LiUNA!

WISCONSIN LABORERS' DISTRICT COUNCIL

Feel the Power

Wisconsin Laborers' Health Fund

Summary Plan Description

2021 Edition

WISCONSIN LABORERS' HEALTH FUND

4633 Liuna Way, Suite 201
DeForest, Wisconsin 53532-2514
Telephone: 608-846-1742 or 800-397-3373

Board of Trustees

Union Trustees	Management Trustees
John Schmitt *Chairman* WI Laborers District Council 4633 LIUNA Way, Suite 101 De Forest, WI 53532-2510	**Derek Allen** Associated General Contractors of Wisconsin, Inc. 4814 East Broadway Madison, Wisconsin 53716-4141
Brian Dehnhoff *Business Manager* Laborers Union Local 268 2233 Birch Street Eau Claire, Wisconsin 54703-3483	**Brian Hornung** J.H. Findorf & Son, Inc. P.O. Box 1647 Madison, Wisconsin 53701-1647
Clark Jensen *Business Manager* Laborers Union Local #140 2771 George Street LaCrosse, Wisconsin 54603	**William Kennedy** Rock Road Companies, Inc. P.O. Box 1779 Janesville, Wisconsin 53547-1779
Gerald Schomaker *Business Manager* Laborers Union Local #330 886 W. Airport Rd. Menasha, Wisconsin 54952-1522	**Kevin Renley** Market & Johnson, Inc. 2350 Galloway Street Eau Claire, Wisconsin 54703
Kent Miller *Assistant Business Manager* Wisconsin Laborers District Council 4633 LIUNA Way, Suite 101 DeForest, Wisconsin 53532	**Dan Voss** Miron Construction 1471 McMahon Drive Neenah,Wisconsin 54956
Tony Neira *Business Manager* Laborers Union Local #113 6310 West Appleton Avenue Milwaukee, Wisconsin 53210-1443	**Mary Wilcox, CPA** Super Excavators, Inc. N59 W14601 Bobolink Ave. Menomonee Falls, Wisconsin 53051
James Foye *Business Manager* Laborers Union Local 464 1438 N Stoughton Rd Madison WI 53714-1242	**Dan Cullen** JP Cullen 330 E Delavan Dr. Janesville, Wisconsin 53547
Philip Thompson *Fund Counsel* Wisconsin Laborers District Council 4633 LIUNA Way, Suite 101 DeForest, Wisconsin 53532	**Matthew L. Marcellis** Allied Construction Employer Assoc 17100 W. Blue Mound Road, Ste. 102 Brookfield, WI 53005

Fund Consultant

Segal Consulting
101 North Wacker Drive, Suite 500
Chicago, Illinois 60606-1724

Administrative Manager

BeneSys, Inc.

Fund Attorneys

Reinhart Boerner Van Deuren, s.c.
1000 North Water Street,
Suite 1700
Milwaukee, Wisconsin
53202-3186

The Previant Law Firm, S.C.
310 West Wisconsin Avenue,
Suite 100MW
Milwaukee, Wisconsin
53212-3958

Administrator

Board of Trustees

Dear Participant:

The Board of Trustees (Trustees) of the Wisconsin Laborers' Health Fund (Fund or Health Fund) is pleased to provide you with comprehensive health and welfare benefits. We continually evaluate the benefits provided and look for opportunities to enhance those benefits while maintaining a financially sound Fund.

The Health Fund Plan Document (Plan or Plan Document) offers the following healthcare benefits, as applicable:

- Comprehensive Major Medical Benefits, including Organ Transplant Benefits, Chiropractic Benefits, Home Health Benefits, Hospice Care Program Benefits, and Wellness Benefits;
- Prescription Drug Benefits;
- Dental Benefits;
- Vision Benefits;
- Hearing Aid Benefits; and
- Disability Benefits.

Refer to the applicable *Schedule of Benefits*, which begins on page 2, to determine which benefits apply to you and your family.

About this Booklet

This Summary Plan Description (SPD) booklet is intended to give you an understanding of Plan benefits as of January 1, 2021. This SPD, which includes all Plan changes adopted since the previous edition, replaces and supersedes any previous SPD.

This booklet is meant to be an easy-to-understand description of your Plan benefits, including descriptions of the Plan's eligibility rules and benefits. We have tried to organize the information in a way that will be useful to you. The booklet includes several sections, including:

- A **Schedule of Benefits** that gives you a brief overview of all the benefits available to you through the Fund as well as provides you with important contact information.
- An **eligibility section** that tells you how you become a participant of the Plan, who in your family is eligible for coverage, what you need to do to continue to be eligible, when coverage under the Plan ends, and what you need to do to reinstate your eligibility.
- Several sections that provide detailed information about each of the **different types of coverage** provided through the Plan, including Medical, Organ Transplant, Prescription Drug, Dental, Vision, Hearing Aid, Disability, and Death Benefits.
- A **"how-to" section on filing claims**, including what you need to do if a claim is denied.
- An **administrative information section**, which includes general Plan information and your rights as a Plan participant.
- A **definitions section** that defines important words used throughout this booklet. If you are not familiar with the terms used in this booklet, please review this section. Several of the terms defined in the definition section are capitalized throughout this booklet.

Statement of Grandfathered Status

The Wisconsin Laborers' Health Fund believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan, and what might cause a plan to change from grandfathered health plan status, can be directed to the Plan Administrator at 608-846-1742 or 800-397-3373. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or via **http://www.dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

A Final Note

We encourage you to read this information and share it with your Spouse or declared Domestic Partner. In addition, we recommend that you keep this booklet with your important papers so you can refer to it and update it when needed.

If you have questions about this booklet or the Plan in general, contact the Fund Office at 608-846-1742 or 800-397-3373.

Sincerely,
Board of Trustees

This booklet is not the legal Health Fund Plan Document. Only the Health Fund Plan Document (the Rules and Regulations) establishes the legal rights, privileges, and obligations under the Health Fund Plan. If there is a conflict or inconsistency between the provisions of the Plan Document and this booklet, the Health Fund Plan Document will govern.

Nothing in this SPD booklet is meant to interpret, extend, or change in any way the provisions expressed in the Plan Document and Trust Agreement. The Trustees' intent is to continue this Plan indefinitely, subject to the provisions of Article VIII of the Trust Agreement. The Trustees have the authority and reserve the right to amend, modify, or discontinue all or part of this Plan whenever, in their sole discretion, if conditions so warrant. Such action may take place by a majority vote at a regularly scheduled Board of Trustees' meeting. The Trustees also have sole and broad discretion in interpreting the provisions of the Plan, this SPD, or any other provisions relating to the operation of the Plan. No Employer or Union Representative is authorized to make representations on behalf of the Plan.

CONTENTS

IMPORTANT CONTACT INFORMATION

For Information About	Contact	At
Eligibility, Medical and Biometric Screening Program, Vision, Hearing Aid, Disability, and Death Benefits	Fund Office • Claims • Eligibility	608-846-1742 800-397-3373 608-842-9101 608-842-9102
In-Network Providers (In and Outside of Wisconsin)	Anthem Blue Cross and Blue Shield	800-810-2583 **www.anthem.com**
Employee Assistance Program	Anthem Blue Cross and Blue Shield	800-865-1044 **www.AnthemEAP.com**
Organ Transplants	Fund Office	608-846-1742 800-397-3373
Prescription Drug Program (Actives and Non-Medicare Retirees)	Sav-Rx	800-228-3108 **www.savrx.com** Sav-RX Phone App
Medical Eligibility and Benefits (For Medicare-Eligible Retirees Only) Prescription Drug Program (For Medicare-Eligible Retirees Only) • Expedited Coverage Decisions • Retail Pharmacy • Mail Order Pharmacy	Wisconsin Laborers' UnitedHealthcare Medicare Advantage PPO Plan UnitedHealthcare Medicare Rx for Groups UnitedHealthcare Medicare Rx for Groups OptumRx®	800-457-8506 800-457-8506 866-691-8209 888-216-4085
Dental Providers, Benefits, and Claims Administration (Actives, Non-Medicare Retirees and Medicare-Eligible Retirees)	CarePlus Delta Dental	800-318-7007 **www.careplusdentalplans.com** 800-236-3712 **www.deltadentalwi.com** Delta Dental Phone App
Hearing Benefits	Epic Hearing Health Care Amplifon Hearing Health Care	877-606-3742 **www.epichearing.com** 866-674-3979 **www.amplifonusa.com/wilaborers**
Vision Benefits and Claims Administration (Actives, Non-Medicare Retirees and Medicare-Eligible Retirees)	EyeMed	866-800-5457 **www.eyemed.com** (Insight network) EyeMed Phone App

SCHEDULE OF BENEFITS

Regular Plan (Active Employees and Dependents)

The Regular Plan is available to active Employees and their Dependents.

Comprehensive Major Medical Benefit	**What You Pay/Applicable Limitations** (Coinsurance Amount Based On Allowable Charge)
Calendar Year Deductible (January 1 – December 31)	You pay: $300 per person; $600 per family
Emergency Room Deductible	You pay $100 per person. Deductible waived if admitted into hospital as a bed patient for at least one day within three consecutive days after visiting the emergency room
In-Network Physician/Specialist Office Visit Copayment	You pay $15 (not applicable for out-of-network providers)
Coinsurance • In-Network Provider • Out-of-Network Provider	 You pay 10% You pay 40%
In certain instances, a different coinsurance or a copayment may apply, as further shown in this schedule. Plan pays the in-network provider rate of covered Emergency Care services regardless of whether the facility and attending Physician are in the Anthem Blue Cross and Blue Shield PPO or POS network. Between March 1, 2020 and the date on which the public health emergency for COVID-19 declared by the Secretary of Health and Human Services ends, virtual/telehealth visits can be used for all provider office visits. These visits will be covered according to this *Schedule of Benefits*, except that office visits in connection with diagnostic testing for COVID-19 will be covered with no cost-sharing.	
Calendar Year Out-of-Pocket Maximum (January 1 – December 31) • In-Network Provider • Out-of-Network Provider	 You pay up to $4,500 per family You pay up to $10,000 per family
Premiums, copayments, deductibles, balance billing, and healthcare this Plan does not cover are not included in the out-of-pocket maximum.	
Preventive Care • In-Network Provider • Out-of-Network Provider	 You pay $0 You pay 40%, after calendar year deductible

Special Benefit Provisions/Limitations	
Radiologist, Pathologist, and Anesthesiologist Services • Provided at In-Network Facility • Provided at Out-of-Network Facility	 You pay 10% You pay 40%
Home Health Care • Visit Maximum	You pay applicable coinsurance (10%; 40%) 40 visits in a 12-consecutive-month period; weekly costs not to exceed weekly cost for confinement in a skilled nursing facility
Skilled Nursing Care • Daily Room Benefit Maximum • Benefit Period Maximum	You pay applicable coinsurance (10%; 40%) Established by local licensing agency 60 days per confinement, concurrent with any other health coverage
Outpatient Day Rehabilitation Center • Lifetime Visit Maximum	You pay applicable coinsurance (10%; 40%) 30 visits

Special Benefit Provisions/Limitations	
Hospice Care Coinsurance	You pay $0
Medically Necessary Ambulance Services • Coinsurance	 You pay 10%
Diabetes Education Program	You pay $0
Biometric Screening Program • Deductible	You pay $0 You and your Spouse/Domestic Partner may be entitled to a deductible waiver or may choose to receive a gift card if certain conditions are met
Employee Assistance Program • Benefits	You pay $0 Face-to-face counseling sessions or online video counseling sessions via LiveHealth Online (three sessions per covered individual per issue) One legal consultation (up to 30 minutes per issue per benefit year) Telephonic financial consultations Unlimited access to the EAP's website
Mental Health Benefits • Inpatient Treatment Coinsurance • Outpatient Treatment Coinsurance	You pay: 10% $0; no charge for LiveHealth Online
Substance Abuse Benefits • Inpatient Treatment Coinsurance – First Occurrence – Second and Subsequent Occurrences • Outpatient Treatment Coinsurance	You pay: $0 10% $0; no charge for LiveHealth Online
TMJ Benefits • Coinsurance	 You pay 50%
Stop Smoking Assistance Benefit • Smoking Cessation Counseling Classes • Smoking Cessation Products	Only for Participants, Spouses, and Domestic Partners You pay $0 Covered Under the Prescription Drug Program
Orthognathic Surgery • Coinsurance • Lifetime Maximum	You pay: 50% $10,000
Chiropractic Benefits • Benefit Maximum • Visit Maximum Per Calendar Year • X-Rays	 Plan pays $75 maximum per visit 26 You pay $0
Diagnostic Genetic Testing • Calendar Year Maximum	 $2,500 per person
Accidental Dental Coverage Coinsurance (Delta) • When Delta Dental Provider is Used • When Delta Dental Provider is Not Used	You pay: 15% 30%
Accidental Dental Coverage Coinsurance (CarePlus) • When CarePlus Provider is Used • When CarePlus is Not Used	You pay: 0% 100%

Organ Transplant Benefit	**What You Pay/Plan Pays** (Contact The Fund Office Before All Transplant Care. Only Care Received At A LifeTrac Network Facility Is Covered Under The Plan)
Out-of-Pocket Maximum*	You pay $10,000 per organ transplant
Organ Procurement Benefit	Plan pays $15,000
Transportation Benefit**	Covered 100%
Deductible	You pay $300 per transplant
Coinsurance	You pay 10%
Mail Order Immunosuppressive Medications (90-day supply) • Generic Prescription • Formulary Brand Name Prescription • Non-Formulary Brand Name Prescription	You pay: $16 $50 $80

* 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. Consult your tax advisor about the tax status of Plan coverage for temporary lodging and meals.

Prescription Drug Benefit	**What You Pay**
Prescription Drug Card Program (30-day Supply) • Generic Prescription • Formulary Brand Name Prescription* • Non-Formulary Brand Name Prescription*	 You pay: $8 $25 $40

* If you request a brand name drug when a generic is available, you must pay the brand name copayment plus the difference in cost between the brand name drug and the generic drug.

Mail Order Program (90-day Supply) • Generic Prescription • Formulary Brand Name Prescription* • Non-Formulary Brand Name Prescription*	You pay: $16 $50 $80

* If you request a brand name drug when a generic is available, you must pay the brand name copayment plus the difference in cost between the brand name drug and the generic drug.

Dental Benefit	**What You/Plan Pays** (Covered Expenses are paid based on the Allowable Charge)	
	CarePlus Plan	**Delta Dental PPO**
Annual Maximum	$2,500 (Cleanings and exams do not apply toward the annual maximum)	$2,000 (for individuals age 19 and over)
Calendar Year Deductible	You pay 0%, no deductible	You pay: $25 per person; $75 per family
Diagnostic—Oral Exams, X-Rays	You pay 0%, no deductible	You pay 0%, no deductible
Preventive—Cleanings, Fluoride, treatments, Sealants, Space Maintainers	You pay 0%, no deductible	You pay 0%, no deductible
Restorative—Amalgam & Composite Fillings	You pay 0%, no deductible	You pay 15%
Crowns	You pay 0%, no deductible	You pay 15%
Prosthodontics—Full and Partial Dentures, Denture Relines & Repair, Fixed	You pay 0%, no deductible	You pay 15%

Dental Benefit	**What You/Plan Pays** (Covered Expenses are paid based on the Allowable Charge)	
	CarePlus Plan	**Delta Dental PPO**
Endodontics—Root Canals/Therapy	You pay 0%, no deductible	You pay 15%
Periodontics—Scaling & Root Planning, Gingivectomy	You pay 0%, no deductible (Does not duplicate medical coverage)	You pay 15% (Does not duplicate medical coverage)
Oral Surgery—Surgical Extractions	You pay 0%, no deductible (Does not duplicate medical coverage)	You pay 15% (Does not duplicate medical coverage)
Implants	You pay 80%	You pay 15%
Orthodontia Lifetime Maximum Benefit	$2,500 50%	$2,000 50% (for individuals age 19 and over)

Vision Benefit	**Vision Benefit** (In-Network) **You Pay/Plan Pays**	**Vision Benefit** (Non-Network) **Plan Pays**
Annual Benefit Maximum for Reimbursement of Out-of-Pocket Vision Costs (In-network and Non-Network services and supplies combined)	Up to $250 combined with Non-Network	Up to $250 combined with In-Network
Exam with dilation (once every calendar year)	No charge	Up to $45
Retinal Imaging	Up to $39 copay	None
Contact Lenses in lieu of lenses (once every two calendar years – materials only) • Conventional • Disposable • Medically necessary	 $130 allowance + 15% discount over the allowance $130 allowance No charge	 Up to $104 Up to $104 Up to $210
Contact Lens Fit and Follow-up • Standard Fitting (two follow-ups) • Premium Fitting (two follow-ups)	 $10 copay $10 copay; 10% discount off of the retail price then a $55 allowance	 Up to $30 Up to $30
Frames Allowance (once every two calendar years)	$130 allowance + 20% discount over $130	Up to $65

Vision Benefit	**Vision Benefit** (In-Network) **You Pay/Plan Pays**	**Vision Benefit** (Non-Network) **Plan Pays**
Lenses (once every two calendar years in lieu of contacts)		
• Single Vision	No charge	Up to $25
• Bifocal	No charge	Up to $40
• Trifocal	No charge	Up to $55
• Lenticular	No charge	Up to $55
• Standard Progressive	$55 copay	Up to $40
• Premium Progressive Tier 1	$85 copay	Up to $40
• Premium Progressive Tier 2	$95 copay	Up to $40
• Premium Progressive Tier 3	$110 copay	Up to $40
• Premium Progressive Tier 4	$175 copay	Up to $40
• Standard Anti-Reflective	No charge	Up to $5
• Premium Anti-Reflective Tier 1	$12 copay	Up to $5
• Premium Anti-Reflective Tier 2	$23 copay	Up to $5
• Premium Anti-Reflective Tier 3	$85 copay	Up to $5
• Standard Polycarbonate	No charge	Up to $24
• Standard Plastic Scratch Coating	No charge	Up to $9
• UV Treatment	No charge	Up to $9
• Tint (Solid & Gradient)	No charge	Up to $9
• Photochromatic (Plastic)	$75 copay	None
• Polarized	20% discount	None
• Other Add-ons and Services, excluding professional services and contacts	20% discount	None
Additional Discounts Freedom Pass	No charge for any frame at Target when using your available frame allowance	
• Additional Pair of Glasses	40% discount	None
• Nonprescription sunglasses	20% discount	None
• Non-covered Items	20% discount	None
• LASIK or PRK Surgery	15% discount	None

Vision Benefit—Safety Eyewear	**Vision Benefit—Safety Eyewear** (In-Network) **You Pay**	**Vision Benefit—Safety Eyewear** (Non-Network) **Plan Pays***
Safety Eyewear Frames	$0 Co-pay; $100 Allowance, 20% off balance over $100	Up to $70
Safety Eyewear Standard Plastic Lenses		
• Single Vision	$0 Co-pay	Up to $30
• Bifocal	$0 Co-pay	Up to $50
• Trifocal	$0 Co-pay	Up to $70
• Lenticular	$0 Co-pay	Up to $70
• Standard Progressive Lens	$65 Co-pay	Up to $50
• Premium Progressive Tier 1	$85 Co-pay	Up to $50
• Premium Progressive Tier 2	$95 Co-pay	Up to $50
• Premium Progressive Tier 3	$110 Co-pay	Up to $50
• Premium Progressive Tier 4	$65 Co-pay, 20% off Charge less $120 Allowance	Up to $50

Vision Benefit—Safety Eyewear	**Vision Benefit—Safety Eyewear** (In-Network) **You Pay**	**Vision Benefit—Safety Eyewear** (Non-Network) **Plan Pays***
Safety Eyewear Lens Options		
• UV Treatment	$15	N/A
• Tint (Solid and Gradient)	$15	N/A
• Standard Plastic Scratch Coating	$15	N/A
• Standard Polycarbonate (19 and over)	$0 Co-pay	Up to $28
• Standard Anti-Reflective Coating	$45	N/A
• Premium Anti-Reflective Tier 1	$57	N/A
• Premium Anti-Reflective Tier 2	$68	N/A
• Premium Anti-Reflective Tier 3	20% off Retail Price	N/A
• Photocromic Transitions	$75	N/A
• Other Add-Ons	20% off Retail Price	
Safety Eyewear Additional Pairs Benefit	Members also receive a 20% discount off complete pair eyeglasses purchases once the funded benefit has been used.	N/A
Safety Eyewear Frequency		
• Lenses	Once every 12 months	
• Frame	Once every 12 months	

*Out-of-network reimbursement will be the lesser of the listed amount or your actual cost from the out-of-network provider. In certain states, you may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator at **www.eyemedvisioncare.com** to determine which participating providers have agreed to the discounted rate.

Hearing Aid Benefit	**Plan Pays**
Benefit Maximum	Plan pays up to $2,000 every five years
Weekly Accident and Sickness Benefit	**Active Employee Only**
Weekly Benefit Amount	$300
Maximum Number of Weeks	19 weeks per period of Certified Disability
Maternity Benefit	Plan pays an $800 weekly benefit in connection with a live birth for active eligible female employees
Benefit Maximum	Payable for six (6) weeks per live birth for a traditional delivery, and eight (8) weeks for a cesarean section delivery
Death Benefit	**Active Employee Only**
Benefit Amount	$12,000
AD&D Benefit	**Active Employee Only**
Maximum Benefit Amount	$12,000

Bare Bones Plan (Active Employees in Self-Payment Status and Dependents)

The Bare Bones Plan is an optional reduced cost program available to active Employees in self-payment status and their Dependents.

Comprehensive Major Medical Benefit	**What you Pay/Applicable Limitations** (Coinsurance Amount Based on Allowable Charge)
Calendar Year Deductible (January 1 – December 31)	You pay: $350 per person; $700 per family
Emergency Room Deductible	You pay $100 per person. Deductible waived if admitted into hospital as a bed patient for at least one day within three consecutive days after visiting the emergency room
In-Network Physician/Specialist Office Visit Copayment	You pay $20 (not applicable for out-of-network providers)
Coinsurance • In-Network Provider • Out-of-Network Provider	 You pay 30% You pay 40%
In certain instances, a different coinsurance or a copayment may apply, as further shown in this schedule. Plan pays the in-network provider rate of covered Emergency Care services regardless of whether the facility and attending Physician are in the Anthem Blue Cross and Blue Shield PPO or POS network.	
Calendar Year Out-of-Pocket Maximum (January 1 – December 31) • In-Network Provider • Out-of-Network Provider	 You pay up to $12,500 per family You pay up to $25,000 per family
Premiums, copayments, deductibles, balance billing, and healthcare this Plan does not cover are not included in the out-of-pocket maximum.	
Preventive Care • In-Network Provider • Out-of-Network Provider	 You pay 30%, after deductible You pay 40%, after deductible

Special Benefit Provisions/Limitations	
Radiologist, Pathologist, and Anesthesiologist Services • Provided at In-Network Facility • Provided at Out-of-Network Facility	 You pay 30% You pay 40%
Home Health Care • Visit Maximum	You pay applicable coinsurance (30%; 40%) 40 visits in a 12-consecutive-month period; weekly costs not to exceed weekly cost for confinement in a skilled nursing facility
Skilled Nursing Care • Daily Room Benefit Maximum • Benefit Period Maximum	You pay applicable coinsurance (30%; 40%) Established by local licensing agency 60 days per confinement, concurrent with any other health coverage
Outpatient Day Rehabilitation Center • Lifetime Visit Maximum	You pay applicable coinsurance (30%; 40%) 30 visits
Medically Necessary Ambulance Services • Coinsurance	 You pay 30%
Diabetes Education Program • Lifetime Maximum	 You pay $0

Special Benefit Provisions/Limitations	
Biometric Screening Program • Deductible	 You pay $0 You and your Spouse/Domestic Partner may be entitled to a deductible waiver or may choose to receive a gift card if certain conditions are met
Employee Assistance Program • Benefits	You pay $0 Face-to-face counseling sessions or online video counseling sessions via LiveHealth Online (three sessions per covered individual per issue) One legal consultation (up to 30 minutes per issue per benefit year) Telephonic financial consultations Unlimited access to the EAP's website
Mental Health Benefits • Inpatient Treatment Coinsurance • Outpatient Treatment Coinsurance	You pay: 25% $0; no charge for LiveHealth Online
Substance Abuse Benefits • Inpatient Treatment Coinsurance – First Occurrence – Second and Subsequent Occurrences • Outpatient Treatment Coinsurance	You pay: $0 25% $0; no charge for LiveHealth Online
Stop Smoking Assistance Benefit • Smoking Cessation Counseling Classes – In-Network Provider – Out-of-Network Provider • Smoking Cessation Products	Only for Participants, Spouses, and Domestic Partners You pay: 30% 40% Covered under Prescription Drug Benefit
Diagnostic Genetic Testing • Calendar Year Maximum	 Plan pays up to $2,500 per person

Organ Transplant Benefit	**What you Pay/Plan pays** (Contact the Fund Office before all transplant care. Only care received at a LifeTrac network facility is covered under the Plan)
Out-of-Pocket Maximum*	You pay $10,000 per organ transplant
Organ Procurement Benefit	Plan pays up to $15,000
Transportation Benefit Coinsurance**	Covered at 100%
Deductible	You pay $300 per transplant
Coinsurance	You pay 10%
Mail Order Immunosuppressive Medications (90-day Supply) • Generic Prescription • Formulary Brand Name Prescription • Non-Formulary Brand Name Prescription	 You pay: $16 $50 $80

* 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. Consult your tax advisor about the tax status of Plan coverage for temporary lodging and meals.

Prescription Drug Benefit	What You Pay
Prescription Drug Card Program (30-day Supply) • Generic Prescription • Formulary Brand Name Prescription* • Non-Formulary Brand Name Prescription*	You pay: $8 $25 $40
* If you request a brand name drug when a generic is available, you must pay the brand name copayment plus the difference in cost between the brand name drug and the generic drug.	
Mail Order Program (90-day Supply) • Generic Prescription • Formulary Brand Name Prescription* • Non-Formulary Brand Name Prescription*	You pay: $16 $50 $80
* If you request a brand name drug when a generic is available, you must pay the brand name copayment plus the difference in cost between the brand name drug and the generic drug.	

Retiree Plan (Non-Medicare-Eligible Retirees and Dependents)

The Retiree Plan is available to non-Medicare-eligible retired Employees and their Dependents. *All dental benefits are fully-insured through Delta Dental whose name and contact information are listed on page 1 of this document. If this section deviates from the certificate of coverage(s) and summary of benefits produced by the insurance companies, the carriers' documents will prevail. Contact the Fund Office for a copy of insurance coverage documents.*

Comprehensive Major Medical Benefit	What you Pay/Applicable Limitations (Coinsurance Amount Based on Allowable Charge)
Calendar Year Deductible (January 1 – December 31)	You pay: $300 per person; $600 per family
Emergency Room Deductible	You pay $100 per person. Deductible waived if admitted into hospital as a bed patient for at least one day within three consecutive days after visiting the emergency room
In-Network Physician/Specialist Office Visit Copayment	You pay $15 (not applicable for out-of-network providers)
Coinsurance • In-Network Provider • Out-of-Network Provider	 You pay 10% You pay 40%
In certain instances, a different coinsurance or a copayment may apply, as further shown in this schedule. Plan pays the in-network provider rate of covered Emergency Care services regardless of whether the facility and attending Physician are in the Anthem Blue Cross and Blue Shield PPO or POS network.	
Calendar Year Out-of-Pocket Maximum (January 1 – December 31) • In-Network Provider • Out-of-Network Provider	 You pay up to $4,500 per family You pay up to $10,000 per family
Premiums, copayments, deductibles, balance billing, and healthcare this Plan does not cover are not included in the out-of-pocket maximum.	
Preventive Care • In-Network Provider • Out-of-Network Provider	 You pay $0 You pay 40%, after calendar year deductible

Special Benefit Provisions/Limitations	
Radiologist, Pathologist, and Anesthesiologist Services • Provided at In-Network Facility • Provided at Out-of-Network Facility	 You pay 10% You pay 40%
Home Health Care • Visit Maximum	You pay applicable coinsurance (10%; 40%) 40 visits in a 12-consecutive-month period; weekly costs not to exceed weekly cost for confinement in a skilled nursing facility
Skilled Nursing Care • Daily Room Benefit Maximum • Benefit Period Maximum	You pay applicable coinsurance (10%; 40%) Established by local licensing agency 60 days per confinement, concurrent with any other health coverage
Outpatient Day Rehabilitation Center • Lifetime Visit Maximum	You pay applicable coinsurance (10%; 40%) 30 visits
Hospice Care Coinsurance	You pay $0
Medically Necessary Ambulance Services • Coinsurance	 You pay 10%
Diabetes Education Program	You pay $0
Biometric Screening Program • Deductible	 You pay $0
Employee Assistance Program • Benefits	You pay $0 Face-to-face counseling sessions or online video counseling sessions via LiveHealth Online (three sessions per covered individual per issue) One legal consultation (up to 30 minutes per issue per benefit year) Telephonic financial consultations Unlimited access to the EAP's website
Mental Health Benefits • Inpatient Treatment Coinsurance • Outpatient Treatment Coinsurance	You pay: 10% $0; no charge for LiveHealth Online
Substance Abuse Benefits • Inpatient Treatment Coinsurance • First Occurrence • Second and Subsequent Occurrences • Outpatient Treatment Coinsurance	 You pay: $0 10% 10%; no charge for LiveHealth Online
Stop Smoking Assistance Benefit • Smoking Cessation Counseling Classes • Smoking Cessation Products	Only for Participants, Spouses, and Domestic Partners You pay $0 Covered Under the Prescription Drug Program
Orthognathic Surgery • Coinsurance • Lifetime Maximum	 You pay 50% $10,000
Chiropractic Benefits • Office Visit Copayment • Benefit Maximum • Visit Maximum Per Calendar Year • X-Rays	 You pay $0 Plan pays $75 maximum per visit 26 You pay $0
Diagnostic Genetic Testing • Calendar Year Maximum	 Plan pays up to $2,500 per person

Organ Transplant Benefit	**What You Pay/Plan Pays** (Contact the Fund Office before all transplant care. Only care received at a LifeTrac network facility is covered under the Plan)
Out-of-Pocket Maximum*	You pay up to $10,000 per organ transplant
Organ Procurement Benefit	Plan pays up to $15,000
Transportation Benefit**	Covered 100%
Deductible	You pay $300 per transplant
Coinsurance	You pay 10%
Mail Order Immunosuppressive Medications (90-day supply) • Generic Prescription • Formulary Brand Name Prescription • Non-Formulary Brand Name Prescription	You pay: $16 $50 $80

* 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. Consult your tax advisor about the tax status of Plan coverage for temporary lodging and meals.

