounts reimbursed are Plan benefits and are treated like any other Plan benefits in satisfying any Plan liability.

Section 14.08 Coordination of Benefits Bonus for Prescription Drugs

If a Participant is covered under another health plan and uses a prescription drug card from the other plan for drugs covered under this Plan, then this Plan will reimburse 100% of any co-payment for that prescription. This provision will not apply if the prescriptions are purchased under a spouse or a Domestic Partner's major medical plan.

ARTICLE 15 EFFECT OF MEDICARE

Section 15.01 In General

This Plan will pay 90% of the difference between the Medicare Allowable Expense and the amount paid by Medicare.

Section 15.02 Allowable Expenses

"Allowable Expenses" means any Medically Necessary Allowable Charges for medical care or treatment that is covered by either this Plan or Medicare. If the Physician accepts Medicare assignment, neither the Eligible Person nor the Plan shall be responsible for paying charges that exceed the legal limits that a Physician can bill Medicare patients above the Medicare allowance for a particular procedure or service. If the Physician does not accept Medicare assignment, then the Plan's Allowable Charges will apply.

Section 15.03 Effect on Benefits

Persons Eligible for benefits in accordance with Article 3 and also Eligible for hospital insurance under Medicare Part A, must enroll in Medicare Part A and the voluntary portion of Medicare Part B. If an Eligible Person is eligible for Medicare Parts A and B and has not enrolled in Medicare A and B, no Health Fund benefits will be payable since the Health Fund will not be able to coordinate benefits with Medicare.

Section 15.04 Order of Benefit Payment

(a) This Plan shall have primary responsibility for expenses incurred by the Eligible Employees or their Dependent spouses who meet the following qualifications:

(1) Eligible Persons are eligible for Medicare Benefits solely because of age; and

(2) With respect to the Eligible Employees only, are actively employed by ADEA (Age Discrimination in Employment Act) employers that pay all or part of the required contributions for Eligibility.

(b) This Plan shall have secondary responsibility for the Eligible Employees and their Dependent spouses if they are not actively employed by ADEA employers that pay all or part of the required contributions for Eligibility and are eligible for Medicare Benefits because of age.

(c) This Plan shall have primary responsibility for expenses incurred by Domestic Partners eligible for Medicare due to disability only if the Eligible Employee is actively employed by ADEA (Age Discrimination in Employment Act) employers that pay all or part of the required contributions for Eligibility.

(d) This Plan shall have secondary responsibility for expenses incurred by Domestic Partners eligible for Medicare due to age, regardless of the Eligible Employee's active employment.

(e) This Plan shall have secondary responsibility for expenses incurred by Eligible Persons who are eligible for primary Medicare benefits because they are disabled.

(f) This Plan shall have primary responsibility for the first 30 months for the claims of Eligible Persons who are eligible for Medicare benefits solely because of end-stage renal disease (ESRD). At the end of 30 months, this Plan shall have secondary liability. If the Eligible Person has dual eligibility under ESRD and age or disability, then the primary coverage periods shall be adjusted pursuant to the governing regulations.

Section 15.05 Definitions Applicable to Article 15

(a) Medicare Benefits means benefits for services and supplies that the Eligible Person receives or is entitled to receive under Medicare Parts A or B.

(b) Age 65 means the age attained at 12:01 a.m. on the first day of the month in which the Eligible Person's 65th birthday occurs.

(c) ADEA Employer means an employer that:

(1) Is subject to the U.S. Age Discrimination in Employment Act (ADEA), and

(2) Has 20 or more employees each working day in 20 or more calendar weeks during the current or preceding Calendar Year.

Section 15.06 Coordination with Medicare Part D

(a) If an Active Employee or the Dependent of an Active Employee enrolls for Medicare Prescription Drug Coverage under Medicare Part D, the Active Employee or the Dependent of the Active Employee will continue to be eligible for the Fund's prescription drug benefits. However, the prescription drug benefits of the Active Employee or Dependent of the Active Employee will be coordinated with Medicare if enrolled in Medicare Part D.

(b) If a Retired Employee or the Dependent of a Retired Employee is eligible for and enrolls in Medicare Prescription Drug Coverage under Medicare Part D, other than the Medicare Part D Employee Group Waiver Plan (EGWP) in which the Plan participates:

(1) The Retired Employee or the Dependent will no longer receive prescription drug benefits under the Plan, but will continue to be eligible to receive medical benefits under the Plan; monthly self-payments for coverage under the Plan will not change as a result of not receiving prescription drug benefits under the Plan, even though the Retired Employee or the Dependent of the Retired Employee is paying monthly premiums for Medicare Prescription Drug Coverage.

(2) If the Retired Employee or the Dependent loses Plan prescription drug benefits through enrollment in Medicare Part D, other than the Medicare Part D Employee Group Waiver Plan (EGWP) in which the Plan participates or later decides to drop Medicare Prescription Drug Coverage, they will be given a one-time opportunity to re-enroll in Plan's prescription drug benefits.

(3) If the Retired Employee or the Dependent drops all coverage under the Plan, enrolls in Medicare Prescription Drug Coverage through Medicare Part D, other than the Medicare Part D Employee Group Waiver Plan (EGWP) in which the Plan participates, and later drops Medicare coverage, retiree coverage under the Plan cannot and will not be reinstated unless the Retired Employee returns to work and satisfies the eligibility requirements for active coverage.

ARTICLE 16 PREFERRED PROVIDER ORGANIZATIONS

Section 16.01 In General

The Fund has entered into an agreement with one or more preferred provider organizations (PPOs), in order to reduce Plan medical costs by providing Eligible Persons economic incentives to choose health care services provided by Physicians and/or Hospitals that negotiate service agreements with the PPOs.

ARTICLE 17 PRESCRIPTION DRUG BENEFIT

Section 17.01 Prescription Drug Benefit, In General

(a) If an Eligible Active Employee, Eligible Retired Employee, or an Eligible Dependent incurs expenses for prescription drugs, benefits shall be payable in accordance with the provisions of this Article 17.

(b) A Retired Employee or the Dependent of a Retired Employee who enrolls for Medicare Prescription Drug coverage, other than the Medicare Part D Employee Group Waiver Plan (EGWP) in which the Plan participates, will not be eligible for prescription drug benefits under the Plan.