Prescription Drug Benefit	**What You Pay**
Prescription Drug Card Program (30-day Supply) • Generic Prescription • Formulary Brand Name Prescription* • Non-Formulary Brand Name Prescription*	You pay: $8 $25 $40

* If you request a brand name drug when a generic is available, you must pay the brand name copayment plus the difference in cost between the brand name drug and the generic drug.

Mail Order Program (90-day Supply) • Generic Prescription • Formulary Brand Name Prescription* • Non-Formulary Brand Name Prescription*	You pay: $16 $50 $80

* If you request a brand name drug when a generic is available, you must pay the brand name copayment plus the difference in cost between the brand name drug and the generic drug.

Dental Benefit	**What You/Plan Pays** (Covered Expenses are paid based on the Allowable Charge)
Calendar Year Deductible	You pay: $25 per person Delta PPO; $50 per person Delta Premier; $50 per person for any other dentist
Coinsurance • Preventive and Diagnostic – Delta PPO – Delta Premier (or any other dentist) • Dental Implants – Delta PPO – Delta Premier (or any other dentist)	 You pay 0%, no deductible 0%, no deductible You pay 50% 50%
Calendar Year Maximum • Delta PPO • Delta Premier (or any other dentist)	Plan pays Up to $1,200 Up to $1,000
Orthodontia Lifetime Maximum • Dependent Children Up to Age 26 • Delta PPO • Delta Premier (or any other dentist)	 Plan pays 50% up to $1,000 50% up to $750

Vision Benefit	**Vision Benefit** (In-Network) **You Pay/Plan Pays**	**Vision Benefit** (Out-of-Network) **Plan Pays**
Annual Benefit Maximum for Reimbursement of Out-of-Pocket Vision Costs (In-network and Out-of-Network services and supplies combined)	Up to $250 combined with Out-of-Network	Up to $250 combined with In-Network
Exam with dilation (once every calendar year)	No charge	Up to $45
Retinal Imaging	Up to $39 copay	None
Contact Lenses in lieu of lenses (once every two calendar years – materials only)		
• Conventional	$130 allowance + 15% discount over the allowance	Up to $104
• Disposable	$130 allowance	Up to $104
• Medically necessary	No charge	Up to $210
Contact Lens Fit and Follow-up	$10 copay	Up to $30
• Standard Fitting (two follow-ups)	$10 copay; 10% discount off of the retail price then a $55 allowance	Up to $30
• Premium Fitting (two follow-ups)	$130 allowance + 20% discount over $130	Up to $65
Frames Allowance (once every two calendar years)		
Lenses (once every two calendar years in lieu of contacts)		
• Single Vision	No charge	Up to $25
• Bifocal	No charge	Up to $40
• Trifocal	No charge	Up to $55
• Lenticular	No charge	Up to $55
• Standard Progressive	$55 copay	Up to $40
• Premium Progressive Tier 1	$85 copay	Up to $40
• Premium Progressive Tier 2	$95 copay	Up to $40
• Premium Progressive Tier 3	$110 copay	Up to $40
• Premium Progressive Tier 4	$175 copay	Up to $40
• Standard Anti-Reflective	No charge	Up to $5
• Premium Anti-Reflective Tier 1	$12 copay	Up to $5
• Premium Anti-Reflective Tier 2	$23 copay	Up to $5
• Premium Anti-Reflective Tier 3	$85 copay	Up to $5
• Standard Polycarbonate	No charge	Up to $24
• Standard Plastic Scratch Coating	No charge	Up to $9
• UV Treatment	No charge	Up to $9
• Tint (Solid & Gradient)	No charge	Up to $9
• Photochromatic (Plastic)	$75 copay	None
• Polarized	20% discount	None
• Other Add-ons and Services, excluding professional services and contacts	20% discount	None
Additional Discounts Freedom Pass	No charge for any frame at Target when using your available frame allowance	

Vision Benefit	**Vision Benefit** (In-Network) **You Pay/Plan Pays**	**Vision Benefit** (Out-of-Network) **Plan Pays**
• Additional Pair of Glasses	40% discount	None
• Nonprescription sunglasses	20% discount	None
• Non-covered Items	20% discount	None
• LASIK or PRK Surgery	15% discount	None

Hearing Aid Benefit	**Plan Pays**
Benefit Maximum	Plan pays up to $2,000 every five years
Death Benefit	**Retired Employee Only**
Benefit Amount	$7,000

Medicare-Eligible Retiree Plan (Medicare-Eligible Retirees and Dependents)

Medical and Prescription Drug Benefits are available to Medicare-eligible retired Employees and their Dependents and are fully insured. Dental benefits are also fully insured. Vision, hearing benefits, and death benefits are self-insured.

This section outlines the insured UnitedHealthcare Group Medicare Advantage PPO Plan benefits provided by UnitedHealthcare Insurance Company in Group Policy number 15550 whose name and contact information are listed on page 1 of this document. All dental benefits are fully insured through Delta Dental whose name and contact information are listed on page 1 of this document. If this section deviates from the certificate of coverage(s) and summary of benefits produced by the insurance companies, the carriers' documents will prevail. Contact the Fund Office for a copy of insurance coverage documents.

Medical Benefit under Group Policy Number 15550	**What you Pay/Applicable Limitations**
Calendar Year Deductible (January 1 – December 31)	$0
Calendar Year Out-of-Pocket Maximum (January 1 – December 31)	You pay nothing for Medicare-covered services from any provider.
Physician/Specialist Office Visit Copayment	$0
Diagnostic Tests, X-Rays, Lab Services, Radiology Services	$0
Preventive Services if Covered by Medicare	$0
Emergency and Urgent Care	$0
Inpatient Hospital	$0
Outpatient Surgery	$0
Outpatient rehabilitation (physical, occupational, or speech/language therapy)	$0
Skilled Nursing	$0 up to 100 days
Diagnostic radiology services (such as MRIs, CT scans)	$0
Lab Services	$0
Outpatient x-rays	$0
Therapeutic radiology services (such as radiation treatment for cancer)	$0
Ambulance	$0

Medical Benefit under Group Policy Number 15550	What you Pay/Applicable Limitations
Emergency care	$0 (worldwide)
Urgent Care	$0 (worldwide)
Routine Physical	$0 1 visit per year (combined limit In-Network and Out-of-Network)
Durable Medical Equipment	$0
Routine Acupuncture • Limitation	$0 26 visits yearly (combined limit In-Network and Out-of-Network)
Routine Chiropractic Care • Limitation	$0 26 visits yearly (combined limit In-Network and Out-of-Network)
Routine Podiatry • Limitation	$0 6 visits yearly (combined limit In-Network and Out-of-Network)
Private Duty Nursing	$0 Up to $5,000 per year
Renew Active Fitness program	Included
Post-Discharge Meals	$0 Coverage of up to 84 home-delivered meals immediately following one inpatient hospitalization when referred by a Case Manager. Benefit is offered one time per year through Mom's Meals NourishCare. Restrictions apply
NurseLine	Speak with registered nurse (RN) 24 hours a day, 7 days a week
Virtual Behavioral Visits	Speak to mental health professionals using your computer or mobile devices. Find providers at **www.UHCRetiree.com**
Virtual Doctor Visits	Speak to health professionals using your computer or mobile devices. Find providers at **www.UHCRetiree.com**

Prescription Drug Benefit	What You Pay
Prescription Drug Card Program • Tier 1 Prescription (Generic) • Tier 2 Prescription (Preferred Brand) • Tier 3 Prescription (Non-Preferred Brand) • Tier 4 Prescription (Specialty Drug)	30-day supply (retail) You pay: $8 $25 $40 $40
Mail Order Program (90-day Supply) • Tier 1 Prescription (Generic) • Tier 2 Prescription (Preferred Brand) • Tier 3 Prescription (Non-Preferred Brand) • Tier 4 Prescription (Specialty Drug)	You pay: $16 $50 $80 N/A
Coverage gap stage	After your total drug costs reach the annual Medicare Part D coverage gap amount the plan continues to pay its share of the cost of your drugs and you pay your share of the cost

Prescription Drug Benefit	**What You Pay**
Catastrophic coverage stage	After your total out-of-pocket costs reach the annual Medicare Part D catastrophic coverage amount, you will pay a $0 copay

Dental Benefit	**What You/Plan Pays** (Covered Expenses are paid based on the Allowable Charge)
Calendar Year Deductible	You pay: $25 per person Delta PPO; $50 per person Delta Premier; $50 per person for any other dentist
Coinsurance • Preventive and Diagnostic – Delta PPO – Delta Premier (or any other dentist) • Dental Implants – Delta PPO – Delta Premier (or any other dentist)	 You pay 0%, no deductible 0%, no deductible You pay 50% 50%
Calendar Year Maximum • Delta PPO • Delta Premier (or any other dentist)	Plan pays Up to $1,200 Up to $1,000
Orthodontia Lifetime Maximum • Dependent Children Up to Age 26 – Delta PPO – Delta Premier (or any other dentist)	 Plan pays 50% up to $1,000 50% up to $750

Vision Benefit	**Vision Benefit (**In-Network) **Plan Pays/You Pay**	**Vision Benefit** (Out-of-Network) **Plan Pays**
Annual Benefit Maximum for Reimbursement of Out-of-Pocket Costs (In-network and Out-of-Network services and supplies combined)	Up to $250 combined with Out-of-Network	Up to $250 combined with In-Network
Exam with dilation (once every calendar year)	You pay $0	Up to $45
Retinal Imaging	Up to $39 copay	None
Contact Lenses in lieu of lenses (once every two calendar years – materials only) • Conventional • Disposable • Medically necessary	 $130 allowance + 15% discount over the allowance $130 allowance No charge	 Up to $104 Up to $104 Up to $110
Contact Lens Fit and Follow-up • Standard Fitting (two follow-ups) • Premium Fitting (two follow-ups)	$10 copay $10 copay; 10% discount off of the retail price then a $55 allowance $130 allowance + 20% discount over $130	 Up to $30 Up to $30 Up to $65
Frames Allowance (once every two calendar years)		

Vision Benefit	**Vision Benefit** (In-Network) **Plan Pays/You Pay**	**Vision Benefit** (Out-of-Network) **Plan Pays**
Lenses (once every two calendar years in lieu of contacts)		
• Single Vision	No charge	Up to $25
• Bifocal	No charge	Up to $40
• Trifocal	No charge	Up to $55
• Lenticular	No charge	Up to $55
• Standard Progressive	$55 copay	Up to $40
• Premium Progressive Tier 1	$85 copay	Up to $40
• Premium Progressive Tier 2	$95 copay	Up to $40
• Premium Progressive Tier 3	$110 copay	Up to $40
• Premium Progressive Tier 4	$175 copay	Up to $40
• Standard Anti-Reflective	No charge	Up to $5
• Premium Anti-Reflective Tier 1	$12 copay	Up to $5
• Premium Anti-Reflective Tier 2	$23 copay	Up to $5
• Premium Anti-Reflective Tier 3	$85 copay	Up to $5
• Standard Polycarbonate	No charge	Up to $24
• Standard Plastic Scratch Coating	No charge	Up to $9
• UV Treatment	No charge	Up to $9
• Tint (Solid & Gradient)	No charge	Up to $9
• Photochromatic (Plastic)	$75 copay	None
• Polarized	20% discount	None
• Other Add-ons and Services, excluding professional services and contacts	20% discount	None
Additional Discounts Freedom Pass	No charge for any frame at Target when using your available frame allowance	
• Additional Pair of Glasses	40% discount	None
• Nonprescription sunglasses	20% discount	None
• Non-covered Items	20% discount	None
• LASIK or PRK Surgery	15% discount	None

Hearing Aid Benefit	**Plan Pays**
Benefit Maximum	Plan pays up to $2,000 every five years
Death Benefit	**Retired Employee Only**
Benefit Amount	$7,000

ELIGIBILITY AND COVERAGE: ACTIVE EMPLOYEES

You are eligible for benefits under the Health Fund if:

- You work under a collective bargaining agreement or other written agreement that requires your Employer to contribute to the Plan on your behalf;
- Your Employer makes these contributions; and
- You meet the Plan's initial eligibility requirements.

The Fund will not accept contributions from an Employer who does not have a labor agreement in effect with a participating Union requiring the payment of contributions to the Fund. In addition, unless otherwise expressly authorized in writing by the Trustees, contributions will be accepted only if they are made on behalf of all of the Employees in the collective bargaining unit.

Initial Eligibility

You are eligible for benefits on the first day of the month following any 12-consecutive-month period during which the Fund receives or credits at least 600 hours of contributions on your behalf. If the Fund receives or credits 600 or more hours of contributions in consecutive months before the completion of 12-consecutive calendar months, then you are eligible for benefits on the first day of the month following the month in which the Fund receives or credits at least 600 hours of contributions on your behalf.

EXAMPLE

The Fund receives more than the 600 hours of contributions on John's behalf between January 1, 2019 and July 31, 2019 (75 hours each month in January, February, March, April, and May, and 150 hours in both June and July). John is eligible for coverage beginning August 1, 2019 and his coverage will continue until December 31, 2019.

Continued Eligibility

Continuing eligibility for coverage is based on three-calendar-month periods, called benefit quarters and contribution quarters. Contribution quarters and benefit quarters are:

Contribution Quarter	Benefit Quarter
May 1 through July 31	October 1 through December 31
August 1 through October 31	January 1 through March 31
November 1 through January 31	April 1 through June 30
February 1 through April 30	July 1 through September 30

Once you meet the Plan's initial eligibility requirements, your eligibility will continue on a benefit quarter basis. You continue to be eligible for subsequent benefit quarters if the Fund receives or credits at least 345 hours of contributions on your behalf in the corresponding contribution quarter. If you do not meet this requirement, the Fund will "look back" to see if the Fund received or credited a specific amount of contributions in previous contribution quarters, as outlined following:

Contribution Quarter **If the Fund receives or credits:**	Benefit Quarter **You will be eligible for coverage in:**
• 345 hours of contributions in February through April; • 690 hours of contributions in November through April; • 1,035 hours of contributions in August through April; or • 1,380 hours of contributions in May through April.	July 1 through September 30
• 345 hours of contributions in May through July; • 690 hours of contributions in February through July; • 1,035 hours of contributions in November through July; or • 1,380 hours of contributions in August through July.	October 1 through December 31
• 345 hours of contributions in August through October; • 690 hours of contributions in May through October; • 1,035 hours of contributions in February through October; or • 1,380 hours of contributions in November through October.	January 1 through March 31
• 345 hours of contributions in November through January; • 690 hours of contributions in August through January; • 1,035 hours of contributions in May through January; or • 1,380 hours of contributions in February through January.	April 1 through June 30

EXAMPLE

After John meets the initial eligibility requirements, the Fund receives 125 hours of contributions on his behalf in August and 100 hours in both September and October. Although the Fund only receives 325 hours of contributions for the current contribution quarter, which is less than the 345 hours per contribution quarter requirement, John is still eligible for coverage because the Fund received 700 hours of contributions on his behalf in the six-month period from May through October (375 + 325 = 700). As a result, John will be eligible for benefits for the January through March benefit quarter.

Special Requirements for Non-Bargained Employees

If you do not work under a collective bargaining agreement, but you work for a Union or for a Contributing Employer who has signed an agreement with the Fund to contribute on behalf of all non-bargained Employees or certain designated non-bargained Employees, you will be eligible for coverage if your Employer makes the required contributions on your behalf in accordance with the written participation agreement with the Fund.

For non-bargained Employees of a Contributing Employer, you will become covered on the first day of the calendar month after the Fund receives or credits the first contribution on your behalf. Your coverage will continue each month as long as the Fund receives or credits the required contributions. You are eligible for active benefits under the Regular Plan, except that you are not eligible for Weekly Accident and Sickness Benefits or the Retiree Contribution Allowance Program.

Employees of a Union will be covered once you work the required number of hours for initial and continuing eligibility under the Fund. Your benefits will be the active benefits under the Regular Plan.

Sole proprietors, partners, 100% shareholders, or members owning 100% membership interest are not eligible to participate as a non-bargained Employee under the Plan.

If you have any questions, please contact the Fund Office.

Special Requirements for Alumni Employees

Eligibility and benefits for alumni Employees are determined in accordance with the applicable participation agreement with the Fund. If you have any questions, please contact the Fund Office.

Sole proprietors, partners, 100% shareholders, or members owning 100% membership interest are not eligible to participate as a non-bargained Employee under the Plan.

Transferees from Other Wisconsin Health Funds

If you are covered as an eligible Employee in another certified Wisconsin multiemployer health fund and transfer to this Fund, you will be eligible for benefits under this Plan if the Trustees determine that:

- The other health fund you are transferring from is a certified Wisconsin multiemployer health fund;
- You, the transferring Employee, were eligible under the other certified Wisconsin multiemployer health fund at the time of your transfer; and
- You are credited with 345 or more hours on your behalf, as a transferring Employee, within 12 months of the date coverage ends under the other certified Wisconsin multiemployer health fund.

Dependent Coverage

Your Dependents are eligible for benefits if you are covered under the Plan. For a definition of Dependent, see page 106. The coverage for your Dependents will be effective on the later of the date:

- You become eligible;
- Your Dependent becomes an eligible Dependent, as defined on page 106;
- A Qualified Medical Child Support Order (QMCSO) is determined to be valid; or
- A child is placed in your home for adoption.

Qualified Medical Child Support Orders (QMCSO)

A QMCSO is a court order that requires you to provide medical coverage for your children (called alternate recipients) in situations involving divorce, legal separation, or a paternity dispute. This Plan provides benefits according to the extent required by a QMCSO, the Plan's terms, and by federal law. The Plan Administrator will notify you and any alternate recipients affected if a QMCSO is received.

The Plan Administrator also has the authority to determine if a National Medical Support Notice, issued by a state agency pursuant to ERISA and related regulations, constitutes a QMCSO.

You or your beneficiary may request a free copy of the Fund's QMCSO procedures from the Plan Administrator.

When Coverage Ends

Coverage for you and/or your Dependents will end on the:

- Last day of the benefit quarter (March 31, June 30, September 30, or December 31) when you do not meet any of the requirements for continuing your eligibility;

- Date you or your Dependent enter active military service for more than 31 days;
- Date the Plan ends; or
- For your Dependent, when he or she no longer meets the Plan's definition of "Dependent," defined on page 106.

In addition, your eligibility for Plan benefits will terminate on the last day of any month in which you are called to work but you refuse to, or stop working under a collective bargaining agreement with the Wisconsin Laborers District Council or its affiliated Local Unions and you subsequently start working:

- In the construction industry in a non-laborers trade; or
- In a laborers' trade or sub-trade in the geographic area of Wisconsin under a collective bargaining agreement that is not with the Wisconsin Laborers' District Council, its affiliated Local Unions or the International Laborers' Union.

EXAMPLE

Let's say you are called to work on August 1, 2019, and you refuse or you stop working under a collective bargaining agreement with the Wisconsin Laborers District Council or its affiliated Local Unions and you subsequently start working in the construction industry in a non-laborers trade or in a laborers' trade or sub-trade in the restricted geographic area, your eligibility for benefits will end on August 31, 2019.

This Plan rule applies if your employer has entered into a collective bargaining agreement with the Wisconsin Laborers' District Council or its affiliated Local Unions.

If your coverage under the Plan ends, you may be eligible to continue coverage under either of two options—the self-payment option, as described on page 23, or the COBRA continuation coverage option, as described on page 35.

Reinstatement of Eligibility

If your eligibility ends because you have not fulfilled the hours of Covered Work required, your eligibility may be reinstated if, within 12 consecutive months after the end of the contribution quarter prior to the date your eligibility ends, the Fund receives or credits 345 or more hours of contributions on your behalf. Your coverage will be reinstated as of the first day of the first calendar month following the period in which you performed the required number of hours of Covered Work.

If the Fund does not receive, or if you are not credited with, 345 or more hours of contributions within the 12 months immediately following the date your coverage ends, you must again meet the Plan's initial eligibility requirements, as described beginning on page 18. Coverage will then continue as long as you meet the Plan's continuing eligibility requirements, as described beginning on page 18.

Also note that if your Plan eligibility ends because you either are called to work and refuse or stop working under a collective bargaining agreement with the Wisconsin Laborers District Council or its affiliated Local Unions and subsequently start working in the construction industry in a non-laborers trade or in a laborers' trade or sub-trade in the restricted geographic area, you may again become eligible upon meeting the Plan's "Initial Eligibility" requirements. This means that you can again become eligible for benefits on the first day of the first calendar month that follows any 12 consecutive calendar months in which you are credited with at least 600 hours of covered work.

EXAMPLE

Let's say your Plan eligibility ended on August 31, 2018, for either of the reasons described above. If the Fund receives more than 600 hours of contributions from your employer on your behalf between December 1, 2018 and November 30, 2019, you will be eligible for coverage on December 1, 2019.

If you are credited with at least 600 hours of covered work in less than 12 consecutive calendar months, you will become eligible for benefits again on the first day of the first calendar month that follows the date on which the 600 hours are credited to you.

EXAMPLE

Let's say your Plan eligibility ended on August 31, 2018, for either of the reasons previously described. If the Fund receives more than 600 hours of contributions from your employer on your behalf between January 1, 2019 and July 31, 2019 (in less than 12 consecutive months), you will be eligible for coverage on August 1, 2019.

Rescission of Coverage

The Plan may not rescind your coverage except for fraud or intentional misrepresentation of a material fact and after the Plan provides you with 30 days' notice, as required by law. A rescission of coverage is a cancellation or discontinuance of coverage that has a retroactive effect, meaning that it will be effective back to the time that you or your Dependent should not have been covered by the Plan. However, the following situations are not considered rescissions and the Plan may terminate your coverage back to the date of loss of eligibility:

- When there is a delay in administrative recordkeeping between your loss of eligibility and notice to the Plan of that loss;
- When you fail to make timely required self-payments for coverage;
- When you and your Spouse divorce; or
- When you terminate your Domestic Partnership.

The Plan may also rescind your coverage in the case of an adverse benefit determination concerning Weekly Accident and Sickness benefits without a finding of fraud or intentional misrepresentation of a material fact.

For any other unintentional mistakes or errors under which you were covered by the Plan when you should not have been covered, the Plan will cancel your coverage prospectively once the mistake is identified.

Special Enrollment

Generally, the Plan does not permit eligible Employees or Dependents to decline Plan coverage. If the option to decline coverage becomes available, and if you are declining enrollment for yourself or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 30 days after your or your Dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. You must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

You and your Dependents may also enroll in this Plan if you (or your Dependents) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your Dependents) lose eligibility for that coverage. You must request enrollment within 60 days after the Medicaid or CHIP coverage ends.

If you are eligible for special enrollment, you become an eligible participant on the first day of the month following the Fund's 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 and an adopted child, will become eligible for coverage on the date the Dependent is acquired.

To request special enrollment or obtain more information, contact the Fund Office.

Self-Payment Option

If you do not complete the required hours of Covered Work due to involuntary unemployment, you may continue coverage for yourself and your family by making self-payments. You can elect to make self-payments for the Regular Plan or the Bare Bones Plan. These Plans are described in the applicable *Schedule of Benefits* at the beginning of this booklet.

If you choose to make self-payments for benefits, you may switch from the Regular Plan to the less expensive Bare Bones Plan on the first day of any benefit quarter. However, once you are covered under the Bare Bones Plan, you cannot elect to switch to the Regular Plan. You can again become eligible for the Regular Plan by working the necessary hours to reinstate your eligibility, as described beginning on page 21, or by once again meeting the Plan's initial eligibility requirements, as described beginning on page 18.

The self-payment option is available to you for up to 10 consecutive benefit quarters. However, if you are called to work and refuse the job or if you are working in a job outside the construction industry, your right to make self-payments will end and you will have to meet the Fund's requirements based on Covered Work to become eligible again (see page 18).

When you lose your right to continue coverage under the Plan because you do not have sufficient hours to meet the continuing eligibility requirements, you are also eligible for COBRA continuation coverage on that basis. In order to elect to continue coverage under the self-payment option, you must waive your right to COBRA coverage.

Your Cost for Coverage

Your cost for coverage under the self-payment option equals the cost for coverage under the Plan minus any contributions made on your behalf to the Plan during the previous three-month contribution quarter.

It is your responsibility to keep the Fund Office informed of your current address. Self-payment notices are sent to the last address the Fund Office has on file for you.

Contact the Fund Office for current self-payment rates. The Trustees determine the rates charged for coverage. Self-payments may be paid by check or charged on your credit card (MasterCard, Visa, or Discover). The Fund Office will provide you with a form to complete to enable you to charge your quarterly self-payments with the self-payment notice.

Note: If you do not make a self-payment by the due date, your coverage will end and you will lose your right to make future self-payments unless you return to Covered Work and become eligible again (see page 18).

The amount of self-payment required is the difference between the number of hours of Employer contributions the Fund received or credited on your behalf and the amount the Board of Trustees determines is necessary to meet the Fund's requirements, up to a maximum difference of 300 hours. The Board of Trustees currently requires 345 hours of Employer contributions per quarter to continue eligibility.

EXAMPLE

John had only 100 hours of contributions on his behalf for November, December, and January. He had a total of 425 hours for August through January and 800 hours for May through January. He does not have enough hours to continue eligibility. He will have to pay the lesser of the difference between:

- 345 hours and the 100 hours he was credited with for the last contribution quarter (245 hours times the self-payment rate); or
- 690 hours and the 425 hours he was credited with for the two contribution quarters (265 hours times the self-payment rate); or
- 1,035 hours and the 800 hours he was credited with for the three contribution quarters (235 hours times the self-payment rate).

Assume the current self-pay rate for the Regular Plan is $6.03 and the current rate for the Bare Bones Plan is $3.92. Under these assumptions, John would have to pay $1,417.05 ($6.03 x 235 hours) for the Regular Plan or $921.20 ($3.92 x 235 hours) for the Bare Bones Plan in order to continue coverage for the April, May and June benefit quarter.

Note: The above rates are used for illustrative purposes only and may not reflect the current rates in effect.

Buying a New Home or Moving

When you buy a new home or move, it is important to contact the Fund Office to update your address. This will help ensure you receive important benefit information in a timely manner.

ELIGIBILITY AND COVERAGE: NON-MEDICARE-ELIGIBLE RETIREES

When you retire, you may purchase retiree coverage through the Health Fund.

When you are no longer actively employed due to retirement or disability and you are eligible for retiree coverage, you must enroll for such coverage.

Health Fund Benefits

Under the Health Fund, retirees are eligible for the following benefits:

- Medical (including Organ Transplant benefits);
- Prescription Drug;
- Hearing Aid;
- Vision Care; and
- Death.

General Eligibility Requirements

In order to be eligible for Fund healthcare coverage after you retire or become disabled, you must:

- Have at least 10 service credits;
- Be eligible for Fund benefits immediately before the date of your retirement or disability; and
- Be receiving either:
  - Pension benefits from the Wisconsin Laborers' Pension Fund (or related pension fund as designated by the Trustees); and
    - Had been eligible in each of the four Plan years prior to retirement or disability for benefits under the Fund's active program; or
    - Have 50,000 hours or more of participation in the Health Fund prior to retirement or disability for benefits under the Fund's active program;

OR

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

A disabled retiree who has at least 50,000 hours or more of participation in the Wisconsin Laborers' Health Fund prior to retirement or disability under the Fund's active program may, instead of satisfying the requirements that he or she be eligible for Fund benefits immediately before the date of retirement or disability satisfy the following requirements:

- Have been eligible to receive and have received disability credits as an active Participant immediately preceding the loss of coverage; and
- Have not been out of the Plan for more than 12 months following the previous disability benefits coverage extension.