Section 17.02 Prescription Drug Benefits Payable

(a) Benefits are payable for Covered Prescription Drug charges incurred, subject to the applicable schedules in Article 5.

(b) The following are covered expenses under the Prescription Drug Benefit:

(1) Products that require a prescription under federal law and carry a federal agent unless listed below as an excluded product.

(2) Insulin, syringes, test strips, lancets, and alcohol swabs when ordered by a Physician.

(3) Injectable medications.

(4) Compounded (mixed) prescriptions of which at least one ingredient is a drug carrying a federal legend.

(5) Over-the-counter aspirin and supplements, if prescribed by a Physician, and if recommended under the provisions of the Patient Protection and Affordable Care Act.

(c) The Prescription Drug Benefit includes a Step Therapy Program that is administered by the Prescription Drug Provider with which the Plan contracts for such services.

Section 17.03 Prescription Drug Card Program

(a) The Prescription Drug Card Program offers benefits for short-term prescriptions (30 days or less). An Eligible Active Employee, Eligible Retired Employee, or an Eligible Dependent will receive a prescription drug card when the Eligible Active Employee, Eligible Retired Employee, or an Eligible Dependent becomes Eligible for coverage under the Plan. The prescription drug card can be used at any pharmacies that are in the network of the Prescription Drug Provider with which the Plan has entered into a service agreement.

(b) To receive benefits, an Eligible Active Employee, Eligible Retired Employee, or an Eligible Dependent must present the prescription drug card and prescription to a network pharmacy for up to a 30-day supply. The prescription drug copayment is listed in the applicable schedules in Article 5. The copayment is not reimbursable under the Plan's Comprehensive Major Medical Benefits and does not apply to the Eligible Active Employee, Eligible Retired Employee, or an Eligible Dependent's medical deductible or out-of-pocket maximum.

(c) If an Eligible Active Employee, Eligible Retired Employee, or an Eligible Dependent has a prescription filled at a non-participating pharmacy, the Eligible Active Employee, Eligible Retired Employee, or an Eligible Dependent must pay the full cost of the prescription at the time it is picked up from the pharmacy, and may then submit a claim form to the Prescription Drug Provider for reimbursement. The Eligible Active Employee, Eligible Retired Employee, or an Eligible Dependent will be reimbursed the contracted pharmacy rate, minus the applicable copayment for that prescription.

Section 17.04 Mail Order Prescription Drug Program

(a) If an Eligible Active Employee, Eligible Retired Employee, or an Eligible Dependent requires a long-term maintenance medication (more than a 30-day supply), such as for a heart condition or diabetes, the Eligible Active Employee, Eligible Retired Employee, or an Eligible Dependent will receive prescription drug benefits only when the Eligible Active Employee, Eligible Retired Employee, or an Eligible Dependent orders the prescription through the mail order program administered by the Prescription Drug Provider with which the Fund has contracted. Prescriptions filled through the Mail Order Program may be obtained for up to a 90-day supply. The prescription drug copayment is listed in the applicable schedules in Article 5. The copayment is not reimbursable under the Plan's Comprehensive Major Medical Benefits and does not apply to the Eligible Active Employee, Eligible Retired Employee, or an Eligible Dependent's medical deductible or out-of-pocket maximum.

(b) The Plan provides a Specialty Medication Program that is administered by the Prescription Drug Provider with which the Plan contracts for such services. The Program includes a specialty mail order program and team of specialists to help Eligible Persons manage their course of therapy. Eligible Persons should use the Specialty Medication Program for prescriptions that are filled for treatment of Hepatitis C, Multiple Sclerosis, bleeding disorders, Rheumatoid Arthritis, Psoriasis, or RSV, and other conditions that may be added to the program.

(c) Eligible Persons may be required to participate in a specialty medication procurement program established by the Prescription Drug Provider with which the Plan contracts for such services. This Program requires that prescriptions for certain specialty medications which have manufacturer coupons available be filled at the Prescription Drug Provider's Specialty Pharmacy. Eligible Persons using a specialty medication selected for this Program will automatically be enrolled into the manufacturer coupon program. Use of the coupon temporarily results in a lower cost to the Plan for the specialty medication and a lower out-of-pocket cost to the Eligible Person for the specialty medication than under the Plan's regular specialty medication copayment structure. A specialty medication that is included in this Program may be discontinued from inclusion in the Program at any time without advance notice to the Eligible Person and at that time, or at the time of the coupon's depletion, the Plan's regular specialty medication copayment structure will apply.

Section 17.05 Self-Payments for Prescription Drug Benefits

If an Eligible Active Employee, Eligible Retired Employee, or an Eligible Dependent makes self-payments for continued Plan coverage, the Eligible Active Employee, Eligible Retired Employee, or an Eligible Dependent is not able to use the Prescription Drug Card or Mail Order Program until the Fund Office has received the self-payment and the pharmacy benefit manager with which the Plan contracts is notified.

Section 17.06 Coordination of Prescription Drug Benefits

(a) If an Eligible Employee or Eligible Retired Employee's Dependents receive primary health care coverage from another plan that has prescription drug benefits, and this Plan pays on a secondary basis, the Prescription Drug Card and Mail Order Programs do not directly cover them.

(b) To receive prescription drug benefits in this case, the Dependent must submit a claim to the primary plan, receive an Explanation of Benefits from the primary plan, and submit the Explanation of Benefits and pharmacy receipts to the pharmacy benefit manager with which the Plan contracts. The Plan will reimburse the difference between the amount paid by the primary plan and the full cost of the prescription, as long as the primary plan paid some amount of the prescription cost. If

the primary plan does not pay any benefits, the Dependent will be reimbursed the purchase price of the medication minus the copayment for that prescription listed in the applicable schedules in Article 5.

(c) If an Eligible Active Employee, an Eligible Retiree, or an Eligible Dependent is covered under another plan, and has a prescription filled under that plan, the Health Fund will reimburse 100% of the copayment paid under the other plan for that prescription. The Eligible Active Employee, an Eligible Retiree, or Eligible Dependent must be eligible for coverage under the Health Fund at the time the prescription is filled to receive reimbursement of the copayment amount. This provision is applicable only if the other plan has prescription drug benefits that are separate from medical benefits. If the other Plan covers prescriptions under that plan's medical benefits, standard coordination of benefit provisions apply.