You also must elect Retiree coverage and waive COBRA coverage.

Electing Coverage

You may elect coverage for your Spouse or Domestic Partner and your Dependent children at the time you elect retiree coverage or you may elect to defer coverage by following the rules under the Retiree In-and-Out Program. Additional Dependents, other than a Spouse or Domestic Partner, who were not covered under the active Plan, may not be covered by the Plan at a later date. However, if you marry or enter into a Domestic Partnership after retirement, you may add a new Spouse or Domestic Partner within 60 days.

If you are over age 65 or otherwise eligible for Medicare, you should apply for Medicare Part A coverage and purchase Medicare Part B coverage. Your medical and prescription drug benefits will be available through a Group Medicare Advantage (PPO) plan underwritten by the UnitedHealthcare Insurance Company. Refer to the next section for details.

If you are a non-Medicare-eligible retiree or a Dependent of a non-Medicare-eligible retiree and you are eligible for and enroll in Medicare Prescription Drug coverage, you will no longer receive Prescription Drug benefits under the Retiree Plan. You will continue to be eligible to receive medical benefits; however, your monthly self-payments for coverage will not change as a result of not receiving Prescription Drug Benefits. If you or your Dependent enroll for Medicare Prescription Drug coverage other than that offered by the Fund, lose Fund Prescription Drug Benefits, and later decide to drop your Medicare Prescription Drug coverage, you will be given a one-time opportunity to re-enroll for the Fund's Prescription Drug benefits.

If you are retired and work in the construction industry for a non-Contributing Employer while self-paying for coverage, your right to make self-payments for retiree coverage may end.

The term "Spouse" means legal Spouse and includes same-sex Spouses.

Refer to the next section for information regarding Plan coverage for Medicare-eligible participants.

Retiree In-and-Out Program

If you have retiree coverage or meet the qualifications for retiree coverage when you retire but you and/or your Spouse or Domestic Partner have coverage available elsewhere, you and/or your Spouse or Domestic Partner can elect to suspend or postpone coverage under the Health Fund until you are no longer eligible for coverage under the other plan. This is the Retiree In-and-Out Program.

You must file a written notice of your decision to suspend or postpone retiree coverage with the Fund Office. If you are covered under the retiree program and wish to suspend coverage until a later date, you must complete a Health Fund Withdrawal Form indicating your election. Your coverage will be suspended the first of the month following receipt of your completed form. If you are electing to postpone retiree coverage when you are first eligible for this coverage, you must notify the Fund Office within 60 days immediately following the date you first become eligible for retiree coverage through the Health Fund.

If you have accumulated eligibility under active coverage when you retire, you may waive your accumulated active eligibility and become eligible to opt-out of retiree coverage upon your retirement. This will allow you to opt-out of retiree coverage immediately, rather than wait until your active eligibility is exhausted. If you and/or your Spouse or Domestic Partner makes this election, any accumulated eligibility that you had at the time of retirement will be lost permanently.

To reapply for coverage from the Health Fund after suspending or deferring coverage, you need to:

- File a written application for Health Fund coverage. The Fund Office must receive your application within the 60 days following termination of your coverage under the other health plan;
- Provide proof that you were continuously covered by the other health plan since the date you elected to suspend or defer your Wisconsin Laborers' coverage; and
- Make the required Health Fund self-payments to maintain coverage.

The option to suspend or postpone retiree coverage and later re-enroll can only be used once in a participant's lifetime. If you postpone retiree coverage at the time of retirement, then this provision cannot be used again.

Contribution Allowance Program

The contribution allowance program is available to all participants of the Health Fund who retire on or after January 1, 2000 and who meet the general eligibility requirements.

Under the contribution allowance program, the Fund shares the cost of Plan coverage with its retired participants. To assist retirees with paying for the cost of retiree coverage, the Trustees provide retirees with service credits. A retiree's service credits are used to calculate his or her contribution allowance, which is subtracted from the Plan's actuarially calculated cost of coverage to determine the retiree's monthly self-payment amount.

Service Credits

Your service credits are determined by dividing your total contribution hours from covered employment under the Health Fund by 1,400 (rounded to the nearest 0.10 credit). Service credits are provided for Employer contribution hours only. Hours for which you make self-payments do not count toward earning service credits.

Service credits earned before a break-in-service are not used when determining retiree eligibility and the amount of your contribution allowance. Before January 1, 2000, a break-in-service occurred when you did not have any hours of covered employment (and no contributions had been received by this Fund) for a five-consecutive-year period.

Calculating Your Contribution Allowance

To determine your contribution allowance, you multiply your service credits by a factor, which is based on whether you are eligible for Medicare. The factor, as of September 1, 2017, is:

- $42.50 per service credit, multiplied by up to a maximum of 30 service credits (42,000 hours), if you are not eligible for Medicare, for a maximum contribution allowance of $1,275.00 per month; or
- $13.50 per service credit, multiplied by up to a maximum of 30 service credits (42,000 hours), if you are eligible for Medicare, for a maximum contribution allowance of $405.00 per month.

The factors and maximum contribution allowance are established by the Board of Trustees and may be changed at their discretion.

Your Monthly Self-Payment Amount

Your monthly self-payment amount is the difference between the Plan's actuarially calculated cost of coverage, as determined by the Trustees and subject to change, and your contribution allowance. The following information highlights how the monthly self-payment amount is calculated based on the type of retirement benefit you receive:

- **Normal Retirement:** Normal retirement occurs when you reach age 62 and have 10 service credits. You receive the full-accrued amount of contribution allowance based on your total contribution hours from covered employment (service credits times contribution allowance based on your Medicare status at retirement).
- **Early Retirement:** You may retire at age 55 with 10 service credits. However, the accrued amount of your contribution allowance is based on total contribution hours from covered employment (service credits times contribution allowance based on your Medicare status at retirement), reduced by .125% for each month you retire before age 62.
- **Disability:** If you have at least 10 service credits and are totally disabled as defined in the rules and regulations for the Wisconsin Laborers' Pension Fund, you are eligible for a contribution allowance based on your Medicare status.
  - **Contribution Allowance Before Medicare Eligibility:** If you are disabled, you 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, you become Medicare-eligible and must switch to the Medicare Supplement plan.
  - **Contribution Allowance After Medicare Eligibility:** Same as for Normal Retirement.
- **Surviving Spouse or Domestic Partner:** If you die either before or after retirement, your surviving Spouse or Domestic Partner may be eligible to continue coverage under the Health Plan provided you earned at least 10 service credits. If this eligibility requirement is met, your surviving Spouse or Domestic Partner will continue to receive the contribution allowance that you were entitled to as a retiree before your death. If you die before retirement, your surviving Spouse or Domestic Partner will receive the full-accrued contribution allowance without any early retirement deduction.

Excess bank hours may be used to continue your active coverage until all hours are used. You 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.

If you retire and subsequently return to work, you will be allowed to continue your active benefits, provided you work enough hours. If you do not have enough hours to maintain your eligibility, you can continue to make partial self-payments up to the maximum allowed, provided you have not elected retiree coverage. After one full self-payment, you must then elect retiree coverage. However, you may elect retiree coverage at any time before then.

Following are some examples of how the monthly self-payment amount is calculated.

EXAMPLE 1

Jake retires at age 62 with 30 service credits. Jake's monthly contribution allowance is $1,275.00 (30 service credits x $42.50) until he is eligible for Medicare at age 65. After becoming eligible for Medicare, Jake's monthly contribution allowance will be $405.00 (30 service credits x $13.50). Here is what Jake will pay:

	Pre-Medicare Eligibility	Post-Medicare Eligibility
Monthly Self-Payment Rate	$1,826.10	$372.68
Monthly Contribution Allowance	-1,275.00	-405.00
Jake's Monthly Self-Payment Amount	**$551.10**	**$0**

EXAMPLE 2

Luke retires at age 62 with 15 service credits. Luke's monthly contribution allowance is $637.50 (15 service credits x $42.50) until he is eligible for Medicare at age 65. After becoming eligible for Medicare, Luke's monthly contribution allowance will be $202.50 (15 service credits x $13.50). Here is what Luke will pay:

	Pre-Medicare Eligibility	Post-Medicare Eligibility
Monthly Self-Payment Rate	$1,826.10	$372.68
Monthly Contribution Allowance	-637.50	-202.50
Luke's Monthly Self-Payment Amount	**$1,188.60**	**$170.18**

EXAMPLE 3

Jeff retires at age 55 with 20 service credits. Since Jeff is retiring early, his contribution allowance is reduced by 10.5% (1.5% per year for seven years). Therefore, Jeff 's monthly contribution allowance is $760.75 (20 service credits x $42.50 x 89.5%) until he is eligible for Medicare at age 65. After becoming eligible for Medicare, Jeff's monthly contribution allowance will be $241.65 (20 service credits x $13.50 x 89.5%). Here is what Jeff will pay:

	Pre-Medicare Eligibility	Post-Medicare Eligibility
Monthly Self-Payment Rate	$1,826.10	$372.68
Monthly Contribution Allowance	-760.75	-241.65
Jeff's Monthly Self-Payment Amount	**$1,065.35**	**$131.03**

The Trustees have the authority and reserve the right, in their sole discretion, to determine, from time to time, the benefits to be provided to retirees and to the surviving Spouse or Domestic Partner and surviving covered Dependents of a deceased participant or retiree. These benefits will not necessarily be the same as those provided to the actively employed participants and may be discontinued or modified at any time. The rate of contribution is also determined by the Trustees and may not necessarily be the same as the self-payment rate for actively employed participants. Understand that rates are subject to change from time to time.

Retired Employees Married to Each Other or in a Domestic Partnership—Self-Pay Rate

If two retired Employees are married to each other or are in a Domestic Partnership, the Plan will consider the two to be one family and the self-pay rate and service credits for the two will be determined as follows:

- All service credits earned by both retired Employees will be combined into one total, up to the amount allowed per participant under the Plan (i.e., 30 Service Credits).
- Only one self-pay rate will be assessed (the one family rule), and will be the cost of coverage minus the combined Service Credits, with the lowest self-pay rate at $0 (i.e., no rebates).
- If one Spouse or Domestic Partner dies, the surviving Spouse or Domestic Partner pays the appropriate participant rate (i.e., Pre-Medicare or Post-Medicare).
- If the retired Employees divorce or terminate a Domestic Partnership, the combined service credits will be allocated to each retired Employee in the amount of the combined total for each, and each retired Employee will pay the appropriate participant self-pay rate (i.e., Pre-Medicare or Post-Medicare), since each will have separate coverage after divorce or termination of Domestic Partnership.

Retired Employees Who Return to Covered Work

Effective August 1, 2019, if you have retired and elected Retiree coverage, and you later return to Covered Work, the contributions made on your behalf for Covered Work will offset your future self-payments to maintain your Retiree coverage. As a Retired Employee, you will not be allowed to reinstate eligibility as an Active Employee, based on hours of Covered Work while you are a Retired Employee, unless you are enrolled in Medicare and you work the required number of hours to meet the initial eligibility requirements. If you then do not work enough hours to maintain Active coverage, you will be eligible to return to the Retiree coverage you previously elected.

When Coverage Ends

Coverage for you and/or your Dependents will end on the earlier of:

- The date your coverage ends; or
- The date your Dependent loses eligibility status because he/she no longer meets the definition of "Dependent," as defined on page 106.

ELIGIBILITY AND COVERAGE: MEDICARE-ELIGIBLE RETIREES

When you become eligible for Medicare, you may enroll in the Wisconsin Laborers' UnitedHealthcare Medicare Advantage PPO Plan.

Eligibility

When you become eligible for Medicare, you may enroll in the Wisconsin Laborers' UnitedHealthcare Medicare Advantage PPO Plan.

To be eligible, you must be:

- entitled to Medicare Part A; and
- enrolled in Medicare Part B.

You can only be enrolled in one Medicare program at a time. This means that you cannot enroll in both the Wisconsin Laborers' UnitedHealthcare Medicare Advantage PPO Plan and any other Medicare Advantage Plan or Part D Plan. If you enroll in another Medicare Advantage Plan or a stand-alone Medicare Part D Plan after your enrollment in the Wisconsin Laborers' UnitedHealthcare Medicare Advantage PPO Plan, you will be automatically disenrolled from the Wisconsin Laborers' UnitedHealthcare Medicare Advantage PPO Plan.

For example, if you enroll in the Wisconsin Laborers' UnitedHealthcare Medicare Advantage PPO Plan effective January 1, 2022 and then enroll in another Medicare Advantage Plan or a stand-alone Medicare Part D Plan effective July 1, 2022, you will be automatically disenrolled from the Wisconsin Laborers' UnitedHealthcare Medicare Advantage PPO Plan effective July 1, 2022.

Additionally, it is important to be aware that if your Spouse is still working and has other coverage through his/her employer, enrolling in the Wisconsin Laborers' UnitedHealthcare Medicare Advantage PPO Plan for you and your family may trigger disenrollment from your Spouse's coverage. You and your Spouse and Dependents should carefully consider these potential consequences before enrolling in the Wisconsin Laborers' UnitedHealthcare Medicare Advantage PPO Plan.

For example, if your Spouse is enrolled in coverage through their employer effective January 1, 2022, and you enroll in the Wisconsin Laborers' UnitedHealthcare Medicare Advantage PPO Plan effective July 1, 2022, your enrollment in the Wisconsin Laborers' UnitedHealthcare Medicare Advantage PPO may trigger disenrollment for your Spouse (and Dependents, if applicable) from your Spouse's employer coverage.

Medical and Prescription Drug Benefits

Your medical and prescription benefits are **combined** under the Group Medicare Advantage (PPO) plan, underwritten by UnitedHealthcare Insurance Company/United Health Insurance Company of New York (for NY residents).

The Wisconsin Laborers' UnitedHealthcare Medicare Advantage PPO Plan allows you the option to use doctors and hospitals that are ***in or out*** of the UnitedHealthcare Medicare network. You have the flexibility to visit doctors and hospitals of your choice, if they are licensed and eligible to receive payment from Original Medicare and can bill UnitedHealthcare. You also have the benefit of Renew Active fitness program.

The medical plan has no coinsurance or copays and the prescription drug program provides you with access to over 67,000 retail pharmacies nationwide. You will still be responsible for paying the appropriate premiums for Medicare Part A and/or Part B.

Opt Out Provision

You can opt out of the Wisconsin Laborers' UnitedHealthcare Medicare Advantage PPO Plan. To do so or if you have any questions, call Labor First at 608-802-7667 (TTY 711) or toll-free at 855-874-4582. Please note that if you opt out, you will no longer have medical or prescription drug coverage through the Wisconsin Laborers' Health Fund.

Dental Benefits

Your dental benefits are underwritten by Delta Dental. Your lowest out-of-pocket costs will come from seeing a dentist in the Delta Dental PPO network, which has more than 165,000 dentist locations nationwide. You will also enjoy cost advantages if you see a dentist in the Delta Dental Premier network, which has more than 247,000 dentist locations nationwide. Dentists in the Delta Dental Premier network have agreed to fee limits (no balance-billing).

Delta Dental will cover treatments (other than preventive care) when you see a non-network dentist at the same level it covers treatments provided by Delta Dental Premier network dentists. However, because non-network dentists have not agreed to fee limits, non-network dentists can pass the balance of their fee to you where their normal charge is higher than the Delta Dental Premier network dentist charge.

Dependent children generally are eligible for coverage through the end of the month in which they attain age 26. A dependent child may be eligible for coverage past age 26 in certain circumstances. You may request a copy of the Delta Dental insurance document(s) for additional details.

Refer to the applicable *Schedule of Benefits* for more information.

Hearing Aid, Vision Care and Death Benefits

Generally, you are eligible for and receive the same hearing aid, vision care and death benefits as non-Medicare-eligible retirees. However, refer to the applicable *Schedule of Benefits*.

Contribution Allowance Program

The contribution allowance program is available to all participants of the Health Fund who retire on or after January 1, 2000 and who meet the general eligibility requirements.

Under the contribution allowance program, the Fund shares the cost of Plan coverage with its retired participants. To assist retirees with paying for the cost of retiree coverage, the Trustees provide retirees with service credits. A retiree's service credits are used to calculate his or her contribution allowance, which is subtracted from the Plan's actuarially calculated cost of coverage to determine the retiree's monthly self-payment amount.

Refer to the prior section for non-Medicare-eligible retirees for further details or call the Fund Office.

CONTINUATION OF COVERAGE DUE TO LIFE EVENTS

Your benefits are designed to meet your needs at different stages of your life. This section describes how your benefits are affected when different lifestyle changes occur.

If You Become Disabled

If you cannot perform Covered Work because of a Certified Disability, you will be credited with disability hours to maintain your eligibility. A Certified Disability is a disability for which you are receiving Weekly Accident and Sickness Benefits through the Fund or weekly workers' compensation benefits. You will be credited with 30 disability hours for each full week of a Certified Disability. Disability hours are limited to 525 hours within any continuous 12-month period. For hours to be credited, you must notify the Fund Office and apply for benefits. Participants covered under the Bare Bones Plan are not eligible for credit hours.

If your Certified Disability lasts more than 12 months, you may earn additional disability hours during the second and each following year by submitting an application for disability hours. You must be eligible for coverage at the time you apply for additional disability hours; disability hours cannot be used to earn eligibility when a lapse in coverage has occurred. In addition, in subsequent years, disability hours will continue to be limited to 525 hours in any 12-consecutive month period.

Extension of Comprehensive Major Medical Benefits

If, when your coverage under the Plan would normally end, you or one of your eligible Dependents is disabled as a result of a Sickness or Injury, your benefits will be extended for that Sickness or Injury if the:

- Expense would have been covered if eligibility had continued;
- Eligible Person remains disabled until the Expense is incurred;
- Eligible Person is under the regular care of a legally qualified Physician; and
- Eligible Person is not entitled to similar benefits under any other group plan when the Expense is incurred.

Benefits will be payable for treatment of the Sickness or Injury that caused the disability subject to the limitations and maximums that were in effect under the Plan at the time eligibility ended.

Benefits will continue until the earliest of:

- The date the eligible Person is no longer disabled;
- The date the eligible Person becomes covered under another group plan; or
- 12 months after coverage under this Plan's Comprehensive Major Medical Benefits ends.

If You Serve in the Military

If you enter into active military service of the United States, you will lose eligibility at the end of the month for which eligibility was generated by the last Contribution paid.

If you serve in the Uniformed Services for up to 31 days, your health coverage will continue as long as you make the required self-payment and you will pay the same amount for coverage

that you normally pay. If you serve in the Uniformed Services for more than 31 days, you may continue your coverage by paying the required self-payments for up to 24 consecutive months or, if sooner, the end of the period during which you are eligible to apply for reemployment in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

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 in time of war or emergency.

Coverage under USERRA will run concurrently with COBRA continuation coverage. If your service exceeds thirty (30) day, the cost of continuation coverage under USERRA will be the same cost as COBRA continuation coverage. The procedures for electing coverage under USERRA will be the same procedures described in the COBRA continuation coverage section beginning on page 23 except that only the Employee has the right to elect USERRA coverage for himself or herself and his/her Dependents, and that coverage will extend to a maximum of 24 months.

Your coverage will continue to the earliest of the following:

- The date you or your Dependents do not make the required self-payments;
- The date you reinstate your eligibility for coverage under the Plan;
- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA;
- The date you lose your rights under USERRA (for instance, for a dishonorable discharge);
- The last day of the month after 24 consecutive months; or
- The date the Fund no longer provides any group health benefits.

You need to notify the Fund Office in writing when you enter the Uniformed Services. For more information about self-payments under USERRA, contact the Fund Office.

If You Do Not Continue Coverage Under USERRA

If you do not continue coverage under USERRA, your coverage will end immediately when you enter the Uniformed Services. Your Dependents will have the opportunity to elect COBRA continuation coverage.

Reinstating Your Coverage

When you are discharged or released from the Uniformed Services, you may apply for reemployment with your former Employer in accordance with USERRA. Reemployment includes the right to elect reinstatement in the existing health coverage provided by your Employer. According to USERRA guidelines, reemployment and reinstatement deadlines are based on your length of service in the Uniformed Services. When you are discharged or released from service in the Uniformed Services that was:

- Less than 31 days, you have one day after discharge (allowing eight hours for travel) to return to work for a participating Employer;
- More than 30 days but less than 181 days, you have up to 14 days after discharge to return to work for a participating Employer; or
- More than 180 days, you have up to 90 days after discharge to return to work for participating Employer.

When you are discharged, if you are hospitalized or recovering from a Sickness or Injury that was incurred during your service in the Uniformed Services, you have until the end of the period that is necessary for you to recover to return to, or make yourself available for, work for a participating Employer. Your prior eligibility status will be frozen when you enter the Uniformed Services until the end of the leave, provided your Employer grants the leave under federal law and makes the required notification and payment to the Fund.

If You Take Family and/or Medical Leave (FMLA)

Under the Family and Medical Leave Act of 1993 (FMLA), eligibility for benefits must be extended to Employees and their Spouse/Domestic Partner and children if:

- The Employer is covered by FMLA;
- The Employee is eligible for and has been granted leave by his or her employer pursuant to FMLA; and
- The Employee's Employer makes the required contributions to the Fund.

The FMLA allows you to take up to 12 weeks of unpaid leave during any 12-month period due to:

- The birth, adoption, or placement with you for adoption of a child;
- The need to care for a seriously ill Spouse, Domestic Partner, parent, or child;
- Your own serious Sickness; or
- A "qualifying exigency" arising out of the fact that an Employee's Spouse, Domestic Partner, son, daughter, or parent is on active duty (or has been notified of an impending call or order for active duty) in the U.S. Armed Forces in support of a contingency operation.

You may also take up to 26 weeks of unpaid leave during any 12-month period to care for a service participant who is your Spouse, son, daughter, parent, or next of kin. The service participant must be undergoing medical treatment, recuperation, or therapy (including on an outpatient basis) for a serious Sickness or Injury incurred in the line of duty while in military service. A service participant for the purposes of this leave means a participant of the U.S. Armed Forces, including the National Guard or Reserves.

Your Employer will be asked to complete some forms to verify your eligibility for benefits while you are on leave. During your leave, you will maintain all the coverage offered under the Plan. You will remain eligible until the end of the leave, provided your Contributing Employer properly grants the leave and makes the required notification and payment to the Fund. Your Employer must pay the cost of coverage in an amount determined by the Fund for each week you are on FMLA leave.

You are eligible for FMLA benefits if you:

- Worked for the same Employer for at least 12 months;
- Have worked at least 1,250 hours during the previous 12 months; and
- Work at a location where at least 50 Employees are employed by the Employer within a 75-mile radius of that location.

You also may be eligible for expanded FMLA benefits if you need to care for your son or daughter whose school or place of care is closed or whose child care provider is unavailable for reasons related to COVID-19. These expanded FMLA benefits are limited to leave taken between April 1, 2020 and December 31, 2020. Contact your Employer if you think you may be eligible for these FMLA benefits.

When taking an FMLA leave, you and your Employer need to inform the Trustees, in writing, so that your rights to healthcare coverage are protected during the leave.

If you return to work within 12 weeks (or 26 weeks, as applicable), you will not lose healthcare coverage. If you do not return to work within 12 weeks (or 26 weeks, as applicable), you will then qualify to continue your coverage under COBRA continuation coverage (see section below). You may make self-payments for COBRA continuation coverage for up to 18 additional months. Contact the Fund Office for additional information about FMLA or continuing your coverage under COBRA continuation coverage.

If you and your Employer disagree over your eligibility or coverage under FMLA, your benefits will be suspended until the disagreement is resolved. Such disputes are between you and your Employer. The Trustees will not become involved in resolving this type of dispute.

If You Experience a Qualifying Event (COBRA Continuation Coverage)

If you recently gained coverage under the Plan, this notice has important information about your right to COBRA continuation coverage, which is the temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other participants of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should contact the Fund Office.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

What Is COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse, and your Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

The following specified events that result in a loss of coverage are considered qualifying events:

- **Employee:** An Employee covered by the Plan has the right to elect COBRA continuation coverage if coverage is lost due to one of the following qualifying events:
  - Termination (for reasons other than gross misconduct) of the Employee's employment (including retirement); or
  - Reduction in the hours of an Employee's employment.
- **Spouse/Domestic Partner:** The Spouse or Domestic Partner of an Employee covered by the Plan has the right to elect COBRA continuation coverage if the group coverage is lost due to one of the following qualifying events:
  - The death of the Employee;
  - Termination of the Employee's employment (for reasons other than gross misconduct) or reduction of the Employee's hours of employment;

- Divorce or legal separation from the Employee; or
- The Employee (or retiree) becomes entitled to (enrolled in) Medicare benefits.

- **Dependent Child:** The Dependent child of an Employee covered by the Plan has the right to COBRA continuation coverage if group coverage is lost due to one of the following qualifying events:
  - The death of the Employee (or retiree) parent;
  - The termination of the Employee parent's employment (for reason other than gross misconduct) or reduction in the Employee parent's hours of employment;
  - The parent's divorce or legal separation, or dissolution of Domestic Partnership of the Employee and the Dependent child's other parent;
  - The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both); or
  - Ceasing to be a Dependent child as defined by the Plan.

Under certain circumstances, you can continue coverage by making self-payments to the Plan for COBRA continuation coverage. Note that coverage will not continue for Weekly Accident and Sickness, Death, or AD&D benefits. By making self-payments, you may continue to receive Medical, Dental, Prescription Drug, and Vision benefits.

COBRA continuation coverage will be identical to the coverage you had under the Plan.

For all Qualified Beneficiaries with COBRA continuation coverage, continued coverage depends on timely and uninterrupted payments on their behalf.

Notices and Election

Under the law, the Employee or his or her Spouse/Domestic Partner or Dependent child has the responsibility to inform the Fund Office of a divorce, legal separation, dissolution of a Domestic Partnership, or a child losing Dependent status under the Plan within 60 days after:

- The date of the qualifying event;
- The date coverage would be lost because of the qualifying event; or
- The date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so.

When is COBRA Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Fund Office of the following events:

- For termination of employment or reduction in work hours;
- Death of the Employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; and
- The Employee becoming covered by Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Fund Office within 60 days after the qualifying event occurs.

How is COBRA continuation coverage provided?

Once the Fund Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will

have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the Spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the Spouse and any Dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the Dependent child stops being eligible under the Plan as a Dependent child. This extension is only available if the second qualifying event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Paying for COBRA Continuation Coverage

The Fund Office will notify you of the cost of your COBRA continuation coverage when it notifies you of your right to coverage. The cost for COBRA continuation coverage will be determined by the Trustees on a yearly basis, and will not exceed 102% of the cost to provide this coverage.

Your first payment for COBRA continuation coverage must include payments for any months retroactive to the day your and/or your Spouse and child's coverage under the Plan ended. The Fund Office will notify you of the first payment due date, which is no later than 45 days after your election. Subsequent payments are due the first of the month and are considered timely if made within 30 days after the first day of the month.

Continuation coverage is provided for each month as long as you make payment for that month before the end of the 30-day grace period for that payment. If you pay a monthly payment later than the first day of the month, but before the end of the grace period for the month, coverage under the Plan may be suspended and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated. Also, the Fund Office will not be able to verify coverage for any inquiring provider.

If you do not make a self-payment within the time allowed, COBRA continuation coverage for all family participants for whom you are making the payment will end and cannot be reinstated.

Coverage for New Dependents

You should contact the Fund Office for any questions regarding COBRA continuation coverage and notify the Fund Office of any changes in marital status or a change of address.

If you have a newborn child, adopt a child, or have a child placed for adoption with you (for whom you have financial responsibility) while your COBRA continuation coverage is in effect, you may add this child to your coverage. You must notify the Fund Office in writing as soon as possible, but not later than 30 days after the birth, adoption, or placement, to have the child added to your coverage.

A child born, adopted, or placed for adoption while you are on COBRA continuation coverage will have the same COBRA rights as your Spouse or Dependents who were covered by the Plan before the event that triggered COBRA continuation coverage. Like all qualified beneficiaries with COBRA continuation coverage, their continued coverage depends on the timely and uninterrupted payment of premiums on their behalf.

Optional Health Care Coverage

The Affordable Care Act provides you with an alternative to employer-sponsored health care coverage and COBRA continuation coverage—the Health Insurance Marketplace (the "Marketplace"). The Marketplace offers health insurance options (called qualified health plans), which include comprehensive health care coverage, including Physician and Hospital-based services, as well as medications. Qualified health plans in the Marketplace present their price and benefit information in simple terms so that you can make apples-to-apples comparisons.

For more information about obtaining coverage through the Marketplace, visit **www.healthcare.gov** or contact the Employee Benefits Security Administration (EBSA) at **www.askebsa.dol.gov** or call the HealthCare.gov Help Line at 1-800-318-2596.

COMPREHENSIVE MAJOR MEDICAL BENEFITS (Active Employees, Non-Medicare-Eligible Retirees, and Dependents)

Comprehensive Major Medical Benefits protect you and your family from potential catastrophic healthcare Expenses.

The Plan's medical coverage is designed to be comprehensive. However, no medical plan coverage, ours included, is designed to reimburse you in full for every healthcare Expense. For instance, day-to-day medical Expenses, such as routinely used vitamins or non-prescription medicines are your responsibility.

Usually, you will have to satisfy a deductible and/or pay some level of coinsurance or copayment toward the amount of eligible medical Expenses you incur. However, once you (or your family) have reached the Plan's out-of-pocket maximum in a calendar year, no further coinsurance is required from you for the remainder of that calendar year (although you will still be required to pay any applicable office visit copayments, the deductible that applies to emergency room visits and any other applicable out-of-pocket Expenses). Note that there are different out-of-pocket maximum limitations for in-network and out-of-network benefits, as shown in each *Schedule of Benefits*.

How the Plan Works

Annual Deductible

The annual deductible is the amount of covered medical Expenses that you and/or your eligible Dependents pay each calendar year before the Plan begins to pay benefits.

If you, your Spouse, or your Domestic Partner are covered under the:

- **Regular Plan or Retiree Plan for Non-Medicare Eligible Retirees**, the individual deductible is $300, up to a family maximum of $600; or
- **Bare Bones Plan**, the individual deductible is $350, up to a family maximum of $700.

Out-of-network Physician Expenses are subject to the medical deductible and out-of-network provider coinsurance.

Any Expense that is applied toward the deductible in the last three months of a calendar year can also be applied against the deductible for the next calendar year. In addition, if two or more family participants are injured in the same accident, only one individual deductible will be charged against Expenses resulting from that accident.

Anthem Networks

The Health Fund has an agreement with Anthem Blue Cross and Blue Shield, which offers you access to a wide range of quality network providers:

- If you are in Wisconsin, your network is the "Blue Preferred Plus POS."
- If you are outside Wisconsin, your network is the "National BlueCard PPO."

If your provider does not participate in either of the Anthem networks, Plan benefits will be paid at the out-of-network level.

Copayments

When you use an in-network Physician and you are covered under the:

- **Regular Plan or Retiree Plan for non-Medicare Eligible Retirees**, you pay a $15 copayment per office visit; or
- **Bare Bones Plan**, you pay a $20 copayment per office visit.

Any lab tests, x-rays, etc. performed during the appointment are subject to the Plan's deductible and coinsurance provisions. The office visit copayment does not apply to the deductible or out-of-pocket maximum.

Plan Coinsurance

Generally, you and the Plan share Expenses. Coinsurance, generally expressed as a percentage, is the amount the Plan pays for covered Expenses after you meet the deductible (when applicable). Benefits are limited to the Allowable Charge for any given medical service.

You will generally pay more for out-of-network services. All out-of-network services remain subject to all applicable coinsurance, deductibles, other limitations, and exclusions. Certain services may be considered emergency care and will be treated as in-network benefits regardless of the status of the facility.

The following table illustrates what you and the Plan generally pay, after you meet your deductible.

	Regular Plan and Retiree Plan		Bare Bones Plan	
	In-Network PPO/POS Provider	Out-of-Network Provider	In-Network PPO/POS Provider	Out-of-Network Provider
Plan Coinsurance	90%	60%	70%	60%
Your Coinsurance	10%	40%	30%	40%

The Fund covers 100% of eligible hospice care Expenses. However, benefits under the Hospice Care Program are not available to participants covered under the Bare Bones Plan.

Out-of-Pocket Maximum

The out-of-pocket maximum limits the amount of Comprehensive Major Medical Benefit Expenses you pay each calendar year. Once you and/or any of your Dependents meet the per family out-of-pocket maximum, 100% of your or your family's Comprehensive Major Medical Benefits will be paid for the remainder of the calendar year, subject to certain benefit maximums, copayments and limitations.

If you are covered under the Regular Plan or the Retiree Plan, your out-of-pocket maximum is:

- $4,500 per family for PPO/POS provider Expenses; and
- $10,000 per family for non-PPO/POS provider Expenses.

If you are covered under the Bare Bones Plan, your out-of-pocket maximum is:

- $12,500 per family for PPO/POS provider Expenses; and
- $25,000 per family for non-PPO/POS provider Expenses.

Copayments and amounts you pay to meet your deductible do not apply toward meeting your out-of-pocket maximum. Transplant expenses do not apply toward meeting your out-of-pocket maximum.

As you can see from the previous chart, the Plan currently covers 60% of the Allowable Charges for out-of-network services. The Plan will utilize the 50th percentile of the FAIRHealth database for determining the Allowable Charge for non-PPO providers. In addition to the out of network coinsurance, you will be responsible for all amounts in excess of the Allowable Charge, and those amounts will not apply toward your out-of-pocket maximum for out-of-network services. You will also be responsible for the out-of-network coinsurance after deductible.

EXAMPLE

To show how this will work, assume your out-of-network provider charges you $175.00 for your covered service. Assume the Allowable Charge under the Plan for the out-of-network service (50th percentile of the FAIRHealth database) is $100.00.

The Plan pays the claim at the 60% out-of-network coinsurance level. Therefore, if your deductible is met, in this example, the Plan will pay $60.00 for the covered service. You pay the difference between the provider charge and the coinsurance level of the Allowable Charge. In other words, you pay the difference between the provider charge and the Plan payment—in this case $115.00. The $40.00 portion of your payment will apply to your out-of-network out-of-pocket maximum (difference between the Allowable Charge and the amount the Plan paid).

Benefit Maximums

Certain covered medical Expenses have separate calendar year or lifetime maximums. See the applicable *Schedule of Benefits* beginning on page 2 for details.

There is no lifetime maximum benefit amount under the Comprehensive Major Medical Benefits for the Regular Plan, the Bare Bones Plan, or the Retiree Plan.

Your Responsibility

It is important to remember that the medical Plan is not designed to cover every healthcare Expense. The Plan pays charges for covered Expenses, up to the limits and under the conditions established under the rules of the Plan. The decisions about how and when you receive medical care are up to you and your Physician—not the Plan. The Plan determines how much it will pay. You and your Physician must decide what medical care is best for you.

Before You Go

It is your responsibility to confirm whether a provider participates in your designated network. To ensure proper handling of your claim, always present your current benefits ID card upon arrival at your appointment. Please contact Anthem at 800-810-2583 or **www.anthem.com** for participating providers.

Using In-Network (PPO/POS) Providers

Depending on where you reside, Anthem Blue Cross and Blue Shield offers you access to its Preferred Provider Organization (PPO) or Point of Service (POS) medical network, which consist of Physicians, Hospitals, and ancillary facilities.

You always have the final say about the Physicians and Hospitals you and your family use. However, when you go to an in-network provider, you save money because the Fund will pay a higher percentage of your covered Expenses. The Fund also saves money because in-network providers have agreed to charge reduced amounts for their services.

Here's an example of how using an in-network provider can save you money.

EXAMPLE

Let's look at what Steve would pay at a PPO Hospital compared to a non-PPO Hospital if he were covered under the Regular Plan or the Non-Medicare Retiree Plan. This assumes that he has not satisfied his calendar year deductible.

	PPO Hospital*	Non-PPO Hospital
Billed Charges	$5,000	$5,000
Discount on Billed Charges	- 2,000	0
Deductible Steve Pays	- 300	- 300
Remaining Expenses for Reimbursement	$2,700	$4,700
Plan Pays	x 90% = 2,430	x 60% = 2,820
Steve Pays	x 10% = $270	x 40% = $1,880
Total Steve Pays	**$570 ($300 + $270)**	**$2,180 ($300 + $1,880)**

In the above example, using a PPO Hospital saves Steve $1,610 because the Plan pays a higher percentage of the cost of in-network services and the out-of-network provider did not discount its services. Also note that out-of-network providers have the right to bill you for the difference between the billed charges and the amount of the Plan's covered Expenses. The additional amount would be over and above your deductible and/or coinsurance. This is called "balance billing." The extra money you could end up paying when you don't use a PPO network provider can amount to significant out-of-pocket costs for you.

** This example assumes a PPO discounted rate of approximately 40%. The actual savings may vary.*

To see if the Physician and/or Hospital(s) you currently use participates in either Anthem network, or to search for a new network provider, visit the Anthem Blue Cross and Blue Shield website at **www.anthem.com**. Use the "Participant Log In" to find a network provider in your area.

If you do not have Internet access, you may call Anthem at 800-810-2583 to find an Anthem network provider. Representatives are available Monday – Friday from 7:30 a.m. – 4:00 p.m. (Central Time). You will need to provide the first three letters on your ID card, your Plan network (Blue Preferred Plus POS in Wisconsin or the National BlueCard PPO outside Wisconsin), the type of provider, and their location.

Anthem also has a phone app for both Apple and Android systems.

Case Management by HealthLink Medical Management

The Fund offers case management services coordinated by medical management specialists from Anthem. The medical management specialists will provide you with supportive services for any inpatient, critical care, and related confinements. They will also assist you with transitioning care, discharge planning, accessing community resources, general education and bridging gaps in coverage. The case management process will be coordinated by Anthem with your physician; you do not need to do anything to obtain this service. Participation is completely voluntary. For more information, please call the HealthLink Medical Management call center at 877-284-0102, option #2. The call center is open Monday – Friday from 7:00 a.m. to 5:00 p.m., Central Standard Time (CST).

Wellness Care Benefits and Programs

The Fund provides you and your family with medical benefits not only to treat, but also to prevent healthcare issues. When you identify certain health conditions as early as possible, they often can be treated before they become serious. To encourage you to take advantage of preventive measures, the Plan provides wellness care benefits.

Preventive Care Benefits

Certain plans are required to cover preventive care benefits at no cost under the federal Affordable Care Act (ACA). As a grandfathered health plan under the ACA, the Plan is not required to provide preventive care services without any cost sharing. However, the Plan voluntarily provides various preventive care services, including annual physical exams, as listed in item #25 in the *Covered Expenses* section beginning on page 47.

Unless otherwise provided, the Plan will provide coverage for the following services:

- Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations;
- Services described in guidelines issued by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC); and
- Health Resources and Services Administration (HRSA) guidelines including the American Academy of Pediatrics *Bright Futures* guidelines and HRSA guidelines relating to services for women.

There is an extensive list of covered services with specific guidelines that is available from the Fund Office or you can visit **www.healthcare.gov**, click on "All Topics," and then "Prevention." A few highlights include:

- Adult annual physical exams
- Newborn and annual well child visits
- Recommended vaccines for adults and children
- Various screenings for adults and Dependents at certain ages and specified circumstances
- Generic aspirin for adults ages 50 – 59 to prevent CVD with a prescription
- Generic folic acid supplements for women who are planning or capable of pregnancy with a prescription
- Application of fluoride varnish to the primary teeth of all infants and children through to age five (in primary practice settings), starting at the age of primary tooth eruption

Preventive Services (Regular Plan and Non-Medicare Eligible Retiree Plan)

With limited exceptions, preventive services provided by an in-network provider that are identified by the Plan as part of the ACA guidelines will be covered with no cost sharing by you or your Dependent if you participate in the Regular Plan or the Retiree Plan for non-Medicare eligible retirees. This means that the service will be covered at 100% of the Plan's Allowable Charge, with no coinsurance, copayment, or deductible. Covered out-of-network provider preventive services will be subject to the deductible and coinsurance.

Preventive Services (Bare Bones Plan)

With limited exceptions, preventive services that are identified by the Plan as part of the ACA guidelines will be covered under the Bare Bones Plan, at the applicable coinsurance rate, after you satisfy the deductible or copayment. The in-network provider coinsurance rate is 70% and the out-of-network provider coinsurance rate is 60%.

Employee Assistance Program (EAP)

The Fund contracts with Anthem BlueCross BlueShield to provide you with access to Anthem's Employee Assistance Program (EAP).

93% of Anthem's EAP professionals also participate in the BlueCard® PPO mental health/ substance abuse provider network.

Anthem has a national network of over 22,000 EAP professionals, including psychologists, social workers, marriage and family therapists, counselors and psychiatric nurses, who can help you deal with life challenges like:

- Stress and/or anxiety
- Depression
- Suicidal thoughts
- Personal and/or emotional challenges
- Grief or loss
- Marital, relationship and family issues
- Alcoholism, drug use and addiction

You will never receive a busy signal, which means that you will have direct access to a customer care representative or clinician 24 hours a day, seven days a week. **All discussions with an EAP counselor will be kept confidential** (except those that pose a threat to someone's safety, such as a child abuse situation; such calls will be an exception to the counseling confidentiality rule).

The EAP will also provide you and your eligible Dependents with:

- Face-to-face counseling sessions or online video counseling sessions via LiveHealth Online (three sessions per covered individual per issue). If there are any issues that cannot be effectively addressed within the three counseling sessions, you may be able to discuss them further with a clinician if they are covered services under the Plan's mental health or substance abuse benefits.
- Work-life services (including child and elder care resources).
- One legal consultation (up to 30 minutes per issue per benefit year) for issues such as divorce/ custody, criminal matters, estate planning/wills/trusts, real estate, landlord/tenant matters, bankruptcy, personal injury/malpractice cases, small claims, adoption and will preparation. The EAP also has a library of legal forms that you can access online and use for a variety of consumer, medical and family situations.
- Telephonic financial consultations for issues like bankruptcy, budgeting (to cope with reduction in household earnings, reduce debt, or save money, for example), buying a home for the first time, major life-event planning (wedding, adoption, divorce), college fund planning, credit card debt (lowering rates, consolidating debt), retirement planning and foreclosure prevention.
- Access to "myStrength." This is an online and mobile "health club for the mind" app you can use to help you manage stress, depression or other matters that you're having difficulty coping with.
- Unlimited access to the EAP's website (**www.AnthemEAP.com**). Access the website when you need to locate an EAP provider. The site also offers information on several subjects, including aging, work/life balance, parenting, child and elder care, and more. Just log on at any time using the login ID: Wisconsin Laborers.

To reach an EAP specialist, call Anthem at 800-865-1044.

Note: Certain services available under the EAP may not be covered under the Plan. For example, the Plan does not provide benefits for marriage counseling or other non-referenced legal services. However, these services are offered by the EAP. You or your Dependents may be responsible for a fee for these types of services.

Biometric Screening Program

Biometric screening services are provided through the Fund Administrator, Benefit Plan Administration of WI, Inc. (BPA). You will not be required to undergo a biometric screening in order to be covered by the Plan. Your participation in the program is voluntary and it is available at NO COST to you.

When you (and your Spouse or eligible Domestic Partner, if applicable) get a biometric screening performed, you will be rewarded. Here's how it will work:

For Active Employees:

- If you (and your Spouse or Domestic Partner, if applicable) undergo a biometric screening during the period July 1, 2019 through November 30, 2020, you will have the choice of either waiving the annual medical deductible based on the date of your biometric screening OR receiving a $150 gift card (your Spouse and/or your eligible Domestic Partner, if applicable, will receive a $150 gift card, as well). Note that if you are married or have an eligible Domestic Partner and you choose to waive the annual medical deductibles, your Spouse or eligible Domestic Partner must agree to waive the deductibles, as well. In addition, regardless of whether you (and your Spouse or Domestic Partner, if applicable) choose to have the annual medical deductibles waived or to receive a $150 gift card, if the results of the screening test are considered out of range, $100 will be contributed to your Health Reimbursement Arrangement (HRA) if and when you (and your Spouse or Domestic Partner, if applicable) complete a mandatory ***coaching*** program. Information about the mandatory coaching program is provided later in this document.
- Beginning in 2021 and going forward, the administration period for the biometric screening will match the calendar year. Accordingly, the 2021 biometric screening period will be January 1, 2021 through December 31, 2021 – meaning that you (and your Spouse or Domestic Partner, if applicable) will have until December 31, 2021 to undergo the screening to either waive the calendar year medical deductible that will apply in 2022, or receive a gift card (your Spouse and/or your eligible Domestic Partner, if applicable, will receive a gift card, as well). In subsequent years, the administration period for this program will match the calendar year, starting on January 1. For example, you will have until December 31, 2022 to undergo the screening to either waive the calendar year medical deductible that will apply in 2023, or receive a gift card (your Spouse and/or your eligible Domestic Partner, if applicable, will receive a gift card, as well). If you (and your Spouse or Domestic Partner, if applicable) choose the gift card, one in the amount of $225 will be awarded, but only if you (and your Spouse or Domestic Partner, if applicable) pass the screening tests. If the screening tests are not passed, you (and your Spouse and/or your eligible Domestic Partner, if applicable) will receive the following:
  - an initial gift card in the amount of $75; and
  - then a second gift card in the amount of $150 once you (and your Spouse or Domestic Partner, if applicable) complete a mandatory ***coaching*** program.

  In addition, if you (and your Spouse or Domestic Partner, if applicable) elect to have the 2021 annual medical deductible waived and the results of your screening test are considered out of range, $100 will be contributed to your HRA, but only if and when you (and your Spouse or Domestic Partner, if applicable) complete the mandatory ***coaching*** program.

For Non-Medicare-Eligible Retired Employees:

- If you (and your Spouse or Domestic Partner, if applicable) undergo a biometric screening during the period ***July 1, 2019 through November 30, 2020***, you (and your Spouse or Domestic Partner, if applicable) will receive a $150 gift card.
- If you (and your Spouse or Domestic Partner, if applicable) undergo biometric screening during the period ***January 1, 2021 through December 31, 2021*** and you (and your Spouse or Domestic Partner, if applicable) ***pass*** all of the screening tests, a $225 gift card will be awarded to you (and your Spouse or Domestic Partner, if applicable). However, if you (and your Spouse or Domestic Partner, if applicable) ***do not pass*** all of the screening tests, the following will occur:

- you (and your Spouse or Domestic Partner, if applicable) will initially receive a $75 gift card instead; and
- then you (and your Spouse or Domestic Partner, if applicable) will receive a second gift card for $150 once you (and your Spouse or Domestic Partner, if applicable) complete a mandatory ***coaching*** program.

You Will Receive a Health Report—After you (and your Spouse or Domestic Partner, if applicable) complete the screening, your test results will be sent to you (and your Spouse or Domestic Partner, if applicable). The health report will be kept confidential and will not be shared with your employer.

About the Coaching Program—The coaching program is administered by Case Management Specialists, Inc. (CMS) and is a valuable complement to the biometric screening benefit. If the results of your (and your Spouse or Domestic Partner, if applicable) screening show that you (and your Spouse or Domestic Partner, if applicable) are considered out-of-range for certain health-related conditions (like BMI, diabetes, back pain, coronary heart failure, high blood pressure or high cholesterol), a wellness coach will contact you (and your Spouse or Domestic Partner, if applicable) and help you set the necessary goals to improve your health and live a healthier lifestyle.

LiveHealth Online Programs

The Fund offers the LiveHealth Online program through Anthem. LiveHealth Online allows you to talk face-to-face with a doctor through your mobile device or computer (with a webcam) to receive advice for common health concerns like colds, the flu, fevers, rashes, infections, allergies, etc. Doctors can answer questions, make a diagnosis, and even prescribe basic medications when needed. Doctors are available 365 days a year, 24 hours a day, 7 days a week (including holidays). This service is free for you to use.

- Mobile App: Download the LiveHealth Online app for free.
- Online: Go to **www.livehealthonline.com**.

LiveHealth Online Behavioral Health Program

You also have access to the behavioral health LiveHealth Online Behavioral Health option, also administered through Anthem. This option provides you with a convenient and private way to get help for psychological issues, including (but not limited to):

- Adult psychological issues—such as stress, anxiety, depression, relationship and family matters, bereavement, and panic attacks.

Through the LiveHealth Online Behavioral Health option, you can talk face-to-face with board-certified Physicians, or licensed psychologists or therapists through your mobile device or your computer's webcam at your convenience. You, your Spouse, (and your Domestic Partner), and dependents can make an appointment to access a therapist from 7:00 a.m. to 11:00 p.m. (all time zones) during the week and on the weekends. Here are a few ways to go about making an appointment:

- Mobile App: Download the LiveHealth Online app for free.
- Online: Go to **www.livehealthonline.com**, log in, select LiveHealth Online Psychology, choose a therapist, and select a day/time that works best for you.
- By Phone: Call 844-784-8409 between 7:00 a.m. and 11:00 p.m.

If you use the mobile app or go online, you are generally able to make an appointment to see an online therapist within four days (or sooner, subject to the availability of a therapist). Keep in mind, however, that online counseling is not appropriate for all kinds of problems. Even though therapists and social workers cannot prescribe medications, they will refer you to the most appropriate level of care, if needed.

Services covered under the LiveHealth Online Behavioral Health option may not be covered under the Wisconsin Laborers' Health Fund. For example, the Regular Plan does not pay benefits for services to treat behavioral problems or conduct disorders. However, LiveHealth Online does provide services for these diagnosis classifications. Also note that LiveHealth Online is not available to Medicare participants.

Case Management Services

The Plan offers case management services coordinated by medical management specialists from Anthem. The medical management specialists provide You and your Dependents with supportive services for any impatient, critical care, and related confinements. They also assist with transitioning care, discharge planning, accessing community resources, general education and bridging gaps in coverage. The case management process is coordinated by Anthem with You or Your Dependent's physicians. You can contact the Anthem case management specialists at 877-284-0102. Participation in case management is voluntary, and there is no penalty for failure to participate.

Covered Expenses

The Plan pays covered Expenses based on Allowable Charges. The following Medically Necessary services and supplies received for the treatment of a non-occupational Injury or Sickness are covered under the Plan.

1. Hospital services and supplies for:
    a. Room and board charges up to the:
        1) Hospital's regular daily semi-private rate;
        2) Most common private room rate charged by a 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
        3) Hospital's charges for intensive care unit or coronary care unit.
    b. Drugs, medicines, and other Hospital services and supplies if used while confined as a resident patient.
    c. Outpatient Hospital charges including:
        1) Charges incurred for outpatient surgery;
        2) Emergency Care; and
        3) 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*. 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.
2. Surgery and surgical-related services and supplies for:
    a. 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;
    b. Services performed by an assistant Surgeon when Medically Necessary;
    c. Anesthetics and administration of the anesthetic by a Physician or professional anesthetist; and
    d. Reconstructive breast surgery following a mastectomy. This includes reconstruction of the breast on which a mastectomy is performed, reconstructive surgery on the other breast to produce a symmetrical appearance, any necessary prostheses required as a result of a mastectomy, and physical complications of any stage of mastectomy, including lymphedemas.

Federal law requires that benefits be provided to a mother and/or newborn child for Hospital confinement in connection with childbirth of at least 48 hours following a normal vaginal delivery or at least 96 hours following a cesarean section. Federal law generally does not prohibit the mother's or newborn's attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, the Plan does not require a Physician to obtain authorization for prescribing a Hospital length of stay not in excess of these periods.

3. Home Health Care services when furnished by a Home Health Care Agency following a Home Health Care Plan, while the Person is under the continuous care of a Physician or Surgeon up to the maximum number of visits shown in the applicable *Schedule of Benefits*. Up to four consecutive hours of home health aide services in a 24-hour period will be considered as one visit. The maximum payable in any week cannot exceed the weekly cost of care in a Skilled Nursery Care Facility. Benefits include:
   a. Part-time or home nursing care from or supervised by a registered nurse;
   b. Part-time or home health aide services that:
      1) Are under the supervision of a registered nurse or medical social worker;
      2) Consist solely of caring for the patient;
   c. Physical, respiratory, occupational, and speech therapy;
   d. Nutrition counseling provided by or under the supervision of a registered dietician;
   e. Evaluation and development of a needs plan, by a registered nurse, Physician's assistant, or medical social worker for home care when approved or requested by the attending Physician or Surgeon; and
   f. Medical supplies prescribed by a Physician or Surgeon and laboratory services, but only to the extent that they would have been covered if the Person was Hospital confined.
4. Charges for services provided by a Skilled Nursing Care Facility up to the daily maximum established by the local licensing agency for up to the maximum number of days per confinement shown in the applicable *Schedule of Benefits*. Successive periods of skilled nursing care 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. The confinement must begin within 24 hours after discharge from a Medically Necessary Hospital confinement lasting at least three days and must be:
   a. Upon a specific recommendation and under the general supervision of a legally qualified Physician or Surgeon;
   b. Re-certified as Medically Necessary every seven days by the attending Physician or Surgeon; and
   c. For the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the preceding Hospital confinement.
5. Hospice Care Program services and supplies (after the individual deductible) when provided to a Terminally Ill Person under a Hospice Care Program through a Hospice Care Agency, including:
   a. Care in the Terminally Ill Person's or family participant's home including the following services and equipment:
      1) Physician services;
      2) Physical, respiratory, and occupational therapy;
      3) Drugs, medications, and medical supplies when provided under the Hospice Care Program through a Hospice Care Agency;

Hospice Care Program benefits are not available under the Bare Bones Plan.

4) Private duty nursing services by a registered nurse or licensed practical nurse, if certified by a Physician;

5) Rental of durable medical equipment; and

6) Oxygen and rental of related equipment.

b. Outpatient care in a licensed medical facility for:

1) Physician services;

2) Laboratory, X-ray, and diagnostic testing; and

3) Ambulance service or alternative types of transportation.

c. Inpatient care in a Hospital or hospice facility for:

1) Room and board, which may include overnight visits by family;

2) Nursing services;

3) All other related Hospital Expenses;

4) Physician services; and

5) Ambulance service or alternative types of transportation.

d. The following additional services provided to the Terminally Ill Person and family participants:

1) 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;

2) 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;

3) Special incidental services for the Terminally Ill Person, such as special dietary requirements, transportation between home and other sites of care; and

4) Bereavement counseling for the immediate family following the death of the Terminally Ill Person.

6. 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*. 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.

7. Services of a legally licensed physiotherapist or registered nurse, provided such services are not rendered by a Person who ordinarily resides in the Employee's home or is a family participant.

8. The following types of emergency transportation:

a. Local professional ambulance service; or

b. 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.

9. Diagnostic x-ray and laboratory services, 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*. 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.

10. Oxygen and the rental of equipment for its administration.
11. Blood and blood plasma and its administration.
12. Radium, radioactive isotopes, and x-ray therapy.
13. Casts, splints, braces, trusses, and crutches.
14. Rental (up to the purchase price) of durable medical equipment, such as Hospital-type beds or wheelchairs.
15. Artificial limbs and eyes to replace natural limbs and eyes, and cochlear implants.
16. 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 will be payable in accordance with the applicable *Schedule of Benefits*, 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 by a Delta Dental dentist. 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 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.
17. Purchase of an insulin infusion pump once in any calendar year after it has been used for at least 30 days.
18. Diabetic Education Program.
19. Medical examinations by a licensed otologist or otolaryngologist to determine the medical diagnosis of a hearing problem, limited to one examination in any 24-month period.
20. Kidney dialysis treatment including rental (or at the Fund's option, purchase) of kidney dialysis equipment for kidney dialysis treatment as a Hospital inpatient, outpatient treatment, or in-home treatment.
21. Inpatient and outpatient mental health and substance abuse treatment, including treatment in Residential Treatment Facilities, as described in the applicable *Schedule of Benefits* beginning on page 2.
22. 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.
23. Routine Prostate Specific Antigen (PSA) blood tests for men age 50 and older.
24. Temporomandibular joint dysfunction (TMJ) at the Plan coinsurance shown in the applicable *Schedule of Benefits* beginning on page x.
25. The Plan covers most preventive services, including annual physical exams, as described on page 51 according to ACA guidelines. These services are updated when the guidelines change. Charges for 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 a 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.

TMJ and non-routine exams are not covered under the Bare Bones Plan.

The Plan provides the following office visit coverage for preventive care services:

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. The following conditions apply to payment for in-network office visits under the Preventive Services benefit. Non-network office visits are not covered under the Preventive Services benefit under any condition.

a. If a preventive item or service is billed separately from an office visit, then the Plan will impose the cost-sharing listed in the applicable *Schedule of Benefits* with respect to the 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 is the delivery of such preventive item or service, then the Plan will pay the amount specified in the applicable *Schedule of Benefits* for preventive services.

c. If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is not the delivery of such preventive item or service, then the Plan will impose the cost-sharing listed in the applicable *Schedule of Benefits* with respect to the office visit, and will impose the cost-sharing specified in the applicable *Schedule of Benefits* for the preventive item or service.

For example, if a person has a cholesterol screening test during an office visit, and the doctor bills for the office visit and separately for the lab work associated with the cholesterol screening test, the Plan will impose the cost-sharing listed in the applicable *Schedule of Benefits* for the office visit, and will impose the cost-sharing listed in the applicable *Schedule of Benefits* for preventive services for the lab work. If a person sees a doctor to discuss recurring abdominal pain and has a blood pressure screening during that visit, the Plan will charge a copayment for the office visit because the blood pressure check was not the primary purpose of the office visit.