Section 17.07 Expenses Not Covered by Prescription Drug Benefits

Prescription Drug Benefits do not cover:

(a) Weight loss medications.

(b) Anti-rejection medications, except as otherwise specifically provided as a Plan covered Expense.

(c) Infertility medications.

(d) Topical Minoxidil (e.g., Rogaine).

(e) Growth hormones.

(f) Retin-A.

(g) Products that do not require a prescription, even when ordered by a Physician, except as otherwise specifically provided as a Covered Expense.

(h) Products that do not carry the federal legend, even when the state a Plan Participant resides in requires a prescription.

(i) Prescriptions and necessary supplies utilized as an inpatient in a Hospital or Skilled Nursing Care Facility, or under a Home Health Care Plan.

(j) Charges for any of the circumstances listed in Section 4.11.

ARTICLE 18 ORGAN TRANSPLANT BENEFIT PROGRAM

Section 18.01 Organ Transplant Benefit, In General

(a) If an Eligible Active Employee, Eligible Retired Employee, or an Eligible Dependent incurs expenses for an organ transplant, benefits shall be payable in accordance with the provisions of this Article 18.

(b) To be eligible for transplant benefits, the Eligible Active Employee, Eligible Retired Employee, or Eligible Dependent must use the network of the transplant provider with which the Fund has contracted to be the exclusive provider network for organ and bone marrow transplants. Benefits are paid for Covered Charges as shown in the applicable schedules in Article 5. Organ transplant benefits are separate from Comprehensive Major Medical Benefits, so that expenses incurred under one benefit do not apply to deductibles or out-of-pocket maximums under the other benefit.

(c) The Organ Transplant Benefit has a separate deductible, out-of-pocket maximum, and coinsurance, as shown in the applicable schedules in Article 5.

Section 18.02 Organ Transplant Transportation Covered Expenses

If an Eligible Employee or Eligible Dependent must travel more than 100 miles from home to the transplant facility specified by the network provider with which the Plan has contracted, the Plan will pay 100% of all transportation, temporary lodging, and meal costs for one adult to accompany the recipient to the transplant facility. If the recipient is under age 18, the Plan will provide transportation, temporary lodging, and meals for two adults.

Section 18.03 Organ Transplant Immunosuppressive Medications

The Plan covers immunosuppressive medications prescribed in conjunction with an Organ Transplant, for up to a 90-day supply through the mail order program. The copayments per prescription are shown in the applicable schedules in Article 5. The Plan will determine whether it will cover immunosuppressive drugs purchased at a retail pharmacy on a case-by-case basis.

Section 18.04 Expenses Not Covered By Organ Transplant Benefits

Organ Transplant Benefits do not cover:

(a) Transplant services provided outside the network of providers in the network with which the Plan has contracted. However, if this Plan is the secondary payer and the primary payer required using, or provided an increased payment for using, a specific transplant facility that is not in the Plan's network, the Plan will pay benefits as if a network facility was used.

(b) Any Expenses not specifically listed as covered in this Article 18.

(c) Any Expenses exceeding specific maximums in the applicable schedules in Article 5.

ARTICLE 19 RETIREE CONTRIBUTION ALLOWANCE

Section 19.01 Retiree Contribution Allowance, In General

The benefits that Retired Employees earn under this Article 19, Retiree Contribution Allowance, may be used to pay for benefits under this Plan.

Section 19.02 Eligibility for Retiree Contribution Allowance

Participants will be eligible for this Article 19, Retiree Contribution Allowance if they retire on or after January 1, 2000, and have earned at least 10 service credits. In addition, the Retiree must be receiving one of the following:

(a) A Wisconsin Laborers' pension (or a pension from another recognized pension plan acceptable to the Trustees) and have been eligible for Health Fund benefits in each of four (4) years preceding retirement; or

(b) Social Security disability benefits or a disability pension from the Wisconsin Laborers' Pension Fund (or another recognized pension plan acceptable to the Trustees) and have been eligible for Health Fund benefits immediately before the date of disability.

A former Participant who is continuously employed by the Laborers International Union of North America immediately following covered employment and immediately preceding permanent retirement shall be treated as having been eligible for Health Fund benefits in each of the four (4) years preceding retirement, as required under Section 19.02(a).

Section 19.03 Service Credits Counted Toward Retiree Contribution Allowance

(a) Service credits will be determined by dividing the Employee's total contribution hours from covered employment under the Wisconsin Laborers' Health Fund by 1,400 (rounded to the nearest .10 credit). Service credits are provided for Employer contribution hours only. Self-pay hours do not count.

(b) For Retired Employees who are married to each other or who are Domestic Partners of each other, service credits will be determined as follows:

(1) All service credits earned by both retired members will be combined into one total, up to the amount allowed per participant under the Plan, which is 30 service credits;

(2) Only one self-pay rate will be assessed per family, and the amount will be the cost of coverage minus the combined service credits;

(3) If one spouse or Domestic Partner dies, the surviving spouse or surviving Domestic Partner will pay the appropriate member rate depending on whether the surviving spouse or surviving Domestic Partner is a Pre-Medicare or Post-Medicare Retired Employee; and

(4) If the Retired Employees divorce or terminate the domestic partnership, the combined service credits will be allocated to each member in the amount of the combined total for each, and each Retired Employee will pay the appropriate member self-pay rate as a Pre-Medicare or Post-Medicare Retired Employee, since each will have separate coverage after divorce or termination of the domestic partnership.

Section 19.04 Break In Service

(a) This provision applies only to hours worked prior to January 1, 2000.

(b) A break in service occurs when an Employee has worked zero hours of covered employment (and no contributions have been received by this Fund) for a five-consecutive-year period. Service credits earned prior to such a break in service are forfeited for the purposes of determining retiree eligibility and the amount of any contribution allowance.

(c) A break in service that occurs due to employment with the Laborers International Union of North America that is described in Section 3.13(a)(5) shall not result in a forfeiture of service credit for purposes of determining retiree eligibility and shall not count toward the amount of such Service credit.

Section 19.05 Accrued Contribution Allowance

(a) A Retired Employee's service credit is multiplied by a factor based on whether the Retired Employee is eligible for Medicare.