The Plan imposes the following preventive services coverage limitations and exclusions:

a. Preventive Services are covered when performed for preventive screening reasons and billed under the appropriate preventive services codes. Service performed for diagnostic reasons are covered under the applicable Plan benefit, not the Preventive Services benefit. A service is covered for diagnostic reasons if the participant 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 Experimental or Investigative, as determined by the Plan.

f. Examinations, screenings, tests, items, or services are not covered when they are provided for the following purposes:

    1) When required for education, sports, camp, travel, insurance, marriage, adoption, or other non-medical purposes;

    2) When related to judicial or administrative proceedings;

    3) When related to medical research or trials; or

4) When required to maintain employment or a license of any kind.

g. Drugs, medicines, vitamins, and/or supplements, whether available through a prescription or over-the-counter, are not covered under the Preventive Services benefit, except as stated above.

h. Tobacco cessation products, drugs, or medicine are not covered, except as provided under the stop smoking assistance benefit.

Even though stop-smoking products may be purchased over-the-counter, the Plan requires that all products have a Physician's prescription to be eligible for reimbursement.

26. Stop-smoking assistance, for participants and Spouses or Domestic Partners only. (If you are a Medicare retiree covered by UnitedHealthcare Medicare Rx for Groups, you should contact UnitedHealthcare for information on possible coverage of smoking cessation products.)

    a. The Plan will pay benefits as shown on the applicable *Schedule of Benefits* beginning on page 2 for a class designed to help an individual stop smoking.

    b. The Plan will cover smoking cessation products for participants and Spouses or Domestic Partners under the Prescription Drug Benefits. All smoking cessation products require a Physician's prescription, including over the counter products, in order to be covered under the Plan.

27. Orthognathic surgery to correct the position of the jaws in relation to each other. Allowable Expenses are paid as shown and up to the lifetime maximums listed on the applicable *Schedule of Benefits* beginning on page 2. Orthognathic surgery must be Medically Necessary (causing functional impediment) and not solely for dental conditions. Related Hospital services are covered under Comprehensive Major Medical Benefits. Pre- and post-surgical dental or orthodontic treatments are not covered under the Plan's Comprehensive Major Medical Benefits; however, they may be covered under the Plan's Dental Benefits.

28. 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:

    a. The Person must be considered Morbidly Obese, as defined by the Plan;

    b. The Morbid Obesity must have existed for at least five years;

    c. The 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 the following criteria:

        1) Participation in the program must be supervised and monitored by a Physician working in cooperation with dietitians and/or nutritionists;

        2) The program must be six months or longer in duration;

        3) The Person must participate in the program within the two-year period before surgery; and

        4) 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).

29. Treatment at outpatient rehabilitation hospitals, including day facilities, for up to 30 outpatient visits per lifetime.

30. Eight pairs of compression stockings per calendar year. This benefit applies only to 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.

31. 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.

32. Diagnostic genetic testing, subject to the applicable deductible and coinsurance, up to an annual maximum of $2,500 provided the:
    a. Person displays clinical features (symptoms) of the mutation in question;
    b. Test results will directly impact the Person's treatment;
    c. Person's diagnosis remains uncertain after a history and physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies;
    d. Plan's administrator confirms the suspected diagnosis and determines that the suspected mutation meets criteria established for the particular genetic test; and
    e. Particular genetic test has not been previously performed on the Person.
33. Contraceptives, subject to deductible, copayments and coinsurance amounts under the Medical and Prescription Drug Benefits. Contraceptives include birth control drugs, contraceptive devices and related Expenses. Contraceptives covered under the Prescription Drug benefit will apply the Plan's Prescription Drug copayments. Contraceptive Expenses covered under the Medical benefit will apply in-network and out-of-network provider benefit levels, deductible, and coinsurances.
34. Charges for ambulatory surgical facilities and associated anesthesia for covered dental services that are provided to a covered person who:
    a. Is a Dependent child age 12 or younger;
    b. Has a medical condition that requires hospitalization or general anesthesia for dental care; or
    c. 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 medical Expenses.

Ambulatory surgical facilities and associated anesthesia for dental care are not covered under the Bare Bones Plan.

35. Effective April 1, 2020, services relating to the treatment of gender dysphoria, which involves a conflict between a person's physical or assigned gender and the gender with which they identify. These services are subject to medical review by the Medical Review Institute of America.
36. Sinus push procedures.
37. Effective March 1, 2020 though the date on which the public health emergency for COVID-19 declared by the Secretary of Health and Human Services ends, diagnostic testing for COVID-19, along with In-Network and Out-of-Network office visits (including virtual/telehealth visits), urgent care visits, and emergency room visits that result in an order for, or administration of, COVID-19 diagnostic testing, as well as items and/or services provided during those visits to the extent that they relate to the furnishing or administration of the diagnostic test or the evaluation of whether the test is needed.

Chiropractic Benefits

The Plan pays benefits for chiropractic care for active Employees and their Dependents covered under the Regular Plan and retired Employees and their eligible Dependents. Chiropractic benefits are not available under the Bare Bones Plan.

Benefits include Medically Necessary treatment that you and/or your Dependents receive from a chiropractor (and/or a chiropractor's office) as illustrated on the applicable *Schedule of Benefits*.

Expenses exceeding the Chiropractic Benefits maximums will not be paid by this Plan. Any covered Chiropractic Benefits, which include, but are not limited to, musculoskeletal treatment, x-rays, and physical therapy, performed, prescribed, or billed by a chiropractor (or chiropractor's office) are subject to the Plan's Chiropractic Benefits per visit maximums, as listed on the applicable *Schedule of Benefits*. Chiropractic services in connection with a non-musculoskeletal diagnosis are not covered.

Expenses Not Covered by Comprehensive Major Medical Benefits

Comprehensive Major Medical Benefits do not cover:

1. Tooth extractions or other dental work, surgery, or anesthesia that involves any tooth or tooth structure, alveolar process, abscess, periodontal disease, or disease of the gingival tissue, except as specifically provided as a covered Expense.
2. Eye refraction (except as specifically provided for Dependents under age 19) or the fitting or cost of eyeglasses or hearing aids. (The Plan's Vision and Hearing Aid Benefits are described beginning on pages 69 and 71, respectively.)
3. Nursing Expense, except as specifically provided as a Comprehensive Major Medical covered Expense.
4. Medical charges not directly related to the treatment of a Sickness or Injury, except as specifically provided as a covered Expense.
5. Prescription drugs, except as an inpatient in a Hospital or Skilled Nursing Care Facility or medications administered as part of a Home Health Care Plan. (The Plan's Prescription Drug Benefits are described beginning on page 57.)
6. 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.
7. Examinations required by an Employer as a condition of employment, or that an Employee is required to provide under a labor agreement.
8. Charges for, or related to, a bone marrow or organ transplant procedure. Organ and bone marrow transplants are covered under the Plan's Organ Transplant Benefits, as described beginning on page 55.
9. Charges for any of the circumstances listed under the General Exclusions and Limitations, beginning on page 84.
10. Charges not listed as a covered Expense.

ORGAN TRANSPLANT BENEFITS (Active Employees, Non-Medicare-Eligible Retirees, and Dependents)

Organ Transplant benefits are separate from Comprehensive Major Medical benefits. Therefore, Expenses you incur under one benefit do not apply to deductibles or out-of-pocket maximums under another benefit.

In general, Organ Transplant Benefits are available to active and non-Medicare-eligible retired Employees and their Dependents.

The Fund has entered into an agreement with LifeTrac to be the Fund's exclusive provider network for organ and bone marrow transplants. LifeTrac is a "centers of excellence" network that offers clinical support and access to hundreds of transplant programs at select transplant facilities.

If you or one of your eligible Dependents becomes a candidate for an organ or bone marrow transplant, contact the Fund Office immediately. The Fund Office will work with you and LifeTrac to gather more information and assist you in selecting an appropriate course of action.

How the Plan Works

Transplant Deductible

The transplant deductible is the amount of covered Expenses that you and/or your eligible Dependents pay per transplant before the Plan begins to pay benefits. The transplant deductible is $300 per transplant.

Plan Coinsurance

Generally, you and the Plan share Expenses. Coinsurance, generally expressed as a percentage, is the amount the Plan pays for covered Expenses after you meet the transplant deductible. After you meet your transplant deductible, the Plan pays 90% of eligible Expenses received from a LifeTrac network facility.

Transplants performed at a non-LifeTrac network facility are not covered.

Out-of-Pocket Maximum

The out-of-pocket maximum limits the amount of Expenses you pay per transplant. Once you or one of your Dependents meet the per transplant out-of-pocket maximum, 100% of covered Expenses will be paid for remaining Expenses related to that transplant, subject to specific maximums and limitations. Your out-of-pocket maximum is $10,000 per transplant, which includes the transplant deductible.

Benefit Maximums

Certain covered transplant Expenses have specific maximums or limitations, as follows:

- Lifetime Maximum: There is no lifetime maximum for transplant benefits.
- Organ Procurement: There is a $15,000 per person per transplant maximum for organ procurement. Organ procurement Expenses include Expenses to find a compatible organ for the transplant recipient.

Transportation Covered Expenses

If you or one of your Dependents must travel more than 100 miles from your home to the transplant facility specified by LifeTrac, 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.

Immunosuppressive Medications

For immunosuppressive medications, you pay the following for up to a 90-day supply through the mail order program:

- $16 copayment per generic prescription;
- $50 copayment per formulary brand name prescription; or
- $80 copayment per non-formulary brand name prescription.

Coverage for immunosuppressive drugs bought at a retail pharmacy is determined on a case-by-case basis.

Expenses Not Covered by Organ Transplant Benefits

Organ Transplant benefits do not cover:

- Transplant services provided outside the LifeTrac network. 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 LifeTrac network, the Plan will pay benefits as if a LifeTrac network facility was used.
- Any Expenses not specifically listed as covered in this section.
- Any Expenses exceeding specific maximums.

PRESCRIPTION DRUG BENEFITS (Active Employees, Non-Medicare-Eligible Retirees, and Dependents)

Prescription Drug Benefits are available to active and retired Employees and their Dependents, including participants covered under the Bare Bones Plan.

Medicare Prescription Drug Plan

If you are a retiree or the Dependent of a retiree and covered by Medicare, your prescription drug coverage is provided under a separate contract with UnitedHealthcare. You must be receiving health benefits under the Health Fund to be eligible for the program. UnitedHealthcare provides the benefit under an insurance contract and makes all decisions on claims and benefits. Refer to page 15 or to the "UnitedHealthcare Medicare Rx for Groups" material for information on the Medicare prescription drug plan.

If you are a retiree or the Dependent of a retiree and are covered by Medicare, and you enroll for Medicare Prescription Drug coverage other than the Health Fund's UnitedHealthcare Medicare prescription drug plan, you will not be eligible for prescription drug benefits under the Health Fund.

Benefits for Active Employees, Non-Medicare-Eligible Retirees, and Dependents

You cannot use the Sav-Rx Prescription Drug Card Program for maintenance prescriptions or maintenance prescription refills. You must use the Mail Order Program for maintenance prescriptions.

The Health Fund has contracted with Sav-Rx to provide prescription drug benefits on behalf of non-Medicare participants. Sav-Rx provides two programs:

1. A Prescription Drug Card Program; and
2. A Mail Order Program.

Plan Requirements

To help manage our Fund Expenses, we work with Sav-Rx to identify cost-efficient ways to provide quality prescription drug benefits. The following programs apply to prescriptions filled at a retail pharmacy and through the mail order program and go a long way toward helping you and the Fund control prescription drug Expenses.

Generic Medication Requirement

Many prescription medications have two names—a generic name and a brand name. By law, both generic and brand name medications must meet the same standards for safety, purity, and effectiveness. However, on average, generic medications can cost half as much as the brand name medication, and, for some medications, this savings can be as great as 90%. To encourage you to request generics, if you have a prescription filled with a brand name when a generic is available, you will be responsible for the difference in cost between the generic and the brand name medication, in addition to your copayment. This provision applies to prescriptions filled at a retail pharmacy and through the mail order program.

Prescription Drug Formulary

There are often several types of medications that can be used to treat the same condition. To ensure high quality care and to help manage costs, most prescription drug programs have a list

of preferred drugs, known as a formulary. A formulary consists of prescription drugs that are either more effective at treating a particular condition than others in their class or as effective as and less costly than similar medications.

While Plan copayments are different for generic and brand name medications, Plan copayments for brand name medications vary depending on whether the medication is a formulary or non-formulary medication. Since formularies are updated periodically and subject to change, you can always get the most up-to-date list online at **www.savrx.com**. When you need to have a prescription filled, talk to your doctor about the Plan's formulary. You may want to bring a copy of the formulary with you when you go to your doctor's office to help you and your doctor find the best prescription for you based on the Plan's formulary.

Prior Authorization Program

The Prior Authorization Program monitors certain prescription medications and their costs so that you can get the right drug at the right cost. That means that you receive an effective medication that is also covered by the Plan. Certain medications will require prior authorization before they will be covered by the Plan. This simply means that when your doctor prescribes one of these medications, he or she needs to contact Sav-Rx to ask if the Plan covers the medication. Your pharmacist might also tell you that a medication needs prior authorization when you go to have your prescription filled. If this occurs, the pharmacist can call your doctor and ask him or her to contact Sav-Rx to see if the Plan covers the medication. You can request a list of medications from Sav-Rx.

When a prescription drug is approved for coverage, you simply pay the applicable copayment. If a medication you are taking or that is prescribed is not approved but you still want to take it, you will be responsible for the full cost of the medication.

Specialty Medication Program

This Program is designed to help manage Expenses for specialty medications, which can be some of the most costly forms of medication. Specialty medications are used to treat ongoing conditions, such as Hepatitis C, Multiple Sclerosis, and Rheumatoid Arthritis. The Program focuses on injectable medications and other medication therapies involving complex administration methods, expensive and difficult-to-find medications, or those with special storage, handling, and delivery requirements. The emphasis of the Program is on patient care and quality customer service.

Using the Specialty Medication Program. Contact Sav-Rx's Specialty Medication Program, at 800-228-3108, when you and/or a Dependent need to have a prescription filled for:

- Hepatitis C;
- Multiple Sclerosis;
- A bleeding disorder;
- Rheumatoid arthritis;
- Psoriasis; or
- RSV.

Once you contact Sav-Rx, a Specialty Medication Program representative will work with you and all specialty medications will be provided through a special home delivery service. Orders can be shipped either to your doctor's office or to your home, depending on where the medication is administered.

Through the Specialty Medication Program, you will have access to a team of specialists including pharmacists, nurse clinicians, social workers, patient care coordinators, and reimbursement specialists who will work with you and your Physician throughout your course

of therapy. The Specialty Medication Program will monitor your medication intake to minimize any adverse reactions and maximize the benefit you receive from your therapy. In addition, the Specialty Medication Program provides you with access to an on-call pharmacist 24 hours a day, 7 days a week.

Step Therapy Program

Often when there are many different medications available to treat a medical condition, it is useful to follow a systematic approach (called "step therapy") to find the best treatment for you. The Step Therapy Program is designed for people who take certain prescription medications regularly for ongoing conditions like arthritis or high blood pressure. It helps you get an effective medication to treat your condition while keeping your costs as low as possible.

Under the program, rather than you immediately filling your prescription with an expensive medication, you are required to work with your doctor to see if you can take an equally effective, yet less expensive generic or formulary medication to achieve the same health benefit as you would with the more expensive medication.

Here's how it works:

- **Step 1** is to ask your doctor if a generic medication is right for you. For most people, generics work as well as brand name medications and they usually cost less. And because these medications have been on the market for a long time, they have a more established safety record than newer medications. Generally, medications prescribed as Step 1 will be the lowest cost medication available proven to be safe and effective to treat your medical condition. If this medication works for you, no further steps are necessary. However, if after trying a Step 1 medication, it does not work or causes problems, a Step 2 alternative medication will be tried.
- **Step 2**, if necessary, is to ask your doctor to prescribe a formulary brand name medication. Be sure to take a copy of the Plan's formulary with you to your appointment. Generally, a formulary brand name medication is a lower-cost brand name medication that has also proven to be safe and effective for your medical condition. However, if after trying a Step 2 medication, it does not work or causes problems, a Step 3 alternative medication will be tried.
- **Step 3**, if necessary, is to ask your doctor for other medication options, which may include a non-formulary brand name medication. Generally, Step 3 medications are the most costly medications.

The first time you fill a prescription for a medication covered under the Step Therapy Program, your pharmacist may inform you that you need to use the Step Therapy Program. So be sure to discuss this program with your doctor before you have your prescription filled. Your doctor can request an override for you, allowing you to bypass the Step Therapy Program if:

- You've already tried the generic medications covered in your Step Therapy Program;
- You can't take a generic medication (for example, because of an allergy); or
- Your doctor decides, for medical reasons, that you need a more expensive brand name medication.

Once an override is approved, you will be responsible for the applicable copayment for your medication. However, if the override is not approved, the medication may not be covered under the Plan.

You may obtain a list of medications covered under the Step Therapy Program by contacting Sav-Rx at 800-228-3108.

High Impact Advocacy Program

Due to the rising cost of certain specialty drugs, the Fund has implemented the High Impact Advocacy Program ("Program") developed by Sav-Rx. The program reduces your out-of-pocket Expense for certain commonly utilized, high-cost medications through the use of manufacturer coupons. If you are taking or have been prescribed a specialty drug medication selected for this Program, you will be notified directly by Sav-Rx regarding financial assistance available from the manufacturer coupons. Sav-Rx will assist you through the simple process of obtaining this assistance.

The following specialty medications are currently subject to the Program:

- Hepatitis C medications such as Harvoni and Epclusa;
- TNF Inhibitors such as Enbrel and Humira, and related medications such as Orencia and Cimzia; and
- Multiple sclerosis medications such as Copaxone and Rebif.
- Certain oncology and HIV drugs (contact Sav-Rx for more specific information)

If a coupon is depleted, the Plan's regular specialty copayment structure will apply. A specialty medication that is included in the program may be discontinued from the program, and additional medications may be included in the program, at any time without notice.

Prescription Drug Card Program

The Prescription Drug Card Program offers benefits for short-term prescriptions (30 days or less). When you become eligible for benefits under the Plan's Prescription Drug Benefit, you are sent a medical ID card with prescription information. You and any of your eligible Dependents can use your card at any pharmacy that participates in the Sav-Rx network (a participating pharmacy). For a list of participating pharmacies, contact Sav-Rx at 800-228-3108 or online at www.savrx.com.

Present your ID card and your prescription to your pharmacist. When you use a participating pharmacy, for up to a 30-day supply you pay only:

- $8 per prescription for generic medications;
- $25 per prescription for formulary brand name medications; or
- $40 per prescription for non-formulary brand name medications.

You can receive the quantity prescribed by your Physician, up to a 30-day supply. No forms, receipts, or submission of claims is necessary. You simply pay the necessary copayment when you fill your prescription.

The copayment is not reimbursable under the Plan's Comprehensive Major Medical Benefits. It is your responsibility and does not apply toward your medical deductible or out-of-pocket maximum. *If you request a brand name medication when a generic is available, you must pay the brand name copayment plus the difference in cost between the brand name and the generic medication.*

You may receive three prescription fills at your local pharmacy. After the third fill, you must use the Mail Order Program for all maintenance prescription refills; they are not covered under the Plan's Prescription Drug Card Program.

If You Do Not Use A Participating Pharmacy

If you have your prescription filled at a non-participating pharmacy, you will have to pay the full cost of your prescription when you pick it up. You will then need to submit a claim form to Sav-Rx for reimbursement. You will be reimbursed the network cost of your medication minus your copayment for that prescription.

To submit a claim, fill out the Sav-Rx Prescription Reimbursement Form. Claim forms are available from Sav-Rx or the Fund Office.

Mail Order Program

You must use the Mail Order Program for all maintenance prescription refills; they are not covered under the Plan's Prescription Drug Card Program.

The Mail Order Prescription Drug Program provides a safe, convenient way for you to have up to a 90-day supply of your medications delivered right to your home. If you take a medication on an ongoing basis (for example, for arthritis, high blood pressure, a heart condition, or diabetes), you can have up to a 90-day supply (a 31-day or more supply) of your prescription filled through the Mail Order Prescription Drug Program.

You receive benefits for maintenance medications only when you order the prescription filled through the mail order program administered by Sav-Rx's mail order company. If your Physician prescribes a long-term medication that you need right away, ask the Physician to provide two prescriptions—one to be filled at a local Sav-Rx network pharmacy using your prescription drug card, and one for the remainder of the medication that can be submitted to the mail order facility. When you use the Mail Order Program for up to a 90-day supply, you pay only:

- $16 per prescription for generic medications;
- $50 per prescription for formulary brand name medications; or
- $80 per prescription for non-formulary brand name medications.

The Mail Order Program pays all necessary postage. The prescription is filled for the quantity indicated by your Physician, up to a 90-day supply. If you request a brand name medication when a generic is available, you must pay the brand name copayment plus the difference in cost between the brand name and the generic medication.

Your First Mail Order Program Prescription

You must fill out a Sav-Rx Mail Order Form to begin receiving prescription drugs through the Mail Order Program. Mail the form, with your original prescription, in the postage-paid envelope provided by Sav-Rx. Alternatively, your Physician may phone in your order to 800-228-3108 or fax your order to 888-810-1394.

Mail Order Program Refills

For maintenance prescription refills, you can:

- Mail in your order to Sav-Rx Mail Order Program;
- Call Sav-Rx Mail Order Program at 800-228-3108; or
- Go online to www.savrx.com.

Self-Payments for Benefits

If you make a self-payment for continued Plan coverage, you are not able to use the Prescription Drug Card or Mail Order Program until the Fund Office has received your self-payment and Sav-Rx is notified. Be aware that there is a time lag between when the Fund Office receives your self-payment and Sav-Rx is notified. During this period, you may pay for your prescriptions at the pharmacy and submit a claim to Sav-Rx on a Sav-Rx Prescription Reimbursement Form. However, claims will not be paid until the Fund Office has received your self-payment.

Coordination of Prescription Drug Benefits for Sav-Rx Participants

If your Dependents receive primary healthcare 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.

To receive Prescription Drug Benefits in this case, follow these steps:

1. Submit the claim to the primary plan.
2. When you receive an Explanation of Benefits (EOB) from the primary plan, submit the prescription receipts showing the retail price of the drug, a copy of the EOB, and a completed Sav-Rx Prescription Reimbursement Form to Sav-Rx.
3. Sav-Rx reimburses 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, you will be reimbursed the contracted rate of the medication minus your copayment for that prescription.

Coordination of Prescription Drug Benefits BONUS

If you are covered under another plan, and you have your prescription filled under that plan first, the Health Fund will reimburse 100% of your copayment under the other plan for that prescription. You must be eligible for coverage under the Health Fund at the time you have your prescription filled to receive reimbursement of the copayment amount.

If the primary plan does not provide an EOB, submit a letter stating the specific reimbursement guidelines instead.

This only applies if the other plan has prescription drug benefits separate from medical benefits. If the other Plan covers prescriptions under the plan's medical benefits, standard coordination of benefit provisions apply.

EXAMPLE

Stan is eligible for coverage under the Health Fund and is covered under his Spouse's plan, which has a retail prescription drug program. When Stan gets his prescription filled, he uses his Spouse's plan, which has a $20 copayment at the pharmacy. Stan saves his receipt and submits it to the Fund Office. The Fund Office reimburses Stan $20, 100% of his copayment under his other plan.

Covered Expenses Under the Prescription Drug Benefit

Prescription Drug benefits cover:

1. Products that require a prescription under federal law and carry a federal legend unless listed in the next subsection 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 Affordable Care Act.

Expenses Not Covered by the Prescription Drug Benefit

Prescription Drug benefits do not cover:

1. Weight loss medications.
2. Anti-rejection medications, except as otherwise specifically provided as a Plan-covered Expense.
3. Infertility medications.
4. Topical Minoxidil (e.g., Rogaine).
5. Growth hormones.
6. Retin-A.

7. Products that do not require a prescription, even when ordered by your Physician, except as specifically covered as a covered Expense.
8. Products that do not carry the federal legend, even when the state you reside in requires a prescription.
9. Prescriptions and necessary supplies utilized as an inpatient in a Hospital or Skilled Nursing Care Facility or under a Home Health Care Plan.
10. Charges for any of the circumstances listed under the General Exclusions and Limitations, beginning on page 84.

Standard of Care for Use of Off-Label Drugs

A Standard of Care has been implemented for the use of off-label drugs. "Off-label use" is any use of a drug other than those indicated on the drug's label as approved by the Food and Drug Administration (FDA).

If a generic medication or brand medication is denied for off-label usage, the following procedure will be followed:

Sav-Rx will conduct a second review of the claim to investigate whether the claim meets the Standard of Care criteria below. If so, Sav-Rx will notify the Health Fund that the claim has been approved for coverage. If the claim does not meet the criteria, Sav-Rx will deny the claim and you will be given the opportunity to proceed with an appeal on your own.

Standard of Care criteria includes the following:

1. The drug is approved by the FDA;
2. The drug is Medically Necessary to treat your or your eligible Dependent's condition; and
3. The drug has been recognized for treatment of your or your eligible Dependent's condition by one of the following:
    a. the American Medical Association Drug Evaluations;
    b. the American Hospital Formulary Service Drug Information;
    c. the United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional"; or
    d. two articles from major peer reviewed medical journals that present data supporting the proposed off label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

The use of the off-label drug must meet all of the above-criteria or it will be considered Experimental or Investigative.

DENTAL BENEFITS
(Active Employees and Dependents)

Dental Benefits are only available to active Employees and their Dependents covered under the Regular Plan. Dental Benefits are not available under the Bare Bones Plan. Dental benefits are available for Medicare-Eligible and Non-Medicare Eligible Retirees and their Dependents under a separate fully-insured contract with Delta Dental.

CarePlus and Delta Dental of Wisconsin

The Fund contracts with the CarePlus Plan (CarePlus) and Delta Dental of Wisconsin ("Delta Dental") for the provision of dental services. You have a choice between these two dental coverage options.

If you enroll in the CarePlus option, you must go to an in-network provider or a Midwest Dental Provider – refer to locations map provider. Please visit **www.Careplusdentalplans.com** to find an in-network CarePlus provider.

Delta has two preferred provider networks of Dentists:

- Delta Premier, a larger network, wherein the Dentists do not offer discounts below Delta Dental's Allowable Charge.
- Delta Preferred, a smaller network, wherein the Dentists do offer additional discounts.

When you use a Delta Dental network provider for your and/or your Dependent's dental care, the Plan covers a higher percentage of the covered Expenses. If you cannot use a Delta Preferred Dentist, it is a good idea to see if a Delta Premier Dentist is available.

There are several advantages of using network providers:

- Delta Dental Dentists accept the Allowable Charge as full payment and will not bill for more than the stated Plan copayments outlined in the applicable *Schedule of Benefits*.
- Delta Dental providers will file claims for you, saving paperwork time.
- Delta Preferred Dentists provide additional discounted fees so that your out-of-pocket costs can be less.

You are not required to use a Delta Dental network provider, but if you do, your out-of-pocket costs will be lower. You can check to see if your Dentist is a Delta Preferred or Delta Premier provider by checking the website, **www.deltadentalwi.com**, or by calling customer service at 800-236-3712. The address for claims submission is:

Delta Dental Plan of Wisconsin
P.O. Box 828
Stevens Point, Wisconsin 54481-0828

Predetermination of Benefits

If you expect a future dental treatment to cost $300 or more, the Fund strongly urges you to submit a *Predetermination of Benefits Claim Form* that includes:

- A description of the proposed dental treatment;
- X-rays; and
- The Dentist's estimated charges.

Delta Dental will estimate the benefits payable by the Plan and return the form to you.

Once you know the exact amount of benefits payable for the treatment, you and your Dentist can discuss the dental treatment that is most appropriate for you.

Dental Benefits Payable

Dental benefits pay for covered Dental Expenses up to the Allowable Charges.

The dental program covers:

- 100% of Allowable Charges for covered preventive and diagnostic dental services, no deductible required; and
- CarePlus: No deductible:
  - 100% of Allowable Charges for other covered dental services (except orthodontia) provided by CarePlus network providers;
  - There is no coverage for dental services provided by non-CarePlus network providers;
  - 50% of Allowable Charges for covered orthodontia dental services for Dependents up to age 27, up to a lifetime maximum of $2,500.
- Delta Dental: After a $25 per person ($75 family maximum) calendar year deductible:
  - 85% of Allowable Charges for other covered dental services (except orthodontia) provided by Delta Dental Preferred network providers;
  - 70% of Allowable Charges for other covered dental services (except orthodontia) provided by non-Delta Dental Preferred network providers;
  - 50% of Allowable Charges for covered orthodontia dental services for Dependents up to age 26, up to a lifetime maximum of $2,000. This lifetime maximum does not apply to Dependent children up to age 19.
- The calendar year maximum for all dental care (excluding orthodontia) is $2,500 per person (CarePlus) or $2,000 per person (Delta Dental). For Delta Dental coverage only, this calendar year maximum does not apply to Dependent children up to age 19.

Preventive Dental Services

Preventive dental care includes the following services, if provided by a licensed Dentist, Physician, or dental hygienist. The Plan pays 100% of Allowable Charges for this care, with no deductible required, up to the calendar year maximum.