(1) Provided Prior to Medicare Eligibility:

The amount stated in the applicable schedules in Article 5 per service credit to a maximum of 30 credits (42,000 hours). The maximum contribution allowance is the rate established by the Board of Trustees times 30 credits.

(2) Provided After Medicare Eligibility:

The amount stated in the applicable schedules in Article 5 per service credit to a maximum of 30 credits (42,000 hours). The maximum contribution allowance is the rate established by the Board of Trustees times 30 credits.

(b) The amount of the allowance per service credit and the maximum contribution allowance is established by the Board of Trustees and may be changed at their discretion.

Section 19.06 Normal Retirement

Normal retirement occurs when the Retired Employee reaches age 62 and has ten service credits. The Retired Employee will receive the full accrued amount of Contribution Allowance based on the Retired Employee's total contribution hours from covered employment (service credits times contribution allowance based on the Retired Employee's Medicare status at retirement).

Section 19.07 Early Retirement

The Retired Employee may retire at age 55 with ten service credits. However, the accrued amount, based on total contribution hours from covered employment, (service credits times contribution allowance based on the Retired Employee's Medicare status at retirement) will be reduced one-eighth of one percent for each month of retirement prior to age 62.

Section 19.08 Disability

If a Retired Employee has at least ten service credits and is totally disabled as defined in the rules and regulations for the Wisconsin Laborers' Pension Fund, the Retired Employee will be eligible for a Contribution Allowance based on his or her Medicare status.

(a) **Contribution Allowance Prior to Medicare Eligibility**:

If a Retired Employee is disabled, he or she will receive a full accrued amount, based on total contribution hours from covered employment, for a maximum of 29 months. After 29 months of continuous disability, the Retired Employee becomes Medicare eligible and must switch to the Medicare Supplement plan.

(b) **Contribution Allowance After Medicare Eligibility**:

Same as for Normal Retirement

Section 19.09 Surviving Spouse or Surviving Domestic Partner

If an Employee dies either before or after retirement, the Employee's surviving spouse or surviving Domestic Partner may be eligible to continue coverage under the Retiree Health Plan provided the Employee earned at least ten service credits. If this eligibility requirement is met, the full accrued amount of the Employee's contribution allowance, based on total contribution hours from covered employment, will be provided immediately to the surviving spouse or surviving Domestic Partner.

Section 19.10 Treatment of Excess Bank Hours

Excess bank hours may be used to stay on active coverage until all hours are used. A Retired Employee can make a partial self-payment to make up any difference in the final quarter. One additional full self-payment is also allowed in the subsequent quarter.

ARTICLE 20 HEALTH REIMBURSEMENT ARRANGEMENT (HRA) Plan

Section 20.01 Establishment of Health Reimbursement Arrangement Plan

(a) As of July 1, 2015 (the "Effective Date"), the Board of Trustees of the Wisconsin Laborers' Health Fund (the "Fund") establishes the Wisconsin Laborers' Health Fund Health Reimbursement Arrangement (HRA) Plan. Capitalized terms used in this Article that are not otherwise defined will have the meanings set forth in Section 20.03.

(b) The HRA Plan is designed to permit a Participant to obtain reimbursement of Medical Care Expenses on a non-taxable basis from the HRA Account beginning January 1, 2016, for claims incurred on or after January 1, 2016. Claims incurred on and after January 1, 2016 may be filed in accordance with Section 20.10.

Section 20.02 Legal Status

The HRA Plan is intended to qualify as a medical reimbursement plan under Code Sections 105 and 106 and regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and will be interpreted to accomplish that objective. The Medical Care Expenses reimbursed under the HRA Plan are intended to be eligible for exclusion from the gross income of Participants and Beneficiaries under Code Section 105(b).

Section 20.03 Definitions

(a) "Beneficiary" as used herein means a Spouse, Domestic Partner or Dependent Child designated by a Participant, or by the terms of the Plan, who is or may become entitled to a benefit thereunder.

(b) "Benefits" means the reimbursement benefits for Medical Care Expenses described in this Article.

(c) "Claim Form" means the paper form provided by the Administrative Manager for the purpose of allowing an Eligible Employee to request reimbursement under the HRA Plan.

(d) "Code" means the Internal Revenue Code of 1986, as amended from time to time, and the regulations promulgated thereunder.

(e) "Compensation" means the wages or salary paid to an Employee by an Employer.

(f) “Contributions” as used in this Article means the money paid or payable into the Fund by an Employer pursuant to a Collective Bargaining Agreement or pursuant to a Participation Agreement.

(g) “Dependent” means an individual who meets the definition of Dependent in Section 2.11. A Domestic Partner is a Dependent for purposes of Article 20 only if the Domestic Partner is a tax dependent of the Participant.

(h) "Domestic Partner" means a person defined in Section 2.42.. A Domestic Partner may receive Benefits from the HRA Plan only if the Domestic Partner is a tax dependent of the Participant.

(i) “ERISA” means the Employee Retirement Income Security Act of 1974, as amended.

(j) "Eligible Person," for purposes of Article 20, means a Participant and a Dependent, as defined in 20.3(g).

(k) “Health FSA” means a health flexible spending arrangement as defined in Prop. Treas. Regulation Section 1.125-2, Q/A-7(a).

(l) “HRA” means a Health Reimbursement Arrangement as defined in IRS Notice 2002-45.

(m) “HRA Account” means the HRA Account described in Section 20.09.

(n) “Medical Care Expenses” has the meaning defined in Section 20.08(b).

(o) "Participant," for purposes of Article 20, means an Eligible Employee and Eligible Retired Employee.

(p) “Period of Coverage” means the Calendar Year during which a Participant is an Eligible Employee, with the following exceptions:

(1) For Employees who first become Eligible to participate in the Health Plan, it means the portion of the Calendar Year following the date participation commences; and

(2) For Employees who terminate participation in the Health Plan, it means the portion of the Calendar Year prior to the date participation terminates as well as the subsequent portion of the Calendar Year and following Calendar Years in which the former Employee continues to have a balance remaining in the HRA Plan. A different Period of Coverage (e.g., monthly) may be established by the Administrative Manager and communicated to Participants.

(q) "Spouse" means legal spouse.

Section 20.04 Initial Eligibility and Coverage

(a) An Employee shall be eligible to participate in the HRA Plan if the Employee meets the eligibility provisions of the Health Plan.