- One routine oral examination in any six-consecutive-month period.
- One routine prophylaxis (cleaning) treatment by a Dentist or dental hygienist in any six-consecutive-month period.
- Dental x-rays, if professionally indicated (one full-mouth dental x-ray in any 12-consecutive-month period).
- Dental sealant for Dependent children up to age 18.
- One topical application of sodium or stannous fluoride by a Dentist or dental hygienist in each 12-consecutive-month period for Dependent children up to age 19.

Other Covered Dental Services

Other covered dental Expenses include the following services, if provided by a licensed Dentist or Physician:

1. Extractions.
2. Oral Surgery (including pre-operative and post-operative care) for:
    a. Excision of a partially or completely impacted tooth.
    b. Excision of a tooth root without the extraction of the entire tooth.
    c. Closed or open reduction of fractures or dislocations of the jaw.

Incision or excision procedures on the gums and tissues of the mouth, when performed in connection with the extraction or repair of teeth.

3. Amalgam fillings on posterior teeth, synthetic porcelain and plastic fillings on anterior teeth only.
4. Injections of antibiotic drugs by the attending Dentist.
5. Endodontic treatment, including root canal therapy and pulp therapy.
6. Treatment for the relief of pain.
7. Space maintainers.
8. Initial installation of a full or partially removable denture, temporary denture, or fixed bridgework, including adjustments during the six-month period following installation.
9. Replacement or alteration of a full or partial denture or fixed bridgework that is necessary because of Oral Surgery:
    a. Resulting from an accident; or
    b. For repositioning muscle attachment; or
    c. For removal of a tumor, cyst, torus, or redundant tissue.

The oral surgery must occur after the person is eligible and the replacement or alteration must be completed within 12 months after such oral surgery.

10. Replacement of a full denture which is necessary because:
    a. Structural change has occurred within the mouth, if more than five years has elapsed since the existing denture was installed;
    b. An opposing full denture is installed for the first time; or
    c. The denture was installed as a temporary denture and the replacement denture is installed within twelve months of when the temporary denture was installed.
11. 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.
12. Inlays, gold fillings (only if no other material can be used), crowns, and porcelain jackets.
13. Replacement of a crown restoration if the crown being replaced had been in place for at least five years before the replacement.
14. Repair or re-cementing of crowns, inlays, bridgework or dentures or relining of dentures.
15. Periodontal treatment and surgery, including periodontal cleaning, scaling, and other treatment for diseases of the gums and tissues of the mouth.
16. General anesthesia administered in connection with Oral Surgery covered under this benefit.
17. Dental implants.

Orthodontia Services

If your Dependent child (up to age 26 for CarePlus and up to age 19 for Delta Dental) receives treatment from an orthodontist, the Plan covers 50% of the Allowable Charges for the initial and subsequent installation of orthodontic appliances, as well as for all orthodontic treatment preceding and subsequent to the installation, up to a lifetime maximum benefit of $2,500 for CarePlus and $2,000 for individuals age 19 and over for Delta Dental, per person. This lifetime maximum does not apply to Dependent children up to age 19. Benefits are paid when the related services are performed.

Dental Benefit Limitations

In some instances, more than one form of dental treatment is available to you. For example, different materials or procedures may be used to fill a cavity. This Plan considers only the most cost efficient or the least elaborate dental procedure that meets nationally established standards as a covered Expense. If you or your Dependent choose a more costly procedure, you will be responsible for paying the applicable copayment for the least costly procedure plus 100% of the remaining cost. These limitations include the following:

1. If a tooth can be restored with amalgam, silicate or plastic, but you select another type of restoration, the Plan will pay only 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 your responsibility.
2. If in the construction of a complete or partial denture you and your 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 you will remain responsible for the difference in cost.
3. If you select a course of mouth rehabilitation, the Plan will 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 your responsibility.

Expenses Not Covered by Dental Benefits

Dental Benefits do not cover:

1. Any Expense for craniomandibular or temporomandibular joint (TMJ) disorders. See the Comprehensive Major Medical Benefits for TMJ coverage.
2. Dental services with respect to congenital malformations, cosmetic surgery, or dentistry purely cosmetic in nature.
3. 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.
4. X-rays, if not professionally indicated.
5. Full-mouth x-rays, if taken more frequently than once each 12 consecutive months.
6. Bitewing X-rays, if taken more frequently than once each six months.
7. Oral examinations, including scaling and cleaning of teeth, if performed more than once during a six-consecutive-month period.

8. Topical fluoride applications if the Person is over age 19 or if performed more frequently than once each 12 consecutive months.
9. Prescriptions, including prescriptions for home application of sodium or stannous fluoride.
10. Oral surgery, except as specifically provided as a covered Expense (see page 65).
11. Expenses incurred after termination of eligibility, except 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.
12. Services for installation of or treatment related to orthodontic appliances and prosthetic services (including bridges and crowns) that were rendered prior to the Person's effective date of coverage under the Dental Benefit.
13. Re-basing or re-lining of a denture in less than six months from the date of initial placement or more than one in any two-year period.
14. Replacement of lost or stolen prosthetics.
15. Replacement of prosthetics less than one year after the Person has been eligible for Dental Benefits, except that benefits will be payable for the replacement of a denture if requested as a result of the placement of an opposing denture.
16. Dental sealants if the person is age 18 or over.
17. Charges for any service for which coverage is not specifically provided as a covered Expense under the Plan's Dental Benefits (including any Hospital charges or prescription drug charges).
18. Any dental Expenses for which benefits may be payable under the Plan's Comprehensive Major Medical Benefits.
19. Charges for any of the circumstances listed under the General Exclusions and Limitations, beginning on page 84.

Retiree Dental Benefit

If you are a retiree, you and your eligible Dependents may choose to enroll in any of the programs that are offered by Delta Dental of Wisconsin through the Fund when you are eligible for this coverage.

Delta Dental of Wisconsin provides the benefits under an insurance contract and Delta Dental makes all decisions on claims and benefits. You must pay the full cost of your coverage.

You must be receiving health benefits under the Health Fund to be eligible for these programs. You may change to a different program as of December 1 each year, provided you are still covered as of November 30 of that year.

Retiree Dental In-and-Out Program. If you and/or your Spouse or Domestic Partner have dental coverage available elsewhere, you and/or your Spouse or Domestic Partner can elect to suspend or postpone coverage under the Fund's Retiree Dental Benefits until you are no longer eligible for coverage under the other dental plan. Details of the Retiree In-and-Out Program are shown on page 26.

The option to suspend or postpone retiree Dental Benefits and later re-enroll can only be used once in a participant's lifetime. If you postpone retiree Dental Benefits at the time of retirement, this provision cannot be used again.

VISION BENEFITS
(Active Employees, Retirees and Dependents)

Under the Bare Bones Plan, vision benefits are not available.

In general, Vision Benefits are available to active Employees and their Dependents under the Regular Plan, and retired Employees and their Dependents. Vision Benefits are not available under the Bare Bones Plan. Coverage for vision exams required under the Affordable Care Act for Dependent children up to age 19 are covered under the Bare Bones Plan's Wellness Care Benefits.

Routine Vision Benefits

To help you manage the cost of routine vision expenses, the Plan provides Vision Benefits for you and your family through an arrangement with EyeMed as well as by paying up to $250 in out-of-pocket vision expenses annually per member or covered spouse or dependent.

You should refer to the applicable *Schedule of Benefits* for Active Employees, Non-Medicare-Eligible Retirees, and Medicare-Eligible Retirees for more information regarding these benefits.

How the Vision Program Works

Vision Benefits cover expenses such as eye exams, frames, lenses and contacts furnished by a qualified optometrist or ophthalmologist.

The vision program administered by EyeMed is a preferred provider organization (PPO) with a large national network of participating providers that have agreed to charge discounted rates for most vision services. That means you pay less out of your own pocket when you use an EyeMed network provider.

You always have the option of using network or non-network providers. However, it is important to remember that when you use an EyeMed PPO provider, you will pay less out of pocket, have greater coverage and Claims for Benefits will be filed for you directly by the EyeMed network provider. In the event you use an out-of-network provider for vision services, you will be required to pay for your services at the time you receive them and then submit a claim reimbursement form to EyeMed.

It is easy to find an EyeMed provider and make the most of your vision benefits under the Plan. Check with your current vision provider to see if they participate in the EyeMed network. Or, you can find an EyeMed provider by visiting **www.eyemed.com** or by calling 1-866-804-0982. For LASIK providers, call 1-877-5LASER6.

In addition to EyeMed coverage, the Fund will pay for your out-of-pocket vision expenses, up to $250 annually per participant or covered spouse or dependent. Vision claims should be submitted to EyeMed first, then to the Fund for reimbursement up to $250 annually. You and your covered spouse and dependents can use this benefit for routine vision expenses that EyeMed does not cover.

Vision Benefits Payable

The Vision Benefit covers vision items and services as stated in the applicable *Schedule of Benefits*, including for:

- Complete examination including dilation of pupil and/or relaxing of focusing muscles by drops, refraction for vision and examination for pathology;
- New or replacement frames and/or lenses (including contact lenses) furnished by an optician or doctor, including fitting; and
- LASIK surgery.

EyeMed Safety Eyewear Program

We want to make sure your eyes are well-protected, even on the job. With the EyeMed Safety Program, you may be eligible to get the right prescription safety glasses for your job, as described in the applicable *Schedule of Benefits*. Please note that this benefit is only available to active participants, and not to spouses, dependents, or retirees.

Expenses Not Covered by Vision Benefits

Vision Benefits do not cover:

1. More than one set of frames, or one pair of lenses per covered person per every two calendar years unless otherwise specified.
2. Any charges or portion of charge(s) for services or supplies that are covered in whole or in part under any other portion of the Plan or under any other medical or vision benefits plan provided by an Employer.
3. Treatment that is solely for cosmetic purposes.
4. Treatment under another benefit provision of the Plan.
5. Treatment covered by workers' compensation benefits.
6. Eye exams required by an Employer as a condition of employment.
7. Special procedures or supplies.
8. Visual analysis that does not include refraction.
9. Medical or surgical treatment of the eyes unless otherwise specified.
10. Non-prescription eyeglasses of any type unless otherwise specified.
11. Any vision service not listed on the Schedule of Vision Benefits on pages 5–7.

HEARING AID BENEFITS
(Active Employees, Retirees and Dependents)

Hearing aids are not covered under the Bare Bones Plan.

In general, Hearing Aid Benefits are available to active and retired Employees and their Dependents. However, Hearing Aid Benefits are not available under the Bare Bones Plan.

Hearing Aid Benefits Payable

The Plan pays 100% of the hearing aid Expenses up to $2,000 per person in any consecutive five-year period. Covered hearing aid Expenses include the Allowable Charge for a necessary hearing aid instrument, as determined by a licensed otologist or an otolaryngologist (an ear, nose and throat Physician, or "ENT"), or another qualified provider in the EPIC Hearing Healthcare network if the hearing aid was obtained through that network. The Board of Trustees may authorize payment before the five-year limit if an eligible school age child needs a new hearing aid prescription.

A hearing aid device replaced without obtaining a new prescription will be a covered Expense provided the original device is obtained while covered under the Fund and a valid prescription for the original device is on file with the Fund Office.

Expenses Not Covered by the Plan's Hearing Aid Benefits

Hearing Aid Benefits do not cover:

1. Medical examinations for the prescription or fitting of a hearing aid, unless provided through the EPIC Hearing Healthcare network.
2. Hearing aids not prescribed by a qualified otologist or otolaryngologist, unless provided through the EPIC Hearing Healthcare network.
3. Charges by a speech pathologist, or any charges for speech therapy, speech reading, or lessons in lip reading.
4. Charges for the rental or purchase of amplifiers.
5. Services or supplies other than for hearing aids, except for services provided through the EPIC Hearing Healthcare network.
6. Charges for any of the circumstances listed under the General Exclusions and Limitations, beginning on page 84.

EPIC Hearing Healthcare Service Program

The Plan offers a hearing service program through EPIC Hearing Healthcare that complements the Fund's Hearing Aid Benefits. This hearing service plan provides participants with access to EPIC's national network of independent and credentialed audiologists, and ear, nose, and throat (ENT) Physicians who perform hearing evaluations and offer discounts off the manufacturers' suggested retail price on all major brands of hearing aids.

You can call EPIC at 866-956-5400 to set up a hearing evaluation with an EPIC network provider. The call center is open 8:00 a.m. to 8:00 p.m. Central Time, Monday through Friday. A hearing counselor will send you a referral packet that includes the name of an EPIC hearing specialist near you. Once you schedule an appointment and have a hearing evaluation, the EPIC provider will determine if hearing aids are an appropriate solution for you.

If you use an EPIC provider, all services, including the hearing exams, will be covered up to the $2,000 Hearing Aid Benefit maximum. If you do not use an EPIC provider, the initial hearing aid covered under the Plan must be prescribed by an otologist or otolaryngologist.

Amplifon's Hearing Service Program

The Plan also offers a hearing service program through Amplifon Hearing Health Care that complements the Fund's Hearing Aid Benefits. This program provides participants with access to Amplifon's credentialed audiologists and hearing aid dispensers who offer discounts off the manufacturers' suggested retail price on major brands of hearing aids.

You can call Amplifon at 866-674-3979 and speak with one of its Patient Care Advocates, who will provide you with the information you need to locate and/or schedule your initial hearing exam with an Anthem in-network ear, nose, and throat (ENT) Physician. The call center is open 7:00 a.m. to 7:00 p.m. Central Time, Monday through Friday. Once your initial hearing exam is completed by an Anthem ENT, a Patient Care Advocate will schedule an appointment for you with an Amplifon provider for hearing aid selection and fitting.

If your initial hearing exam is performed by an Anthem ENT and your hearing aid is dispensed by an Amplifon provider, all services, including the hearing exam, will be covered up to the $2,000 Hearing Aid Benefit maximum.

For further information on Amplifon's services, visit **www.amplifonusa.com/wilaborers**.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

A Health Reimbursement Arrangement (HRA) is designed to provide reimbursement of certain healthcare Expenses on a tax-free basis. You can use it to pay for non-reimbursable healthcare Expenses you and your Dependents incur while you are an active Employee and after you retire (if eligible for retiree coverage) to help offset your out-of-pocket healthcare costs.

Eligibility

You are eligible for the HRA if you are eligible for coverage under the Plan (see the eligibility sections for active and retired Employees, beginning on page 18, 25 and 30), if you work for an Employer that contributes to the Health Fund on your behalf, and you are enrolled in coverage through the Health Fund or through other group health plan coverage. If you are enrolled in other group health plan coverage through your spouse or domestic partner, that coverage must provide minimum value and you must provide proof of coverage or your reimbursements will be limited.

If you become ineligible or are never eligible for coverage under the Health Fund, your HRA contributions will be frozen and possibly forfeited. While contributions are only made on your behalf while you are working for a contributing employer in a bargaining unit position or through a participation agreement, you do not have to be an active participant to use your HRA account. Your HRA account balance is available as long as you have money in your HRA account and are eligible for active or retiree health coverage, provided you have not waived coverage under the HRA. In addition, your HRA account balance is available to your surviving Spouse and/or eligible Dependents for reimbursement in the event of your death.

You are eligible for reimbursement of eligible Expenses incurred by you and any of your Dependents whom you can claim as a dependent on your tax return. If you are an active Employee, your Dependents must be covered by the HRA and the same group health plan as you, on either a primary or secondary basis.

Establishing the Account

When you are initially eligible for Plan coverage and Employer contributions are received on your behalf, an HRA account is established in your name and a portion of the Employer contributions made on your behalf are credited to that account. Thereafter, you may submit claims for eligible Expenses that are incurred by you, your Spouse, and your Dependents.

The Plan establishes and maintains an HRA account for each eligible participant to keep track of contributions and available reimbursement amounts.

While contributions are only made on your behalf while you are working for a contributing Employer, you do not have to be an active participant to use your HRA account. Your HRA account balance is available when you are self-paying to continue Plan coverage when you're not working enough hours, and after retirement (if you are eligible for retiree coverage), which means that as long as you, your Spouse, or Dependents are self-paying to continue coverage under the Plan, you may continue to use your HRA account. Note, however, that you have the ability to permanently opt out and waive future reimbursement on an annual basis.

Contributions

Your HRA account is funded exclusively through contributions made by your Employer on your behalf in accordance with the collective bargaining agreement or participation agreement applicable to you.

The more you work for a contributing Employer, the more contributions are made to your HRA account, which means your HRA account continues to grow. Plus, money in your HRA account and amounts reimbursed for eligible Expenses are not included in your income and therefore, you are not taxed on this money.

If You Do Not Work Enough Hours

When you, your Spouse, and/or your Dependents are eligible for COBRA continuation coverage, your HRA account balance may be used for self-contributions to continue this coverage.

If you do not work enough hours to continue eligibility for Plan coverage, you may use your HRA account to make self-contributions to continue your coverage (if eligible). You must contact the Fund Office and complete any necessary paperwork to use your HRA account balance towards any required self-contribution amounts, including COBRA continuation coverage. You do not receive Employer contributions to your HRA account for hours for which you are making self-contributions; however, you will receive contributions for hours you work.

If you work under a reciprocity agreement, reciprocal contributions will first be applied toward the HRA account and then applied toward the monthly cost to maintain Plan coverage.

Your HRA Account Balance

Your HRA account balance is the total of Employer contributions made on your behalf for the HRA minus any reimbursements you request from your HRA account. The amount available for reimbursement of eligible Expenses is the amount credited to your HRA account. Contributions made on your behalf will be credited to your HRA account within 30 days after they are received by the Fund. Therefore, there may be a lag between the time contributions are required on your behalf and when they are available for you to use.

If money remains in your HRA account at the end of a year, it rolls over into the next year, allowing you to save for future health care Expenses.

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.

Continued Eligibility

Your eligibility for the HRA is based on your continued eligibility for Plan coverage.

Once you are eligible, your eligibility will continue as described in the Eligibility section of this SPD, provided the required contributions are made on your behalf. You will continue to receive HRA contributions as long as you are actively working. Once you stop working, contributions made into your HRA will stop, but you can continue to use the balance in your HRA for eligible Expenses, except as described below in the *If You Refuse or Stop Working* section.

If You Refuse or Stop Working

Your HRA account will be frozen beginning on the first day of the first month following the date that you either are called to work and refuse or stop working under a collective bargaining agreement with the Wisconsin Laborers District Council or its affiliated Local Unions and then you subsequently start working:

- In the construction industry in a non-laborers trade; or
- In a laborers' trade or sub-trade in the geographic area of Wisconsin under a collective bargaining agreement that is not with the Wisconsin Laborers' District Council, its affiliated Local Unions or the International Laborers' Union.

This Plan rule applies if your employer has entered into a collective bargaining agreement with the Wisconsin Laborers' District Council or its affiliated Local Unions.

Your frozen HRA account will be forfeited (in other words, closed and forever unavailable to you) as of the first day of the 12th month following the month you are called to work and refuse or stop working under a collective bargaining agreement with the Wisconsin Laborers District Council or its affiliated Local Unions and subsequently start working in the construction industry in a non-laborers trade or in a laborers' trade or sub-trade in the restricted geographic area. If, however, prior to forfeiture, you return to work for an employer that is required to make contributions to the Fund under a collective bargaining agreement with the Wisconsin Laborers' District Council, its affiliated Local Unions or the International Laborers' Union, your account will not be forfeited.

Note: If your frozen account is not forfeited, it may be reinstated on the first day of the month following the month in which you satisfy the Plan's initial eligibility requirements.

EXAMPLE

Let's say you were called to work on August 1, 2018, and you refused or you stopped working under a collective bargaining agreement with the Wisconsin Laborers District Council or its affiliated Local Unions and you subsequently started working in the construction industry in a non-laborers trade, or in a laborers' trade or sub-trade in the restricted area, your HRA account was frozen on September 1, 2018. If your HRA account remains frozen for 12 months, your account will be forfeited on August 1, 2019. If prior to forfeiture, let's say June 1, 2019, you return to work for an employer that is required to make contributions to the Fund under a collective bargaining agreement with the Wisconsin Laborers' District Council, its affiliated Local Unions or the International Laborers' Union, and you work consecutively 600 hours between June 1, 2019 through May 31, 2020, and the Fund receives contributions from your employer for 600 hours on June 1, 2020, your account could be reinstated when the eligibility requirements are met.

When Eligibility Ends

Your eligibility for reimbursements from the HRA ends on the earliest date of the following occurrences:

- The date you waive coverage under the HRA; or
- The date your balance in your HRA account equals $0; or
- The date you are no longer eligible for the Health Fund.

In addition, your HRA funds may also be frozen if you refuse to work or stop working, as described above.

Once you waive coverage under the HRA, are no longer eligible for the Health Fund or you retire, no further contributions will be made to your HRA account. You will be asked if you would like to opt out of the HRA and waive future reimbursements.

In addition, if your eligibility or your Dependent's eligibility ends because of a COBRA qualifying event, you, your Spouse, and any Dependents will be given the opportunity to elect COBRA continuation coverage. You will also have the same access to your HRA account that you had before the qualifying event occurred.

If you lose eligibility under the Plan due to lack of hours and then become eligible again prior to a two-year break in eligibility, the HRA contributions that were earned during the ineligibility period will be credited to your HRA account once your eligibility for Plan coverage has been re-established. However, if your period of ineligibility for coverage under the Plan is longer than

two years, then only HRA contributions earned in the two-year period immediately prior to your re-established eligibility date for Plan coverage will be credited to your HRA account. You will be given access to the HRA funds only after you become eligible for benefits under the Plan. No Employer contributions are made to an HRA account on behalf of an Employee after an Employee's termination of employment or retirement.

Your HRA Account Balance After Eligibility as an Active Employee Ends

Once you are no longer eligible for coverage from the Health Fund as an active Employee, you may continue to submit eligible Expenses for reimbursement from your HRA account for Expenses you incurred before your coverage ended, unless your HRA account is frozen. Contributions into your HRA account will stop.

When You Retire

If you are eligible for retiree coverage, self-contributions are required for retiree coverage. When you retire, you may use the balance in your HRA account toward these self-contributions for retiree coverage. In addition, as long as you are eligible for retiree coverage, you may also use your HRA account to pay for eligible Expenses incurred during retirement. Your HRA account balance is carried forward until no balance remains or until you are no longer eligible for coverage under the Health Fund. However, no contributions will be made to your HRA account once you are retired, unless you return to work for which contributions are required on your behalf.

In the Event of Death

Your HRA account will continue to be available to provide reimbursement for your surviving Dependents' eligible Expenses in the event of your death. In other words, your HRA account balance is available to your surviving Spouse and/or eligible Dependents after your death. Your Spouse and/or eligible tax-dependent Domestic Partner may use your HRA account to pay for eligible Expenses (including Expenses you incurred before your death) or to make self-contributions to continue coverage until the earliest of when your HRA account balance is zero, or the Plan's HRA program ends. Your other Dependents may use your HRA account to pay for eligible Expenses until the earlier of the date they no longer meet the definition of "Dependent," the date your HRA account balance is zero, or the date the Plan's HRA program ends. However, in no event will amounts be paid in cash to any person for other than reimbursement of an eligible Expense (for example, there are no lump-sum distributions of the HRA account balance as a death or termination benefit).

If you have no surviving Spouse and/or other eligible Dependents at the time of your death, any balance in your HRA account will be forfeited and become a part of the Plan's general assets.

While your surviving Spouse and/or Dependents may continue to use your HRA account as long as they are eligible for Plan coverage (including COBRA continuation coverage), no further Employer contributions will be made to the HRA account.

Opting Out of HRA Coverage

Annually on January 1, you and your eligible Dependents are allowed to permanently opt out of HRA coverage and waive future reimbursements from your HRA account. For instance, you may wish to opt if you cannot have access to an HRA because you are receiving a subsidy for the premiums of an individual insurance plan purchased from a state or federal Health Insurance Marketplace. If you opt out, you will not receive any contributions toward your HRA account and the balance in your HRA account will be frozen. Note that when your account is frozen pursuant to your opt-out, it may be reinstated as follows:

- If you remain eligible, your frozen HRA account will be reinstated on the earlier of the January 1 following your election to opt-in to the HRA, or your death;
- If you lost eligibility, your frozen HRA account will be reinstated if you regain eligibility for the Health Fund and the HRA;
- If you retire and are eligible for retiree coverage from the Health Fund, your HRA will be reinstated on the earlier of the January 1 following your election to opt-in to the HRA, or your death;
- If you die, your HRA will be reinstated on the January 1 following your Spouse's or Dependent's election to opt-in to the HRA. Any amounts remaining in your HRA will be forfeit to the Fund upon the Dependents' death.

Reimbursable and Non-Reimbursable Expenses

You determine how you want to use the money in your HRA account. You can use it as you incur eligible health care Expenses or save up and use it in the future.

As you, your Spouse, and/or your eligible Dependents incur eligible healthcare Expenses, you can use the money in your HRA account to pay for these Expenses.

Reimbursable Expenses

Examples of eligible Expenses, as defined by the Plan, if you are enrolled in the Plan include:

- Coverage costs, including self-payment contributions or premiums:
  - To continue Plan coverage when you are not working enough hours;
  - For COBRA continuation coverage;
  - For retiree coverage, if eligible; and
  - Healthcare Expenses, including:
    - Medical, prescription drug, dental, and vision Expenses;
    - Out-of-pocket Plan costs, such as deductibles, copayments, and coinsurance; and
    - Expenses not covered, or only partially covered, under the Plan.

If you are enrolled in other group health plan coverage (not the Plan) and the coverage does not provide minimum value, or if you fail to provide proof of other coverage, your reimbursable eligible Expenses will include only:

- Copayments, coinsurance, deductibles and premiums for the other group health plan coverage, to the extent such premiums are paid on an after-tax basis; and
- Expenses for medical care, as defined under Internal Revenue Code Section 213(d), that does not constitute an essential health benefit.

If you are enrolled in coverage other than the Plan, and have questions about what items can be reimbursed, please contact the Fund Office at 608-842-9101 or 800-397-3373.

In general, Expenses eligible for reimbursement only include those that:

- Are incurred while you are eligible for coverage under the Plan's HRA;
- You, your Spouse, and/or your Dependents are required to pay;
- Are not reimbursed by insurance or any other source; and
- You, your Spouse, and/or your Dependents have not taken (or will not take) as a tax deduction.

Only healthcare Expenses that are permitted under the terms of Sections 105 and 213(d) of the Internal Revenue Code (IRC) are eligible for reimbursement from your HRA. Please note that federal and state tax regulations are subject to change.

An eligible healthcare Expense is defined as an Expense incurred by you and/or your Dependents for medical care, as defined in IRC Sections 105 and 213(d). For more detailed information on eligible healthcare Expenses, please refer to IRS Publication 502 entitled, "Medical and Dental Expenses," Catalog Number 15002Q. It is available at **www.irs.gov/pub/irs-pdf/p502.pdf**.

Even if an Expense is a medical Expense applicable under IRC Sections 105 and 213(d), or listed in IRS Publication 502, it may not necessarily qualify as an eligible healthcare Expense under the HRA program. For instance, the HRA program cannot reimburse long-term care Expenses or premiums paid through salary reduction contributions to an IRC Section 125 Plan. Likewise, IRS Publication 502 states that nonprescription drugs are ineligible. In addition, the Fund has the right to limit or deny reimbursements for certain Expenses even though they may be allowed under federal law.

Non-Reimbursable Expenses

Amounts credited to your 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.
- "Medical Care Expenses" also 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.
  - Long-term care services.
  - 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.
  - The salary Expense of a nurse to care for a healthy newborn at home.
  - Funeral and burial Expenses.
  - Household and domestic help (even though recommended by a qualified Physician due to an eligible person's inability to perform physical housework).
  - Massage therapy.
  - Home or automobile improvements.
  - Custodial Care.
  - 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.
  - 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.
  - Social activities, such as dance lessons (even though recommended by a Physician for general health improvement).
  - Bottled water.
  - Maternity clothes.

- Diaper service or diapers.
- Cosmetics, toiletries, toothpaste, etc.
- Vitamins and food supplements, even if prescribed by a Physician.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Transportation Expenses of any sort, including transportation Expenses to receive medical care.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a Physician.
- Any item that does not constitute "medical care" as defined under Code Section 213.
- Premiums paid through salary reduction contributions under the terms of a Code Section 125 plan.
- Over-the-counter drugs without a prescription unless insulin.

How to Use Your HRA Debit Card

To make it easy for you to access the funds in your HRA, you will be provided with a debit card that you can use at the point-of-service or point-of-sale to pay for eligible Expenses out of your HRA as you incur them. Note that the debit card has been provided only as a way for you to pay for those Expenses that are eligible under the HRA. The HRA debit card is not a credit card.

You may use the debit card at the point-of-service or point-of-sale for eligible medical expenses at medical care providers or at approved merchants who provide health-related services and products and who accept the Plan's card. For example, you may use the card for medical office visit copayments, deductibles and coinsurance or for prescription drugs.

The card will remain active if you or, if applicable, your Dependents upon your death, continue to participate in the HRA—up until the time the amount in your HRA account is used up. The card will be automatically canceled if it is used for impermissible Expenses. If you or, if applicable, your Dependents lose your HRA debit card, the Fund may assess the HRA account an administrative charge for a replacement card.

Claims submitted through the use of a debit card will be considered submitted on the date of the debit card transaction.

You should maintain copies of receipts for any Expenses incurred with the HRA debit card. You are required to provide the Fund Office with a copy of your receipt for certain types of Expenses. When applicable, the Fund Office will send a letter to you requesting that a copy of your receipt be sent to the Fund Office. The quickest and most convenient way for you to send a copy of your receipt to the Fund Office is through the WEX link on the participant portal at www.wilbenefits.com and logging into MemberXG. You can upload your receipt on the participant portal by selecting "Dashboard" and then "I Want To" file a claim.

If the Fund Office does not receive a copy of the receipt within 30 days of the date of its letter, you will receive a second notice. If the Fund Office does not receive a copy of the receipt within 15 days of the date of the second notice, use of your debit card will be suspended until a copy of the requested receipt is received. Suspension of your debit card will end within 10 business days of the Fund Office's receipt of the needed document.

If the debit card purchase and receipt do not qualify as an eligible Expense, you will need to reimburse the HRA fund. You will then have those monies available to you for a future qualified Expense. Your debit card will be suspended until you have reimbursed the HRA fund.

Any receipts requested but not received and any reimbursements requested but not received by December 31 will be reported as taxable income.

Claims and Reimbursement Procedures

If you do not use your debit card to pay for an eligible Expense or if your debit card is not accepted (for example, if you use an unapproved vendor), you must submit a written claim form to the Fund Office within one year of the date you incurred the Expense in order to receive reimbursement. Mail the completed form and any required documentation to the Fund Office.

To limit administrative Expenses, the Fund requires that requests for reimbursement be for a minimum of $100. If you do submit claims for less than $100, the Fund will hold them until the total reimbursement reaches a minimum of $100. In the event your Plan coverage ends, you may submit eligible expenses totaling less than $100 to close out your HRA account.

If there is an insufficient amount in the HRA account to cover the claim, it is your responsibility to resubmit the balance when the HRA account has sufficient funds.

Claim Decisions

A request for reimbursement of an eligible Expense is considered a claim. Claim decisions are subject to the Plan's claims procedures for post-service claims listed on page 88. If your request for reimbursement is denied, you may appeal the decision. Review the filing claims and appeals section of this SPD for more information on how to appeal a denied claim.

Coordination of Benefits

Benefits under the HRA 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. Without limiting the foregoing, if the medical care Expenses are covered by both the HRA and by a Health FSA, then the HRA cannot reimburse such medical care Expenses until after amounts available for reimbursement under the Health FSA have been exhausted.

The HRA Plan will not be considered a group health plan for coordination of benefits purposes under the Plan, and its reimbursement benefits will 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.

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 Plan if they enroll for Medicare Part D, they will be subject to the information in the above paragraph.

Tax Consequences

The Plan makes no guarantee that any amounts reimbursed to you, your Spouse, or your Dependents under the HRA will be excludable from your gross income for federal, state, or local income tax purposes. It is your responsibility to determine whether payments under the HRA are excludable, and to notify the Plan if you have any reason to believe that such payment is not excludable.

The Plan may be disqualified if reimbursement under the HRA is made on a tax-free basis when the payment does not qualify for tax-free treatment under the Internal Revenue Code. In this situation, you will be required to indemnify and reimburse the Plan for any liability incurred for failure to withhold federal income taxes, Social Security taxes, or other taxes.

Domestic Partners

If your domestic partner is not a Dependent under this Plan, as defined in Section 152 of the Internal Revenue Code, then your domestic partner and his or her dependent child(ren) are not considered a Spouse or Dependent for purposes of the HRA.

IN THE EVENT OF YOUR DEATH OR SERIOUS INJURY (Active Employees and Retirees)

Weekly Accident and Sickness Benefits are not available under the Bare Bones Plan.

The benefits described in this section are available to active Employees in the Regular Plan only, except that a $7,000 Death Benefit is available to eligible retired Employees. If you should die or become seriously Injured or Sick, the Plan helps protect you and your family from the loss of your income. The following benefits are offered by the Plan:

- Weekly Accident and Sickness Benefits;
- Death Benefits; and
- Accidental Death and Dismemberment Benefits.

Weekly Accident and Sickness Benefit

The Weekly Accident and Sickness Benefit is payable if you are disabled due to an Injury or Sickness that is not work-related or covered by workers' compensation laws, and you cannot work as a result. You must also be under the care of a Physician to receive this benefit.

If eligible, you will receive $300 each week under the Weekly Accident and Sickness Benefit. For partial weeks of disability, you will be paid a daily rate of one-seventh of $300. Benefits are paid for up to 19 weeks for any one period of Certified Disability.

A second Certified Disability will be considered a new period of disability if the Certified Disabilities are:

- Unrelated and you return to active full-time Covered Work for at least one full day between Certified Disabilities; or
- Related and you return to full-time Covered Work, or you are ready and available for Covered Work, for at least two continuous weeks between periods of disability.

When Benefits Begin

Weekly Accident and Sickness Benefits begin on the:

- First day of a Certified Disability due to an accidental bodily Injury; or
- Eighth day of a Certified Disability due to Sickness.

However, you will be paid retroactively to the first day of a Certified Disability due to Sickness if you remain ill and are unable to work 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.

Non-Work Hours

During your Certified Disability, you will be credited with 30 disability hours for each full week of disability, up to an annual maximum of 525 hours. In no event will you receive more than 525 disability hours in any 12 consecutive-month period, regardless of the number of periods of disability you have. Credit hours will be applied toward continuing eligibility requirements; however, self-contributions may still be required. For more information, see page 23.

Maternity Benefit

The Plan offers an $800 weekly benefit (payable at birth) in connection with a live birth for active eligible female employees. The benefit is payable for six (6) weeks per live birth for a traditional delivery, and eight (8) weeks for a cesarean section delivery.

Limitations

Weekly Accident and Sickness Benefits will not be paid to:

- Participants covered under the Bare Bones Plan;
- Salaried Employees receiving salary continuation from their Employer while disabled; or
- Retirees.

The Weekly Accident and Sickness Benefit is subject to federal and state income taxes as well as Social Security taxes. The necessary deductions will be taken before you receive your check. The Fund Office will send you a W-2 Form after the end of the year indicating the amount you received.

Death Benefits

In the event of your death, $12,000 ($7,000 if you are an eligible retired Employee) will be paid to your beneficiary in accordance with Plan provisions upon receipt of written proof of your death. Note that generally, death benefits that are self-funded, like the Plan's, will be taxable to the beneficiary. Consult a tax professional for details.

Designating Your Beneficiary

In the event of your death, your Death Benefit is paid to your designated beneficiary. To designate your beneficiary, complete a form provided by the Fund Office. You may name more than one beneficiary and indicate the percentage of the Death Benefit you want each beneficiary to receive. If more than one beneficiary is named, and you do not specify the beneficiaries' respective interests, the beneficiaries will share the Death Benefit equally. If any named beneficiary dies before you, his or her interest in the Death Benefit will end and his or her share will be payable equally to the other named beneficiaries who survive you, unless you change your beneficiaries.

You can change your beneficiary at any time by submitting a new form. Beneficiary designations are effective as of the date you sign the form, provided the Fund Office receives a copy of the form.

If there is no named beneficiary at the time of your death, your Death Benefit is paid to the first surviving class listed below:

- Your Spouse or Domestic Partner;
- Your children;
- Your parents;
- Your brothers and sisters; or
- Your estate.

If the appropriate class includes more than one Person, the Death Benefit is divided equally among the group.

Accidental Death and Dismemberment Benefit

The Accidental Death and Dismemberment ("AD&D") Benefit is payable for active Employees in the Regular Plan only. The AD&D Benefit outlined below is paid if you sustain one of the specified losses as a result of an accident. The loss must occur within 90 days of the accident. This benefit is in addition to any other benefits you may receive from the Plan. If you die, the benefit is paid to your beneficiary; otherwise, the benefit is paid to you.

For Loss Of	Benefit Payable
Life	$12,000
Two limbs, or sight of both eyes	$12,000
One limb and sight of one eye	$12,000
One limb, or sight of one eye	$7,000

Note: To qualify as a loss of a limb, severance must occur above the wrist joint or ankle joint. Loss of sight means the total and permanent loss of sight. If more than one of the above losses is sustained as the result of the same accident, benefits are paid only for the loss that pays the greatest amount.

Exclusions

No AD&D Benefit is payable for any loss caused wholly or partly, directly or indirectly by:

- Bodily or mental infirmity;
- Ptomaines;
- Bacterial infections, except infections caused by pyogenic organisms that may occur with and through an accidental cut or wound;
- Disease or sickness of any kind;
- War or any act of war;
- Service in any military, naval or air force of any country while such country is engaged in a war, civil war or insurrection; or
- Police duty as a member of any military, naval or air organization.

GENERAL EXCLUSIONS AND LIMITATIONS

The Plan does not pay for the Expenses listed below:

1. Any Injury, Sickness, or dental treatment for which you or your Dependent have received or are entitled to receive benefits under a workers' compensation or occupational disease law, or that arises out of or in the course of engaging in any occupation or employment (except for Death Benefits and AD&D Benefits). However, the Fund will cover such Expense, subject to the terms and conditions of the Plan, if:
    a. You or your Dependent have been denied workers' compensation or occupational disease benefits; and
    b. You or your Dependent and your or your Dependent's 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 your behalf or your Dependent's behalf for said Injury out of any recovery proceeds, whether by settlement or otherwise.

Failure by you or your Dependent to comply with the agreement allows the Fund, at its discretion, to take any of the following actions:

    a. Take a credit against future claims of you or your covered Dependents up to the amount of the Fund's expenditures on such Expense;
    b. Initiate legal proceedings to recover the Fund's expenditures; and/or
    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 you or your Dependent, to the extent of the Fund's expenditures, whether the recovery is paid to, or in the possession of, you or your Dependent, your attorney or your Dependent's attorney, or any other individual or entity.

2. Any Expense incurred after eligibility ends, except as specifically provided under any extension of benefits provision of this Plan.
3. Any Expense that is in excess of the Allowable Charges.
4. Any Expense or charge for services or supplies not recommended by a Physician, or not Medically Necessary (as defined by the Plan) in treating an Injury or Sickness.
5. Any Expense or charge for services or supplies that are:
    a. Not provided in accordance with generally accepted professional medical standards; or
    b. Experimental or Investigative treatments and procedures, as defined on page 109.
6. 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.
7. Any physical or mental examination, evaluation, or treatment that is required for insurance, employment, or special licensing purposes.
8. Any Expense or charge for preventive immunizations, except as specifically provided as a covered Expense.
9. Any Expense or charge for Custodial Care or long-term care, except as specifically provided as a covered Expense.
10. Any loss, Expense, or charge that results from Cosmetic Surgery or Reconstructive Surgery, except:
    a. When such service is incidental to or follows surgery resulting from Injury of the involved part;

b. Repair of congenital defects of Dependent children;

c. Repair of defects that result from surgery for which benefits are paid under the Plan; or

d. As required by the Women's Health and Cancer Rights Act of 1998.

11. Any Expense or charge in connection with dental work or dental surgery, except as specifically provided as a covered Expense, including:

    a. Treatment involving any tooth structure, alveolar process, abscess, or disease of the periodontal or gingival tissue;

    b. Surgery or splinting to adjust dental structure; or

    c. Anesthesia or Hospital Expenses for outpatient surgery.

12. Inpatient or outpatient charges resulting from behavioral problems, conduct disorders, learning disabilities, and developmental delays. Treatment of these conditions is excluded.

13. Any loss, Expense, or charge that results from appetite control or any treatment of obesity, except for surgery to treat Morbid Obesity and services that may be covered under the Comprehensive Major Medical Benefit in limited situations.

14. 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 specifically provided as a covered Expense.

15. Any Expense or charge for eye exercises or vision training (orthoptics).

16. Any Expense or charge for failure to appear for an appointment as scheduled or for completion of claim forms and obtaining medical records.

17. Any loss, Expense, or charge for any treatment related to sexual dysfunction.

18. Any Expense or charge for which a person would not be required to pay in the absence of these benefits.

19. Any loss, Expense, or conditions suffered while engaged in the commission of a felony or while attempting to commit a felony, or while engaged in a riot, other than when engaged in, as part of, or in connection with a labor dispute, except that injuries or Sickness caused by acts of domestic violence will be covered by the Plan.

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

21. Any loss, Expense, or charge:

    a. That is incurred while a Person is on active duty or training in the armed forces, national guard, or reserves of any state or country; or

    b. For which any governmental body or its agencies are liable.

22. Any Expense or charge for the promotion of fertility including, but not limited to:

    a. Fertility tests;

    b. Reversal of surgical sterilization; and

    c. Any attempts to cause pregnancy by hormone therapy, artificial insemination, in-vitro fertilization, or embryo transfer.

23. Any Expense or charge for chelation therapy, except for acute arsenic, gold, mercury, or lead poisoning.

24. Any Expense or charge for services or supplies that are provided or paid for by the federal government or its agencies, except for:

    a. The United States Department of Veterans Affairs, when services are provided to a veteran for a disability that is not service connected;

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

c. A group health plan established by the government for its own civilian Employees and their Dependents.

25. Elective abortions, but benefits will be paid for Medically Necessary abortions, and complications of abortion.

26. 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 waterbed.

27. Special home construction.

28. Speech therapy principally for developmental delay and speech therapy unless required because of a physical impairment caused by a Sickness or Injury.

29. Ambulance service, except as specifically provided as a covered Expense.

30. 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:

    a. For Emergency Care;

    b. When surgery is performed within one day of such admission; or

    c. For the birth of a baby.

31. Any inpatient Expense or charge incurred more than one day before 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 before surgery is needed.

32. Well-child care, except as specifically provided as a covered Expense.

33. Any Expense incurred for mental health and substance abuse treatment, except as specifically provided as a covered Expense.

34. Any Expense for wigs.

35. Any Expense for radial keratotomy and/or laser surgery to correct vision, except as specifically provided as a covered Expense.

36. Any Expense for a mechanical heart implant, including subsequent medication and maintenance.

37. Any Expense for swimming and physical fitness programs.

38. Any Expense for the services of a chiropractor, except as specifically provided as a covered Expense under the Plan's Chiropractic Benefits.

39. Any Expense for nutritional supplements even if prescribed by a Physician or chiropractor.

40. Any Expense or charge for non-Experimental organ transplants, except as specifically provided as a covered Expense.

41. Elective pregnancies where the Employee or Dependent acts as a surrogate mother including Expenses and charges incurred by the child of such surrogate pregnancy.

42. Any Expense for genetic or DNA testing, except as specifically provided as a covered Expense.

43. Any Expense or charge for prescription drugs, except as provided while in a Hospital or Skilled Nursing Care Facility or under the Plan's Prescription Drug Benefits.

44. Any Expense for preventive or routine care, including screenings due to family or personal history, except as specifically provided as a covered Expense.

CLAIMS AND APPEALS PROCEDURES

If you are a Medicare-eligible retiree, contact UnitedHealthcare for information regarding its claims and appeals procedures for medical and prescription drug benefits. If you are a Medicare- or a non-Medicare-eligible retiree, contact Delta Dental of Wisconsin for information regarding its claims and appeals procedures for dental benefits.

If you incur an Injury or Sickness for which you will make a claim, you need to submit a written notice to the Fund Office within 90 days after the date that services for that Injury or Sickness begin, or as soon as reasonably possible thereafter, but in no event later than one year.

When Benefits are Paid

Weekly Accident and Sickness Benefit generally are paid no later than the end of each two-week period, once benefits have been applied for and approved. All other claims will be paid as they accrue upon receipt of due written proof of such loss and approval of such claims.

Medical Claim Decisions

Most providers will file claims for you. However, if your provider does not and you need to file a claim, follow these steps:

- Have your Physician either submit a completed HCFA health insurance claim form or submit a HIPAA-compliant electronic claim submission.
- Forward the completed HCFA health insurance claim form, with all itemized bills attached, to: Wisconsin Laborers' Health Fund, 4633 Liuna Way, Suite 201, DeForest, Wisconsin 53532-2514.
- Mail any further bills or statements for any medical or Hospital services covered by the Fund to the Fund Office as soon as you receive them.

Reimbursement for covered charges will be made to the provider of service unless the participant has requested otherwise in writing.

If benefits are not paid directly to the provider of service, unpaid benefits for outstanding Hospital, nursing, medical or surgical claims are payable to you, if living, otherwise, any outstanding claims will be payable to your estate.

Generally, all healthcare benefits will be processed as soon as administratively possible. You will be notified of an initial decision within certain timeframes. If a claim for post-service or concurrent care is approved, payment will be made and the payment will be considered your notice that the claim was approved. However, for urgent care and pre-service claims, you will be given oral and written notice of a decision on your claim.

The deadlines differ for the different types of claims as shown in the following information.

- **Urgent Care Claims.** An initial determination will be made within 72 hours from receipt of your claim, unless additional information is needed. Notice of a decision on your urgent care claims may be provided to you orally within 72 hours and then confirmed in writing within three days after the oral notice. If additional information is needed to process your claim, you will be notified within 24 hours of receipt of your claim. You will then have up to 5 days to provide the additional information. The initial 72-hour deadline is suspended for up to 5 days or, if sooner, until the information is received. Notice of the decision will be provided no later than 48 hours after the Fund Office receives the additional information or, if sooner, the end of the period given for you to provide this information.

- **Pre-Service Claims.** An initial determination will be made within 15 days from receipt of your claim. If the Fund Office determines that additional time is necessary to make a determination, due to matters beyond the control of the Plan or the provider, the initial period may be extended for up to 15 additional days. Within the initial 15-day deadline, you will be informed of the extension, including the circumstances requiring the extension and the date the Plan expects to make a determination. If additional information is needed to process your claim, the Fund Office will notify you of the information needed. You then have up to 45 days from receipt of the notice to provide the requested information. After 45 days or, if sooner, after the information is received, a determination will be made within 15 days.
- **Post-Service Claims.** An initial determination will be made within 30 days from receipt of your claim. If the Fund Office determines that additional time is necessary to make a determination due to matters beyond the control of the Plan or the provider, the initial period may be extended for up to 15 days. Within the initial 30-day deadline, you will be informed of the extension, including the circumstances requiring the extension and the date the Plan expects to make a determination. If additional information is needed to process your claim, the Fund Office will notify you of the information needed. You then have up to 45 days from receipt of the notice to provide the requested information. After 45 days or, if sooner, after the information is received, a determination will be made within 15 days.
- **Concurrent Care Claims.** While other claims have certain deadlines throughout the claim and appeal process, there is no formal deadline to notify you of the reconsideration of a concurrent claim. However, you will be notified as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated. If you request an extension of approved urgent care treatment (i.e., longer than the prescribed period of time or number of treatments), the Plan or provider will act on your request as soon as possible and you will be notified within 24 hours after the Plan or provider receives your request, provided your claim is received at least 24 hours before the expiration of the approved treatment (i.e., prescribed period of time or number of treatments). 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.

Weekly Accident and Sickness Claims

If you are submitting a claim for the Weekly Accident and Sickness Benefit, you must submit a claim form that was completed by you and your Physician. This form may be obtained from the Fund Office.

For Weekly Accident and Sickness claims, the Fund will make a decision on the claim and notify you of the decision within 45 days of the Fund's receipt of your claim. If the Fund requires an extension of time due to matters beyond the control of the Fund, the Fund will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45-day period. A decision will be made within 30 days of the time the Fund notifies you of the delay. The period for making a decision may be delayed an additional 30 days if due to matters beyond the control of the Fund and provided the Administrative Manager notifies you, before the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Fund expects to render a decision.

If an extension is needed because the Fund needs additional information from you, the extension notice will specify the information needed. In that case, you will have 45 days from receipt of the notification to supply the additional information. If you do not provide the information within that time, your claim will be decided on the basis of the information that the Plan has, and may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). Once you respond to the Fund's request for the information, you will be notified of the Fund's decision on the claim within 30 days.

Death and AD&D Benefit Claims

Generally, you will receive written notice of a decision on your initial claim within 90 days of receipt of your claim. If additional time or information is required to make a determination on your claim (for reasons beyond the control of the Plan or provider), you will be notified within this 90-day deadline. This 90-day period may be extended up to an additional 90 days maximum.

Denial of Claim or Adverse Benefit Determination Notice

The denial of a claim or other adverse benefit determination includes the following:

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, and includes decisions based on a determination of eligibility to participate in the Plan, or a determination that a benefit is not a covered benefit;
- 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
- Any rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions.

The Fund must provide you with a notice of their initial determination about your claim that has been denied, in whole or in part, within certain timeframes after they receive your claim. The notice must provide you with the following information:

- The specific reason or reasons for the denial of benefits or other adverse benefit determination;
- A specific reference to the pertinent provisions of the Plan upon which the decision is based;
- A description of any additional material or information, if any, that is needed to process your claim and an explanation of why the information is needed;
- An explanation of the Fund's review procedures and time periods to appeal your claim, plus a statement of your right to bring a lawsuit under ERISA Section 502(a) following the review of your claim;
- A copy of any internal rule, guideline, protocol or similar criteria that was relied on, if applicable, or a statement that a copy is available to you at no cost upon request; and
- A copy of the scientific or clinical judgment or statement, if applicable, or a statement that a copy of such is available to you at no cost upon request for Medical and Weekly Accident and Sickness Benefit claims that are denied due to:
  - Medical Necessity;
  - Experimental treatment; or
  - Similar exclusion or limit.

If the denial is for an urgent care claim, the notice will also include a description of the expedited review process.

For Weekly Accident and Sickness claims, the notice of denial will also include an explanation for not following or disagreeing with the following:

- The views presented by you to the Plan of the health care professionals treating you and vocational professionals who evaluated you;

- The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
- A disability determination presented by you to the Plan made by the Social Security Administration; and
- For Weekly Accident and Sickness claims, the notice of denial will also include the specific internal rules, guidelines, protocols, standards or other similar criteria the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist. The notice of denial for Weekly Accident and Sickness claims will include a statement that the claimant is entitled to receive, upon request and without charge, reasonable access to and copies of all documents, records, and other information relevant to the claim.

Right to Request a Review of a Denied Claim

If your claim is denied, in whole or in part, or you disagree with the Fund's determination of your eligibility for or amount of benefits, you may submit a written appeal to the Board of Trustees. Your written appeal must be filed within:

- 180 days after you receive the notice of denial for healthcare, prescription drug, or Weekly Accident and Sickness Benefit claims; or
- 90 days after you receive the notice of denial for Death or AD&D Benefit claims.

Your written appeal should explain the reasons you disagree with the decision on your claim and you may provide any supporting documents or additional comments related to this review. When filing an appeal, you may:

- Submit additional materials, including comments, statements, or documents;
- Request to review all relevant information without charge;
- Request a copy of any internal rule, guideline, protocol, or other similar criteria on which the denial was based; and
- Request 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.

If your claim or appeal is denied, in whole or in part, on the basis of a medical judgment, the Trustees will consult with a healthcare 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 denial of your claim. You have the right to be advised of the identity of any medical experts consulted in making a determination of your appeal, without regard to whether the advice was relied on in making the determination.

When appealing a claim, you may authorize a representative to act on your behalf. However, you must provide notification to the Fund Office authorizing this representative.

You may also request a hearing, at which you or your authorized representative will have the opportunity to appear.

Appeal Timeframes

A determination on your appeal will be made within certain timeframes. The deadlines differ for the different types of claims as shown in the following information:

- Health Care Claims:
  - **Urgent Care Claims.** A determination will be made within 72 hours from receipt of your appeal.
  - **Pre-Service Claims.** A determination will be made within 30 days from receipt of your appeal.

  - **Post-Service Claims.** A determination will be made at the Trustees' next regularly scheduled meeting following receipt of your appeal. However, if the request is filed within 30 days of the date of the meeting, the determination may be made at the second meeting following receipt of your appeal. If special circumstances require a further extension, a decision will be made at the third meeting following receipt of your appeal. You will be notified if any extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a decision. You will be notified of the decision in writing within five days of the meeting at which the decision is made.
  - **Concurrent Care Claims.** A determination will be made before reduction or termination of your benefit.

For Weekly Accident and Sickness claims only, before the Plan issues an adverse benefit determination on appeal, the Plan must automatically provide you with any new or additional evidence or rationale considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination in connection with the claim, free of charge. You will be given a reasonable opportunity to respond.

- Weekly Accident and Sickness, Death Benefits, and AD&D Benefits:
  - A determination will be made at the Trustees' next quarterly meeting following receipt of your appeal. However, if the request is filed within 30 days of the date of the meeting, the determination may be made at the second quarterly meeting following receipt of your appeal. If special circumstances require a further extension, a decision will be made at the third quarterly meeting following receipt of your appeal. You will be notified if any extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a decision. You will be notified of the decision in writing within five days of the meeting at which the decision is made.

Appeal Decision Notice

The decision on any appeal of your claim will be given to you in writing. The notice of a denial of a claim on appeal will state:

- The specific reason(s) for the determination.
- Reference to the specific Plan provision(s) on which the determination is based.
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge.
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review and the specific limitations period that applies and, for Weekly Accident and Sickness claims, the calendar date on which the limitations period expires on the claim. You must bring any lawsuit within two years from the date the claim was required to be received by the Fund Office.
- If an internal rule, guideline or protocol was relied upon by the Fund, then you 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 Investigative, or other similar exclusion, then you may receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

For Weekly Accident and Sickness claims, the notice of denial will also include an explanation for not following or disagreeing with the following:

- The views presented by you to the Plan of the health care professionals treating you and vocational professionals who evaluated you;
- The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;
- A disability determination presented by you to the Plan made by the Social Security Administration; and

- For Weekly Accident and Sickness claims, the notice of denial will also include the specific internal rules, guidelines, protocols, standards or other similar criteria the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist. The notice of denial further include a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

Payment of Benefits

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.

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 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 will be deemed to be an amendment to the Plan or establish a precedent, or obligate the Plan to make such payments or provide such services or equipment in the case of any subsequent claim. The Trustees may delegate this determination to the Administrative Manager.

If any person, claimant, or beneficiary under the Plan 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 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 that incompetent person. If the incompetent person dies 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 incompetent person's surviving Spouse, Domestic Partner, parent, child or children, or to any other person or persons who, in the Trustees' opinion, are entitled to the Plan benefits.

Trustees' Discretion

The Trustees have the sole, broad, and absolute discretion to construe and interpret the Plan, the Summary Plan Description (SPD), and any and all of their provisions, rules, regulations, or procedures. The Trustees also have broad discretion to determine eligibility for benefits under the Plan, SPD, 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.

Plan benefits 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, SPD, Trust, or eligibility for benefits will be final and binding. All questions or controversies of whatever character arising in any manner or between any parties or persons in connection with the Plan, SPD, its operation, whether as to any claim for benefits, as to the construction of the language of the Plan or this SPD, or any rules and regulations adopted by the Trustees, or as to any writing, decision, instrument, or account in connection with the operation of the Plan, SPD, or otherwise, will be submitted to the Board of Trustees for decision.

Legal Actions

You may not begin any legal action, including proceedings before administrative agencies, until you have followed the procedures and exhausted the appeals opportunities described in this booklet. You may not begin legal action for benefits until after you have requested a review by the Board of Trustees and a final decision has been reached, or until the appropriate timeframe described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. No legal or equitable action (including actions or proceedings before administrative agencies) with respect to a claim concerning eligibility for, or the amount of benefits from and under the Fund or Plan may begin later than two years from the date the claim was required to be filed under the procedures described on page 87 of this booklet.

COORDINATION OF BENEFITS

Under the Health Plan, your benefits may be coordinated under two types of circumstances—if you are eligible for Medicare or Medicaid, or if another group plan or source is obligated to make benefit payments for you or your Dependents. Benefits coordination ensures that you receive maximum benefits, and that benefits are not paid for more than 100% of the actual charges incurred.

When healthcare coverage is available from more than one group plan or other coverage source such as no-fault insurance protection benefits or personal injury protection benefits, the primary plan pays benefits first. Your primary plan determines benefits as if that plan were the only coverage available. Then the secondary plan pays according to their coordination of benefits rules. This Plan defines allowable Expenses as the Allowable Charges for Medically Necessary services, supplies or treatment, part or all of which would be covered under any of your plans.

If you or a Dependent is covered by another group health plan in addition to the Health Fund, the order of benefit payment will be determined according to the following guidelines.

Coordination of Benefits with Plans Other than Medicare or Medicaid

For coordination with other plans (other than Medicare or Medicaid), the following rules apply:

- A plan without coordination of benefits rules will be primary and will pay benefits before this Plan.
- A no-fault insurance protection benefit and/or personal injury protection benefit policy will always calculate and pay its benefits first, and this Plan will pay secondary.
- A plan that covers a Person other than as a Dependent is primary and pays benefits before a plan that covers the Person as a Dependent.
- For claims on behalf of Dependent children whose parents are not divorced or separated or who have signed a joint custody agreement, or never married and are not living together, the plan that covers the parent whose birthday (month and day) falls first in the calendar year is primary and will pay benefits first, and plan of the parent whose birthday falls later in the Calendar Year will pay second. If both parents have the same birthday, the plan covering the parent for the longer period of time will be primary and pay benefits first.