(b) In order to comply with the Affordable Care Act and applicable guidance with regard to integration rules for a health reimbursement arrangement, the following eligibility rules also apply to the HRA Plan:

(1) If an active Employee who is eligible for coverage under the Health Plan is not actually enrolled in the Plan, such Employee must be actually enrolled in another group health plan that provides minimum value pursuant to Internal Revenue Code Section 36B(c)(2)(C)(ii) in order to use the HRA Plan for reimbursements, regardless of whether the other group health plan is sponsored by this Health Plan. A group health plan provides minimum value if the coverage has an actuarial value of at least 60 percent under standards determined by the Internal Revenue Service and provides substantial coverage of in-patient hospital and physician services.

(2) Proof of other group health plan coverage will be required in a manner to be determined by the Trustees. If proof is not provided, HRA Plan benefits will be restricted, as defined in subsection (3) below.

(3) If an Employee under subsection (1) above does not provide proof of enrollment in other group health plan coverage that provides minimum value, in a manner determined by the Trustees, benefits from the HRA Plan will be reduced as required by IRS Notice 2013-54. Specifically, if an Employee under subsection (1) above is enrolled in other group health plan coverage, but the coverage does not provide minimum value, then the HRA Plan benefit is limited to reimbursement of copayments, coinsurance, deductibles, and premiums for the other group health plan coverage to the extent such premiums are paid on an after-tax basis, as well as medical care as defined under Internal Revenue Code Section 213(d) that does not constitute essential health benefits.

(4) Amounts credited to a Participant's HRA Account cannot be used to reimburse premiums for individual market coverage or insurance plans purchased from a state or federal Health Insurance Marketplace. Medicare premiums (Parts B and D), Medicare Supplement

premiums, and Medicare Advantage policies are also not reimbursable for active Employees. However, Medicare Part B premiums, Medicare Part D premiums, group Medicare Advantage premiums and Medicare supplemental plan premiums are reimbursable for terminated Employees, including Retired Employees or Dependents of deceased Participants who are spending down the HRA Account balance. Dental policy premiums and vision policy premiums are also reimbursable for Eligible Persons. Participants and Dependents of deceased Participants who enroll for Medicare Part D coverage will not be eligible for prescription drug reimbursements from the HRA.

(5) Any Employee who has an HRA Account balance will be allowed, at least annually, to permanently opt out of HRA Plan coverage and waive future reimbursements from the Employee's HRA Account. Additionally, the Plan allows an Employee who has an HRA Account to permanently opt out of HRA Plan coverage and waive future reimbursements from the Employee's HRA Account upon termination of employment, the loss of Plan eligibility, or when becoming eligible for Retiree coverage. The Plan also allows a Participant's Dependents to permanently opt out of HRA Plan coverage and waive future reimbursements from the Participant's HRA Account upon the death of the Participant. A forfeiture is in accordance with Section 20.09(b)(6). Notwithstanding the forgoing, effective September 1, 2017, if a Participant or Dependent, upon the death of the Participant, elects to opt out of HRA Plan coverage, the HRA Account balance will be frozen in accordance with Section 20.09(b)(6).

(6) An Employee who terminates employment may elect, effective on the date of employment termination or later, to forfeit the Employee's HRA Account balance. A forfeiture is in accordance with Section 20.09(b)(6). Notwithstanding the forgoing, effective September 1, 2017, if an Employee elects to opt out of HRA Plan coverage, the Employee's HRA Account balance will be frozen in accordance with Section 20.09(b)(6).

(c) **Death of a Participant**

(1) Upon the death of a Participant, the surviving Spouse or eligible tax-dependent Domestic Partner of the Participant will continue to be entitled to reimbursements for Medical Care Expenses until the earlier of the date the Participant's HRA Account reaches a zero balance or the HRA Plan terminates. Other Dependents of the deceased Participant covered under the HRA Plan may continue participation in the HRA Plan until the earlier of the date they

no longer meet the definition of "Dependent," the date the Participant's HRA Account reaches a zero balance, or the date of termination of the HRA Plan.

(2) If there are no Dependents, amounts left in the Participant's HRA Account will not be paid to any other individual. All amounts remaining in such case will be forfeited and revert to the Plan and will be used for administrative expenses. In no event will the remaining assets be paid in cash to any Person.

(d) **FMLA and USERRA Leaves of Absence**

Notwithstanding any provision to the contrary in this HRA Plan, if an Employee goes on a qualifying leave under the FMLA or USERRA, then to the extent required by the FMLA or USERRA, as applicable, the Fund will continue to maintain the Employee's Benefits on the same terms and conditions as if the Employee were still an active Employee (as further described in the Document). If an Employee goes on a leave of absence that is not subject to FMLA or USERRA, the Employee will be treated as having terminated participation, as described in Section 20.04(b).

Section 20.05 Benefits Offered

(a) When an Employee becomes a Participant in accordance with Article 3, an HRA Account will be established for such Participant to receive Benefits in the form of reimbursements for Medical Care Expenses, as described in Section 20.08. In addition, an eligible Retired Employee will continue to have access to any HRA Account previously established in his or her name, as described in this Article.

(b) In no event will Benefits be provided in the form of cash or any other taxable or non-taxable benefit other than reimbursement for Medical Care Expenses.

(c) Payments will only be made to Participants and Beneficiaries. There will be no assignment of Benefits to providers and no Benefit payments may be paid to providers, except as provided through the use of the HRA debit card.

Section 20.06 HRA Plan Contributions

(a) **Employer Contributions**

The HRA Plan is funded solely with Employer contributions. Employer contributions on the behalf of active Employees made pursuant to an applicable Collective Bargaining Agreement or Participation Agreement will fund the full amount of the HRA Accounts. For initial eligibility,

only contributions used in the calculation to determine eligibility based on a rolling 12-month period are credited to an Employee's HRA. If an Employee loses eligibility under the Health Plan due to lack of hours and then becomes eligible again prior to a two-year break in eligibility, the HRA contributions that were earned during the ineligibility period will be credited to the Employee's HRA Account once such Employee's eligibility for Heath Plan coverage has been re-established. However, if an Employee's period of ineligibility for coverage under the Health Plan is longer than two years, then only HRA contributions earned in the two-year period immediately prior to the Employee's re-established eligibility date for Health Plan coverage will be credited to the Employee's HRA Account. An Employee will be given access to the HRA funds only after the Employee becomes eligible for benefits under the Health Plan. No Employer contributions are made to an individual HRA Account on behalf of an Employee after an Employee's termination of employment or retirement.

(b) **Participant Contributions**

There are no Participant contributions for Benefits under the HRA Plan.

(c) **No Funding Under Cafeteria Plan**

Under no circumstances will HRA Benefits be funded with salary reduction contributions, Employee contributions (e.g., flex credits), or otherwise under a cafeteria plan pursuant to Code Section 125, nor will salary reduction contributions or employer contributions under a cafeteria plan be treated as Employer contributions for the purposes of the HRA Plan.

(d) No contributions will be made after a Participant is no longer Employed in the Industry.

(e) **Contributions Received Under Reciprocal Agreements**

Contributions that are received under Reciprocal Agreements in accordance with Section 3.22 will first be allocated to the Employee's HRA Account and then applied toward the monthly cost to maintain Plan coverage.

Section 20.07 Funding the HRA Plan

All of the amounts payable under the HRA Plan will be paid from the general assets of the Fund. Nothing herein will be construed to require the Fund to maintain any fund or to segregate any amount for the Benefit of any Participant or Beneficiary, and no Participant or other person will have any claim against, right to, or security or other interest in, any fund, account, or asset of the Fund from which any payment under the

HRA Plan may be made. The Fund has no obligation to fund the HRA Plan or its nominal accounts beyond the amounts attributable to Employer contributions.

Section 20.08 Benefits and Reimbursement Procedures

(a) The HRA Plan will reimburse Participants and, as applicable, Dependents of deceased Participants for Medical Care Expenses incurred by:

(1) Active Employees and their Dependents while covered by the HRA Plan and the Health Plan or other group health plan coverage. Effective September 1, 2017, active Employees' Dependents must be covered by the HRA Plan and the same group health plan as the Employee on either a primary or secondary basis;

(2) Retirees and their Dependents while covered by the HRA Plan; and

(3) Dependents of deceased Participants while covered by the HRA Plan up to the unused amount in the Participant's HRA Account.

(b) **Eligible Medical Care Expenses**

Under the HRA Plan, a Participant or, as applicable, Dependents of deceased Participants may receive reimbursement for Medical Care Expenses incurred during a Period of Coverage beginning on January 1, 2016 when Benefits are payable as described in Section 20.05.

(1) Incurred: A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the Eligible Person incurring the expense is formally billed for, is charged for, or pays for the medical care. Medical Care Expenses incurred before an Eligible Person first becomes covered by the Health Plan are not eligible. However, a Medical Care Expense incurred during one Period of Coverage may be paid during a later Period of Coverage, provided that the Eligible Person was covered by the HRA Plan during both Periods of Coverage under the terms of the Plan.

(2) Medical Care Expenses Generally:

(A) Subject to Section 20.04(b)(4), "Medical Care Expenses" means expenses incurred by an Eligible Person for medical care, as defined in Code Section 105 and Section 213(d) (including, for example, amounts for certain Hospital bills, doctor and dental bills and prescription drugs), but do not include expenses that are described in Subsection 105(c) of the Code. Medical Care Expenses include premiums for

Part B of Title XVIII of the Social Security Act (Medicare Part B premiums), premiums for group health insurance covering medical care (including premiums for group Medicare Supplement, Medicare Prescription Drug Plan (Medicare Part D), or Medicare Advantage policies), COBRA premiums, or premiums for any qualified long-term care insurance contract as defined in Code Section 7702B(B) provided, however, that any such premiums are not paid through salary reduction contributions under the terms of a Code Section 125 plan. Reimbursements due for Medical Care Expenses incurred by the Eligible Person will be charged against the Participant's HRA Account.

(B) An Employee who is short of hours for an eligibility quarter must affirmatively elect to use the Employee's HRA Account for self-payments. The Employee's HRA Account balance will not automatically be used to make the Employee's self-payments.

(3) Medical Care Expenses Exclusions: "Medical Care Expenses" do not include the following expenses even if they otherwise meet the definition of "medical care" under Code Section 213 and may otherwise be reimbursable under IRS guidance pertaining to HRAs.

(A) Long-term care services.

(B) Cosmetic or Reconstructive Surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, personal Injury resulting from an accident or trauma, or disfiguring disease. "Cosmetic or Reconstructive Surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat Sickness or disease.

(C) The salary expense of a nurse to care for a healthy newborn at home.

(D) Funeral and burial expenses.

(E) Household and domestic help (even though recommended by a qualified Physician due to an Eligible Person's inability to perform physical housework).

(F) Massage therapy.

(G) Home or automobile improvements.

(H) Custodial Care, or long-term care.

(I) Costs for sending a child with discipline issues to a special school for benefits that the child may receive from the course of study and disciplinary methods.

(J) Health club or fitness program dues or equipment for general well-being, even if the program is necessary to alleviate a specific medical condition, such as obesity, unless the participant has a physician's letter stating a specific diagnosis and prescribing the membership or equipment.

(K) Social activities, such as dance lessons (even though recommended by a Physician for general health improvement).

(L) Bottled water.

(M) Maternity clothes.

(N) Diaper service or diapers.

(O) Cosmetics, toiletries, toothpaste, etc.

(P) Vitamins and food supplements, even if prescribed by a Physician.

(Q) Uniforms or special clothing, such as maternity clothing.

(R) Automobile insurance premiums.

(S) Transportation expenses of any sort, including transportation expenses to receive medical care.

(T) Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a Physician.

(U) Any item that does not constitute "medical care" as defined under Code Section 213.

(V) Premiums paid through salary reduction contributions under the terms of a Code Section 125 plan.

(W) Premiums for individual market coverage or insurance plans purchased from a state or federal Health Insurance Marketplace. Medicare premiums (Parts B and D), Medicare Supplement premiums and Medicare Advantage policies are also not reimbursable for active Employees. However, Medicare Part B premiums, Medicare Part D premiums, group Medicare Advantage premiums and Medicare supplemental plan premiums are reimbursable for terminated Employees, including Retired Employees or Dependents of deceased Participants who are spending down the HRA Account balance. Dental policy premiums and vision policy premiums are also reimbursable for an Eligible Person.

(X) Over-the-counter drugs without a prescription unless insulin.

(Y) Prescription drugs for Participants who enroll for Medicare Part D coverage.

(4) Cannot Be Reimbursed or Reimbursable from Another Source: Medical Care Expenses can only be reimbursed to the extent that the Eligible Person incurring the expense is not reimbursed for the expense nor is the expense reimbursable through another health insurance plan, other insurance, or any other accident or health plan (but see Section 20.11 if the other health plan is a Health FSA). If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because another health insurance plan imposes co-payment or deductible limitations), the HRA Account can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article.

(c) The Health Fund may charge a Participant's HRA Account for reasonable administrative expenses, such as for issuance of a replacement debit card.

Section 20.09 Establishment of Account

(a) The Trustees will establish and maintain an HRA Account with respect to each Participant but will not create a separate fund or otherwise segregate assets for this purpose.

(b) The HRA Account so established will be a recordkeeping account with the purpose of keeping track of Employer contributions, as well as reimbursement amounts, and administrative fees.

(1) Crediting of Accounts: A Participant’s HRA Account will be credited within 30 days of the date of receipt of the Employer’s contribution on the Participant’s behalf with an amount equal to the applicable dollar amount for the annual Period of Coverage as determined by the applicable Collective Bargaining Agreement or Participation

Agreement. On the first day of each Calendar Year thereafter, the HRA Account will consist of the unused Account balance from all prior Period(s) of Coverage. Future Employer contributions will be added to such amount.

(2) Debiting of Accounts: A Participant's HRA Account will be debited during each Period of Coverage for any reimbursement of Medical Care Expenses incurred during the Period of Coverage and for any administrative expenses charged to the Participant's HRA.

(3) Investment Earnings: Investment earnings will not be credited to Participants' accounts, but will instead be used to offset the administrative expenses of the HRA Plan benefits.

(4) Available Amount: The amount available for reimbursement of Medical Care Expenses is the amount of Employer contributions credited to the Participant's HRA Account, reduced by prior reimbursements. A Participant or, as applicable, Dependents of deceased Participants shall be able to access his or her HRA Account only if it has a positive balance.

(5) Carryover of Accounts: If any balance remains in the Participant's HRA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance will be carried over to reimburse the Participant for Medical Care Expenses submitted for reimbursement during a subsequent Period of Coverage. Upon termination of employment, the Participant's coverage will continue without further Employer contributions, and expenses submitted for reimbursement after such time will be reimbursed to the extent that a balance remains in the Participant's HRA account, subject to the provisions of Section 20.10.

(6) Forfeiture of Accounts: The Health Fund will maintain the Participant's HRA Account following the Participant's date of termination of participation in the Health Plan without further Employer contributions until the earlier of the date the HRA Account balance is exhausted or the date the Participant or, if applicable, the Dependent waives or forfeits the balance under Section 20.04(b)(5) or (6). Any amount in an HRA Account that is forfeited will be used to pay administrative expenses of the HRA Plan. Further, any HRA contributions received on the Employee's behalf will be forfeited to the Plan until the HRA Account is reinstated.

Notwithstanding the forgoing, effective September 1, 2017, if a Participant or, if applicable, Dependent elects to opt-out of the HRA Plan, the Participant's HRA Account will be frozen as of the date of opt-out and will be reinstated as set forth below. Any HRA

contributions received on the Employee's behalf will be forfeited to the Plan until the HRA Account is reinstated.

(A) Annual Opt-Out: The Participant's frozen HRA Account will be reinstated on the earlier of:

(i) The January 1 following the Participant's election to opt-in to the HRA Plan; or

(ii) The Participant's death.

(B) Loss of Plan eligibility: The Participant's frozen HRA Account will be reinstated if the Participant regains Health Plan and HRA Plan eligibility.

(C) Becoming eligible for Retiree coverage: The Retired Employee's frozen Account will be reinstated on the earlier of:

(i) The January 1 following the Retired Employee's election to opt-in to the HRA Plan; or

(ii) The Retired Employee's death.

(D) Death of the Participant: The frozen Account will be reinstated on the January 1 following the Dependent's election to opt-in to the HRA Plan. Any amounts remaining in the Participant's Account will forfeit to the Plan upon the Dependents' death.

(7) Statement: A Participant or, if applicable, Dependent of a deceased Participant periodically may be provided with an electronic statement showing the balance of his or her HRA Account.

(8) Alienation: The Participant or any other individual may not assign, transfer or alienate any interest in the HRA Account.

Section 20.10 Claims and Reimbursement Procedures

(a) **Deadline for Submission of Claims**

(1) Paper and Debit Card Claims can be submitted for claims incurred on and after January 1, 2016.

(2) Paper Claims: Claims that are not charged to the debit card can be submitted as paper claims up to 12 months after the date of occurrence. Aggregate claims must total $100 or more, except for the last claim filed in any Calendar Year or following the period of coverage. If there is an insufficient amount in the HRA Account to cover the claim, it is the Participant's responsibility to resubmit the balance when the HRA Account has sufficient funds.

(3) Debit Card Claims: Claims submitted through the use of a debit card will be considered submitted on the date of the debit card transaction.

(b) **Timing of Reimbursement of Claims**

Within 30 days after receipt by the Administrative Manager of a reimbursement claim from an HRA Plan Participant, the Fund will reimburse the Participant or, if applicable, the Dependent of the deceased Participant for the Eligible Person’s Medical Care Expenses (if the Administrative Manager approves the claim), or the Administrative Manager will notify the Participant or, if applicable, the Dependent of the deceased Participant that the claim has been denied (see Sections 4.12 and 4.13 regarding procedures for claim denials and appeals).

(c) **Claims Substantiation**

(1) Debit Card Claims: Participants or, if applicable, Dependents of the deceased Participant submitting claims by means of a debit card transaction do not need to provide any additional substantiation, unless requested by the claims processor. Subject to procedures established by the Administrative Manager and in accordance with IRS guidance in Revenue Ruling 2003-43, Notice 2006-69, Notice 2007-2, proposed Treasury Regulation Section 1.125-6 and any subsequent IRS guidance, Participants or, if applicable, Dependents of the deceased Participant may use a debit card provided by the Administrative Manager and the Plan for payment of Medical Expenses, as follows:

(A) Payment of Medical Care Expenses. Each Participant or, if applicable, Dependent of the deceased Participant issued a card shall agree to certify upon enrollment and each Plan year thereafter that such card shall only be used for Medical Care Expenses that have been incurred. The Participant or, if applicable, Dependents of the deceased Participant shall also certify that any Medical Care Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant or, if applicable, Dependents of the deceased Participant will not seek reimbursement from any other plan covering health benefits. The Participant or, if applicable, Dependents of the deceased Participant must also agree to obtain and maintain sufficient documentation for Medical Care Expenses paid with the card.

(B) Card Issuance. The card shall be issued to an Eligible Person upon participation in the HRA Plan and shall remain active if the Participant or, if applicable, Dependents of the deceased Participant continues to participate in the HRA Plan. The card shall be automatically cancelled upon the Participant's death or termination of employment if the Participant or Beneficiaries no longer participate in the HRA Plan or withdraw from the HRA Plan, or if the Participant or, if applicable, Dependent of the deceased Participant uses the card for impermissible expenses pursuant to subsection (F) below. If a Participant or, if applicable, Dependents of the deceased Participant loses his or her HRA debit card, the Health Fund may assess the Participant's HRA account an administrative charge for a replacement card.

(C) Maximum Amount. The dollar amount of coverage available on the card shall be the balance of the HRA Account at the time of the reimbursement.

(D) Limitation on Use. The Administrative Manager shall limit the use of the card to medical care providers and certain stores allowed under IRS guidance for card payments of Medical Care Expenses.

(E) Substantiation. A Participant's or, if applicable, Dependent's of the deceased Participant use of the card for Medical Care Expenses shall be subject to substantiation by the Administrative Manager or the claims processor, usually by submission of a receipt from a medical provider or certain stores describing the service, the date and the amount of the service. All charges shall be conditional

pending confirmation and substantiation. Notwithstanding the foregoing, the submission of receipts for card payments is not required for Medical Care Expenses that are substantiated copayment matches, certain recurring Medical Care Expenses, real-time substantiation of Medical Care Expenses at the time of sale and Medical Care Expenses substantiated through an inventory information approval system if IRS requirements for these types of substantiations are satisfied.

(F) Correction Methods. If a Participant or, if applicable, Dependent of the deceased Participant fails to provide the Administrative Manager with requested substantiation for a Medical Care Expenses or if a Participant's or, if applicable, Dependent's of the deceased Participant card purchase is later determined by the Administrative Manager to not qualify as a Medical Care Expense, the Administrative Manager and/or the Board of Trustees shall use the following correction methods to make the Plan whole:

(i) Deactivate the card until the amount of the improper payment is recovered and then use methods (ii) and (iii) below in any order;

(ii) Require the Participant or, if applicable, Dependent of the deceased Participant to repay the improper amount;

(iii) If the amount remains unpaid, offset future claims until the amount is repaid; and

(iv) As a final option, if the amount continues to remain unpaid, in its discretion, the Board of Trustees may treat the improper payment as any other business indebtedness of the Plan.

(2) Paper Claims: Participants or, if applicable, Dependents of the deceased Participant seeking Benefits by filing a paper claim must submit a written application for Benefits to the Administrative Manager in such form as the Administrative Manager may prescribe, setting forth:

(A) The Eligible Person or Eligible Persons on whose behalf Medical Care Expenses have been incurred;

(B) The nature and date of the Medical Care Expenses so incurred;

(C) The amount of the requested reimbursement; and

(D) A statement that such Medical Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source and that Health FSA coverage, if any, for such Medical Care Expenses has been exhausted.

The written application must be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and the amounts of such Medical Care Expenses, together with any additional documentation that the Administrative Manager may request.

Except for the final paper reimbursement claim for a Period of Coverage, no paper claim for reimbursement may be made unless and until the aggregate claim for reimbursement is at least $100 per individual.

(d) Claims Denied: For appeals of claims that are denied, see the appeals procedures in Section 4.13.

Section 20.11 Coordination of Benefits; Health FSA to Reimburse First

Benefits under this HRA Plan are intended to pay Benefits solely for Medical Care Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise eligible Medical Care Expense is payable or reimbursable from another source, that other source will pay or reimburse prior to payment or reimbursement from the HRA Plan. Without limiting the foregoing, if the Eligible Person's Medical Care Expenses are covered by both the HRA Plan and by a Health FSA, then the HRA Plan is not available for reimbursement of such Medical Care Expenses until after amounts available for reimbursement under the Health FSA have been exhausted.

Section 20.12 COBRA

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, any Participant or Beneficiary (Qualified Beneficiary) whose coverage terminates under the Plan because of a COBRA qualifying event, will be given the opportunity to continue on a self-pay basis the same coverage that the Participant or Beneficiary had under the Plan the day before the qualifying event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA), as set forth in Section 3.09.

Section 20.13 Coordination of Benefits

(a) **General**

The HRA Plan shall not be considered a group health plan for coordination of benefits purposes under the Plan, and its reimbursement benefits shall not be taken into account when determining other benefits payable under this Plan or benefits payable under any other health plan except for Medicare. The use of Benefits under the HRA Plan may be restricted under some circumstances for active Employees and their Dependents who are enrolled in Medicare pursuant to the Medicare Secondary Payer Rules.

(b) **Medicare Part D**

The eligibility of active Employees and their Dependents for prescription drug benefits under the HRA Plan may continue, effective on the date of enrollment in a Medicare Part D plan. However, the prescription drug benefits will no longer be reimbursed under the HRA after the Participant enrolls in Medicare Part D. Because Retired Employees and their Dependents will no longer receive prescription drug benefits under the Health Plan if they enroll for Medicare Part D, they will be subject to Section 20.13(a) above.

SIGNATURE PAGE

The Health and Welfare Plan of Benefits provided by the Wisconsin Laborers' Health Fund is restated and set forth herein to describe the benefits in effect as of September 1, 2016.

In Witness Whereof, the undersigned have executed this restated document as the Trustees of the Wisconsin Laborers' Health Fund this _____ day of _____, 2017.

By _____, Chairman

By _____, Secretary/Treasurer

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