If one parent's plan uses the gender rule and the other parent's plan coordinates benefits as in this subsection, the rules of the plan using the gender rule will determine the order of benefit payment. Under the gender rule, the plan that covers a person as a Dependent of a male employee will pay its benefits before a plan that covers the person as a Dependent of a female employee.

- For claims on behalf of Dependent children whose parents are divorced or separated (including the termination of a Domestic Partnership), the following rules apply:
  - If there is a court decree that establishes financial responsibility for medical Expenses, the plan covering the parent who has such financial responsibility will be primary.
  - If there is no court decree and the parent with custody has not remarried or established another Domestic Partnership, the plan that covers the parent with custody will be primary.
  - If there is no such court decree and the parent with custody has remarried or established a Domestic Partnership, the order of benefit coordination will be the plan of the:
    - Parent with custody is primary and pays benefits first;
    - Step-parent with custody pays benefits second; and
    - Parent without custody pays benefits third.

- 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 below rule 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 will be determined by applying the birthday rule as provided above to the Dependent child's parent(s) and the Dependent's Spouse.
- If none of the above rules apply, the plan that has covered the claimant for the longer period of time will be primary and pay benefits first, except when:
  - One plan covers the claimant as a laid-off or retired Employee (or a Dependent of such an Employee); and
  - 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) is primary and will pay benefits first.

Sub-Plan Provision

A special rule will apply if a participant and/or Dependent have other health plan coverage containing 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 will be applied by this Plan:

- The Sub-Plan provision will be treated as arbitrary and capricious and a subterfuge and will 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.
- If the first additional rule 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 will include the discretion to interpret the language of other plans, to determine whether other plans consist of a single plan or multiple plans, to determine whether a Sub-Plan exists, along with any other determinations deemed appropriate by the Plan. The Board of Trustees' determination (or the designee's determination) in this regard will be binding and final for all purposes, including but not limited to all coordination of benefit purposes, and will not be reversed unless a court of competent jurisdiction determines that such determination is arbitrary and capricious.

Coordination of Benefits with Medicare

This Plan shall have primary responsibility for expenses incurred by the Participant or their

Dependent spouses who meet the following qualifications:

- Persons who are eligible for Medicare Benefits solely because of age; and
- With respect to 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.

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.

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.

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.

This Plan shall have secondary responsibility for expenses incurred by eligible Persons who are eligible for primary Medicare benefits because they are disabled.

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.

In circumstances when Medicare is the primary payor, a person who is 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.

Coordination of Benefits with Medicare Part D

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. Retirees and Retirees' Dependents who enroll for Medicare Part D other than through the United Healthcare Medicare plan are ineligible for prescription drug benefits under the Wisconsin Laborers' Health Fund.

Coordination of Benefits With Medicare (Medicare-Eligible Retirees)

Coordination of benefits with Medicare for Medicare-Eligible Retirees are generally subject to the rules under the United Healthcare Medicare plan. If you are covered by the United Healthcare Medicare plan or another Medicare Advantage Plan, the Plan will presume that you have complied with the rules necessary for your expenses to be covered by the United Healthcare Medicare plan or another Medicare Advantage plan.

Coordination of Benefits with Medicaid

The Plan honors any Medicaid assignment of rights made on your behalf. The Plan also honors any reimbursement or subrogation rights that a state may have by virtue of payment of Medicaid benefits for Expenses covered by the Plan. In addition, the Plan will not consider Medicaid eligibility or medical assistance provided by Medicaid in determining Plan benefits or eligibility.

Subrogation and Reimbursement

Subrogation or reimbursement rules apply if the Fund pays out benefits for you or your covered Dependents related to an accident, Injury, Sickness, or death caused by a third party. Under these circumstances, the Fund is entitled to reimbursement of its expenditures.

Other sources may include, but are not limited to:

- Other benefit plans;
- Insurance company;
- Workers' compensation; or
- Any other third party that is obligated to make payments that the Fund would otherwise be obligated to make.

Whenever the Fund has been or is providing Medical, Hospital, Dental, Vision, or Disability Benefits, as a result of an Injury, Sickness, or death that results in any possible recovery including but not limited to indemnity, compensation, damages, remuneration or restitution from any party (including an insurer), including uninsurance and underinsurance coverage, no-fault insurance, personal injury protection insurance, and workers' compensation benefits, the Fund may make a claim or maintain an action against such party.

By virtue of accepting such benefits as a result of an Injury, Sickness, or death that results in any possible recovery including but not limited to indemnity, compensation, damages, remuneration or restitution from any party (including an insurer), including uninsurance and underinsurance coverage, no-fault insurance, personal injury protection insurance, and workers' compensation benefits, you or your covered Dependents thereby assign to the Fund the right to make a claim against such party to the extent of the amount of such benefits. You or your covered Dependents must not do anything after a loss for which the benefits were provided to prejudice the Fund's right of recovery. You or your covered Dependents must promptly advise the Administrative Manager of this Fund in writing whenever a claim against any party is made by you or on your behalf or on your covered Dependent's behalf with respect to any loss for which benefits were, or are being, received from the Fund.

You or your covered Dependents have 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.

You, your covered Dependents, or the Fund, may make a claim against a party, or commence an action against a party and join the other as provided under Section 803.3 of the Wisconsin Statutes or applicable state or federal law. You, your Dependents, or your attorney must hold any proceeds you recover from a third party in trust for the Fund.

The proceeds from any settlement or judgment in any claim made against any party will be allocated as follows:

- First, a sum sufficient to reimburse the Fund fully for all benefits advanced will be paid to the Fund. No court costs or attorney's fees may be deducted from the Fund's recovery without prior express written consent of the Fund. This right will not be defeated by any so-called "Fund Doctrine," "Common Fund Doctrine," "Attorneys Fund Doctrine," or any other similar doctrine or theory.
- Any remainder will be paid to the recipient of Fund Benefits on whose behalf claim is made.
- The Fund will receive a credit, up to the full amount of any remainder paid to the recipient of benefits pursuant to the prior paragraph, 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.
- The aforesaid allocation of proceeds will be paid from the first dollar of any proceeds received and will have a priority over competing claims regardless of whether the total amount of the recovery for you, or those claiming under you, is less than the actual loss suffered, or less than the amount necessary to make you, or those claiming under you, whole. The Fund's rights

will 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 Expense damages.

- Furthermore, such allocation will apply to claims of you or your Dependents covered by the Fund, regardless of whether such recipient was legally responsible for Expenses of treatment.
- In the event you or your covered Dependent makes a recovery in a claim from any party and the proceeds are not allocated in accordance with the prior paragraphs, the Trustees will 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 you or your covered Dependent, to the extent of the Fund's expenditures, whether the recovery is paid to, or in the possession of, you, your covered Dependent, your attorney, your covered Dependent's attorney, or any other individual or entity, or to take a credit on future Fund obligations to you or your covered Dependent 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 also may be taken against any future obligations to you or your Dependents.

Overpayments and Erroneous Payments

Overpayments or erroneous payments of benefits made to you or your Dependents (or to your or your Dependent's provider) may be recovered by the Fund, including by making deductions or offsets from benefits that may be payable to you or your Dependents in the future. Where appropriate, recovery will also be sought from providers, insurance companies, or other organizations that have received such payment.

Prohibition Against Assignment to Providers

You or your Dependents may not assign any right under the Plan or any statutory right under applicable law to a provider of services or supplies. The prohibition against assignment of these rights includes, but is not limited to:

- You or your Dependent's right to receive benefits;
- You or your Dependent's right to claim benefits in accordance with Plan procedures and/or federal law;
- You or your Dependent's right to start a legal action against the Plan, Trustees, Fund, or its agents or Employees;
- You or your Dependent's right to request Plan Documents or other instruments under which the Plan is established or operated;
- You or your Dependent's right to request any other information that you or your Dependent may be entitled to receive upon written request to the Administrative Manager; and
- Any and all other rights you or your Dependent may be entitled to under the Plan, Restated Trust Agreement, federal law, and state law.

However, the Administrative Manager or the Trustees may continue to mail payments of your or your Dependent's Plan benefits to a provider of services or supplies.

THE PLAN'S USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION (PHI)

For purposes of this section, the Board of Trustees is the Plan Sponsor.

In compliance with the Privacy Rule and the Security Rule contained in the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 and the related regulations found at 45 C.F.R. Parts 160, 162 and 164 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), this section is intended to allow disclosure of Protected Health Information (PHI) including electronic PHI, as defined under HIPAA, to the Board of Trustees. For purposes of this section, the Plan Sponsor is the Board of Trustees (the Trustees).

Generally, PHI, as defined under HIPAA, includes all individually identifiable information related to an individual's past, present or future physical or mental health condition or to payment for health care Expenses. PHI includes information maintained by the Plan in oral, written, or electronic form. PHI does not include information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Electronic PHI (ePHI) refers to PHI that is transmitted by or maintained in electronic media including electronic storage media (such as hard drives, magnetic tapes or disks, optical disks, and digital memory cards) and electronic transmission media (such as the Internet, extranets, leased lines, dial-up lines, private networks, telephone voice response systems and faxback systems, but not paper-to-paper faxes or voicemail messages).

This section applies only to the "health care components" of the Plan as that term is defined in 164 CFR §504 of the Privacy Rule contained in the Administrative Simplification Provisions of HIPAA. Accordingly, all benefits under the Plan other than disability and life insurance are hereby designated as health care components of the Plan.

To the extent that there is any conflict between this section of the Plan and any other Plan provisions, the terms of this section control.

Disclosure of PHI

Notwithstanding anything in the Plan to the contrary, in no event will the Plan be permitted to use or disclose PHI in a manner that is inconsistent with HIPAA.

In accordance with HIPAA, Plan may disclose PHI to the Trustees in the following circumstances:

1. The Plan may disclose PHI to the Trustees when the Plan receives an authorization from you to disclose PHI to the Trustees.
2. The Plan may disclose information to the Trustees on whether you are participating in the Plan, or are enrolled in or have disenrolled from a health insurance plan or HMO (if any) offered as part of the Plan.
3. The Plan may provide summary health information to the Trustees so that the Trustees may solicit premium bids from health insurers for providing health insurance coverage under the Plan, or so that the Trustees may modify, amend or terminate the Plan. Summary health information is information that summarizes the claims history, claims Expenses, or type of claims, from which individual identifiers (other than certain limited geographical information), such as names and social security numbers, have been removed.

Otherwise, the Plan will disclose PHI to the Trustees only to the extent necessary for the Trustees to perform administrative functions on behalf of the Plan. (If the Trustees do not perform such functions, Plan will not disclose PHI to the Trustees other than as indicated above.) Administrative functions include activities that would meet the definition under the HIPAA Privacy Rule of treatment, payment, and health care operations activities. Such activities include, but are not limited to, the following:

1. Review and resolution of claims for benefits and appeals;
2. Determinations with respect to eligibility, coverage and cost sharing;
3. Determining employer contribution rates (or, if applicable, Employee contribution rates);
4. Exercise of subrogation rights;
5. Coordination of benefits;
6. Obtaining payment under a reinsurance contract (such as stop-loss insurance);
7. Utilization review;
8. Quality assessment;
9. Auditing, monitoring, and fraud detection and investigation programs;
10. Cost management;
11. Solicitation of proposals for services to be provided to or on behalf of the Plan; and
12. Related computer and systems programming and development.

Notwithstanding anything to the contrary, in no event will the Trustees be permitted to use or disclose PHI in a manner that is inconsistent with HIPAA. The Plan may also disclose PHI to Business Associates pursuant to the terms of the applicable Business Associate Agreement.

The Plan Sponsor's Certification

Pursuant to amendment of the Plan, the Plan will disclose PHI to the Plan Sponsor only in accordance with the following provisions:

1. **Prohibition on Unauthorized Use or Disclosure of PHI.** The Plan Sponsor will not use or disclose any PHI received from the Plan, except as permitted in the Plan documents or as required by law.
2. **Agents (Including Subcontractors).** The Plan Sponsor will require each of the Plan's agents, including subcontractors, to whom the Plan Sponsor provides PHI that it received from the Plan, to agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information.
3. **Impermissible Purposes.** The Plan Sponsor will not use or disclose PHI for employment-related actions and decisions or in connection with any other of Plan's benefits or employee benefit plans.
4. **Reporting.** The Plan Sponsor will report to the Plan any use or disclosure of PHI, of which it becomes aware, that is inconsistent with the uses and disclosures permitted by the Plan. Specifically, the Plan Sponsor will report to the Plan any Breach as defined by 45 CFR § 164.402.
5. **Access to PHI by Participants.** The Plan Sponsor will make PHI available to the Plan to permit you upon request to inspect and copy your PHI to the extent provided by 45 CFR § 164.524.
6. **Amendment of PHI.** The Plan Sponsor will make your PHI available if you request to amend or correct PHI that is inaccurate or incomplete and will incorporate any amendments to PHI to the extent required and/or permitted by 45 CFR § 164.526.

7. **Accounting of PHI.** The Plan Sponsor will make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528.

8. **Disclosure to the Secretary.** The Plan Sponsor will make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the Department of Health and Human Services or its designee for the purpose of determining the Plan's compliance with HIPAA.

9. **Breach Notification.** Plan Sponsor will cooperate with Plan's efforts to comply with the Breach notification regulations set forth in 45 CFR §§ 164.404, 164.406 and 164.408.

10. **Return or Destruction of PHI.** When the PHI is no longer needed for the purpose for which disclosure was made, the Plan Sponsor must, if feasible, return to the Plan or destroy all PHI that the Plan Sponsor received from the Plan, and retain no copies in any form. If return or destruction is not feasible, the Plan Sponsor agree to limit further uses and disclosures to the purposes that make the return or destruction infeasible.

11. **Adequate Separation.** The Plan Sponsor must ensure that adequate separation exists between the Plan and the Plan Sponsor so that PHI will be used only for plan administration. Only the minimum necessary Employees have access to and may use PHI, but only to the extent necessary to perform the administration functions that are to be performed by the Plan Sponsor as set forth above.

    In the event that any of the Plan Sponsor or its Employees do not comply with the requirements set forth herein, such persons will be subject to disciplinary action for noncompliance, pursuant to the Plan Sponsor's discipline and termination or removal procedures. The Plan Sponsor will take whatever actions necessary to resolve such noncompliance. Regardless of whether a person is disciplined, terminated or removed pursuant to this paragraph, the Plan reserves the right to direct that the Plan Sponsor modify or revoke any person's access to or use of PHI, and the Plan Sponsor will take such action as warranted. Anyone who suspects an improper use or disclosure of PHI may report the occurrence to the Plan's Privacy Officer at the telephone number and address provided in the Plan's notice of privacy practices.

12. **Protection of Electronic PHI.** If electronic PHI is created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor will do the following:

    a. Ensure that the adequate separation, described above, is supported by reasonable and appropriate security measures;

    b. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of such electronic PHI;

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

    d. Report to the Plan any security incident of which it becomes aware. For purposes of this provision, "security incident" is defined as the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

Notwithstanding the above, if the only ePHI that is disclosed to the Plan Sponsor is disclosed pursuant to a HIPAA-compliant authorization or is limited to summary health information (as defined in the Privacy Rule) disclosed for the purpose either of obtaining premium bids for providing health insurance coverage under the Plan, or modifying, amending or terminating the Plan, and information regarding your participation, enrollment or disenrollment, the requirements of this subsection regarding e-PHI do not apply.

ADMINISTRATIVE INFORMATION

This section provides general information about the Plan.

Plan Name

Wisconsin Laborers' Health Fund

Board of Trustees

A Board of Trustees is responsible for the operation of this Plan. The Board of Trustees consists of Employer and Union representatives, selected by the Employers and Union that have entered into collective bargaining agreements that relate to this Plan. These collective bargaining agreements are described below. If you wish to contact the Board of Trustees, you may do so by calling or writing the Administrative Manager at the address below:

BeneSys, Inc.
Administrative Manager
Wisconsin Laborers' Health Fund
4633 Liuna Way, Suite 201
DeForest, Wisconsin 53532-2514
Telephone: 608-846-1742
Toll-Free: 800-397-3373

The Board of Trustees is listed on the inside front cover of this booklet.

Plan Sponsor and Plan Administrator

The Board of Trustees is the Plan Sponsor and Plan Administrator. However, the Trustees have delegated an Administrative Manager to perform various administrative duties for the Fund.

Plan Numbers

The Plan number is 501.

The Employer Identification Number (EIN), assigned to the Board of Trustees by the Internal Revenue Service, is 23-7009055.

Together, the Plan's name and number, and the Trustees' EIN identify the Plan with government agencies.

Agent for Service of Legal Process

Tracy Suber
Administrative Manager
Wisconsin Laborers' Health Fund
4633 Liuna Way, Suite 201
DeForest, Wisconsin 53532-2514

Service of legal process also may be made upon the Board of Trustees or on any individual Trustee at the address of the Wisconsin Laborers' Health Fund.

Source of Contributions

Employers make contributions to the Fund in accordance with their collective bargaining agreements with participating local Unions of the Laborers International Union of North America and Operative Plasterers' and Cement Masons' International Association.

The Fund Office will provide you, upon written request, information as to whether a particular Employer is contributing to this Fund on behalf of participants working under a collective bargaining agreement.

nation of the procedures for appealing claim decisions.

Amendment or Termination of the Plan

The Trustees reserve the right to amend or terminate the Plan if, in their sole and broad discretion, such amendment or termination is necessary to maintain a sound and economical program of benefits within the limits of the funds available to them. The Trustees reserve the right to:

- 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 will retroactively reduce benefit entitlement or benefit levels then in effect; and/or
- Alter the method of payment of any benefit; and/or
- Amend any other provisions of the Plan; and/or
- Interpret the provisions of the Plan.

The Trustees or the Trustees' delegate have the sole and absolute discretion to amend or terminate the Plan and their decisions are 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. The decisions of the Trustees or the Trustees' delegate will be granted judicial deference to the extent that the decision does not constitute an abuse of discretion.

You will be notified in writing of any Plan amendment that is adopted pursuant to the terms of the Trust Agreement governing the Plan.

If the Plan is terminated, benefits for covered Expenses incurred before the termination date will be paid on your behalf 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.

Benefits Are Not Vested

Your participation in the Plan does not constitute a guarantee of employment. In addition, benefits under the Plan are not vested and may be amended or terminated by the Trustees.

ERISA Rights

As a participant in the Wisconsin Laborers' Health Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to the following rights.

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and Union halls, all documents governing the Plan, including insurance contracts, your collective bargaining agreement, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public

Disclosure Room of the Employee Benefits Security Administration (EBSA);

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, your collective bargaining agreement, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description (the Plan Administrator may make a reasonable charge for the copies); and
- Receive a summary of the Plan's annual financial report, which the Plan Administrator is required by law to furnish to each participant.

Continue Group Health Plan Coverage

You also have the right to continue healthcare coverage for yourself, Spouse, Domestic Partner, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. (You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the other documents governing the Plan on the rules governing your COBRA continuation coverage rights.)

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures.

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the EBSA at:

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

For more information on your rights and responsibilities under ERISA or for a list of EBSA offices, contact EBSA by:

- Calling 866-444-3272;
- Sending electronic inquires to **www.askebsa.dol.gov**; or
- Visiting the website of the EBSA at **www.dol.gov/ebsa**.

DEFINITIONS

Many of the following defined terms have been capitalized throughout this booklet for your ease in identification.

Administrative Manager

The individual or company designated by the Trustees according to the Trust Agreement to perform any and all necessary and proper Plan administration duties.

Allowable Charge

Allowable Charge means:

- With respect to an in-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.
- With respect to an out-of-network provider, the Allowable Charge is defined as the median amount charged by a licensed Physician or other professional provider for a given service 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, as determined by reference to the 50th percentile of the FAIRhealth database for non-network service providers.
- Under no circumstances shall the Plan pay an Allowable Charge for non-network services or supplies that are determined by any provider, facility, or other person or organization other than the Board of Trustees.
- With regard to Medicare, the Medicare Act limits the amount that Physicians can bill Medicare patients above the Medicare allowance for a particular procedure or service. Neither the Medicare patient covered by the Plan nor the Plan will be responsible for paying any charges that exceed such legal limits or the limiting charge under the law.

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. Such facilities must be reviewed and approved by the appropriate state's Board of Health or similar agency to provide medical treatment.

Board of Trustees or 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, are the administrator of this Plan as that term is used in the Employee Retirement Income Security Act of 1974.

Certified Disability

A disability for which an Employee receives the Fund's Weekly Accident and Sickness Benefit or submits evidence that he or she receives weekly workers' compensation benefits.

Contributing Employer or Employer

An Employer who, according to the terms of a collective bargaining agreement or other agreement, agrees to contribute to the Wisconsin Laborers' Health Fund on behalf of its Employees.

Cosmetic Surgery or Reconstructive Surgery

A surgical procedure performed primarily to:

- Improve physical appearance;
- Change or restore bodily form without materially correcting a malfunction; or
- Prevent or treat a mental or nervous disorder through a change in bodily form.

Covered Work

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

Custodial Care

Care designed to help a disabled Person with daily living activities when:

- There is no plan of active medical treatment to reduce the disability; or
- The plan of active medical treatment cannot be reasonably expected to reduce the disability.

Dentist

A holder of a certificate or license issued by a governmental body authorizing such holder or licensee to perform the particular dental service. For purposes of this definition, Dentist includes oral Surgeons.

Dependent

An individual who is your:

- Spouse (including same-sex Spouse) or Domestic Partner who qualifies as a dependent under Section 152 of the Internal Revenue Code. (When both you and your Spouse or Domestic Partner are covered as Employees under this Plan, each of you will be covered as both an Employee and a Dependent when coordinating benefits.); and
- Child who is your natural-born child, legally adopted child, child placed with you for adoption, stepchild or foster child and who is:
  - Less than 26 years of age; or
  - Any age provided the child is unmarried, totally and permanently disabled (as defined in Internal Revenue Code Section 22(e)(3)) at any time during the calendar year, has the same principal residence as you for more than one-half of the calendar year, and depends upon you for more than one-half of their support and maintenance. The child must have become totally and permanently disabled before age 26. The 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. Coverage for such a child will continue as long as you remain eligible and the child remains disabled. Proof of disability must be submitted within 31 days of the date the Dependent's coverage would otherwise end and from time to time thereafter as requested by the Trustees.
- Unmarried child for whom you have legal guardianship if the child is younger than age 26, has the same principal place of residence as you for more than one-half of the calendar year, is dependent on you for more than one-half of his or her support for the calendar year, and is a U.S. citizen or national.
- Unmarried child for whom you have legal guardianship, or unmarried disabled child who has reached age 26, who does not live with you, provided that:
  - 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;
  - The child's parents provide over one-half of the child's support; and

Your "Spouse" is your lawful Spouse under Wisconsin or any other state law, or the law of another country.

- 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.

- Unmarried child who is named as an alternate recipient in a Qualified Medical Child Support Order (QMCSO) approved by the Trustees.
- Unmarried grandchild who has the same principal place of residence as you do for more than one-half of the calendar year, is dependent on you for more than one-half of his or her support for the calendar year, and is a U.S. citizen or national, if the parent of the grandchild meets the definition of an eligible Dependent child under the Plan and is younger than age 18.

Coverage will end for a Dependent child or other Dependent (i.e., stepchild or foster child) at the end of the month in which the Dependent child or other Dependent turns age 26, with the exception of a child who was disabled prior to age 26 and is considered physically or mentally handicapped.

If both you and your Spouse or Domestic Partner are covered as Employees under this Plan, your children will be covered as Dependents of both you and your Spouse or Domestic Partner for purposes of coordinating benefits.

Diabetes Education Program

A program of instruction provided by a Physician, registered nurse, licensed pharmacist, dietician, or other health professional to teach diabetic patients and their families to:

- Understand the diabetic disease process;
- Manage the daily diabetic therapy; and
- Avoid frequent Hospital confinement and/or complications.

Such program must meet any standards the state uses to certify or approve such programs. Diabetes Outpatient Self-Management Education Programs do not include programs that are mainly for the purpose of weight reduction.

Domestic Partner

Generally, your Domestic Partner may be a person of the same or opposite sex. With the exception of tax treatment, your Domestic Partner has the same rights as a Spouse under the Plan and your Domestic Partner's children will be considered your Dependent children.

Opposite sex Domestic Partners are only entitled to these benefits and rights if the partnership is established in Dane county, or have followed the procedures for registration of your opposite sex Domestic Partnership in the state, city or county where you reside. Your Domestic Partner is eligible for Plan coverage if you and your Domestic Partner:

- Are of legal age to marry in the state where you both reside;
- Are not related to each other by blood to the extent that it would otherwise prohibit you from legally marrying in the State where you both reside;
- Have completed the State of Wisconsin, or if applicable, Dane County, Declaration Process for your Domestic Partnership, or have followed the procedures for registration of your Domestic Partnership in the state, city or county where you reside;
- Are not married to anyone else or in another Domestic Partnership; and
- Complete and submit to the Plan as proof of your Domestic Partnership a state, city or county Declaration of Domestic Partnership.
- Agree to pay your portion of the Federal Insurance Contributions Act (FICA) tax or any other employment tax due because of the provision of benefits to Domestic Partners.

You must notify the Plan when your Domestic Partnership ends. Your Domestic Partner will be eligible for COBRA continuation coverage.

Emergency Care

Emergency Care is Medical and Dental 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:

- The patient's health being placed in serious jeopardy;
- Bodily function being seriously impaired; or
- Serious dysfunction of a bodily organ or part.

Dental Emergency Care includes only events that require the patient to go to the Emergency Room on weeknights, weekends or holidays. You will still have to pay the ER deductible, major medical deductible, and the coinsurance.

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.

All Emergency Care obtained by participants will be processed as in-network medical benefits, regardless of the network status of the facility and attending Physician, and will be subject to coinsurance, the Emergency Room Deductible, and the Calendar Year Deductible as provided in the applicable *Schedule of Benefits*.

Employee

An individual:

- Represented by the Union and working for an Employer that is required to make contributions to the Trust Fund on his or her behalf;
- That is 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;
- Working for a Contributing Employer that is required to make payments or contributions to the Trust Fund at the rate fixed for contributions for other Employers;
- Employed by the Trust Fund;
- Represented by or under the jurisdiction of the Union, employed by a governmental unit or agency, and on whose behalf payment of contributions are made at the rate fixed for contributions for other Employers in accordance with a written agreement, ordinance, or resolution, including an individual who has been so employed and who is temporarily making self-payments under rules established by the Trustees;
- That is a non-bargained Employee of the Union or an Employer if the:
  - Union or Employer has signed a participation agreement with the Fund and has applied for welfare coverage for all non-bargained Employees; and
  - Employee works 25 or more hours per week; and
- An alumni Employee employed by the Union or for an Employer who has signed a participation agreement with the Fund, was previously covered by a collective bargaining agreement that provided for contributions to this Fund, and meets the Plan's special eligibility rules for alumni Employees.

Expense

Charges incurred for a covered service or supply ordered or prescribed by a Physician or Surgeon. An Expense is considered incurred on the date the service or supply is received. Expense does not include any charges for services or supplies that are:

- Not Medically Necessary (as defined by the Plan); or
- In excess of the Allowable Charge for such services or supplies.

Experimental or Investigative

A service, procedure, drug, device, or treatment modality for a specific diagnosis is Experimental or Investigative if:

The Trustees have the authority to determine 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 modality does not, in itself, make it eligible for payment.

- 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 body;
- Reliable evidence does not establish 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;
- The service, procedure, drug, device, treatment modality, or the patient informed consent document utilized with the service, procedure, drug, device, or treatment modality 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;
- Reliable evidence shows that the service, procedure, drug, device, treatment modality is the subject of ongoing phase I or phase II clinical trials; is the research, experimental, study, or investigational arm of ongoing phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis; or
- Reliable evidence shows that the prevailing opinion among experts regarding the service, procedure, drug, device, or treatment modality is that further studies or clinical trials are needed to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence means 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 of another facility studying substantially the same service, procedure, drug, device, or treatment modality; or the written informed consent used by the treating facility or by another facility studying substantially the same service, procedure, drug, device, or treatment modality.

Fund or Health Fund

The entire Trust estate of the 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, Employer's contributions and any and all other assets, property, or money received by or held by the Trustees for the use and purposes of this Trust.

Home Health Care

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

- By a Home Health Care Agency,
- In the Eligible Person's home, and
- In accordance with the Home Health Care Plan.

Home Health Care Agency

A public or private agency that:

- Is certified under the Social Security Act; or
- Is licensed under state law or approved by the state or local agency responsible for licensing home healthcare agencies; and
- Is a state-certified rehabilitation agency.

Home Health Care Plan

A program for care and treatment for a 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 that a longer interval between reviews is sufficient, 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 the necessary care and treatment are not available from the Person's immediate family or other persons residing with the Person without causing undue hardship. If the Person was hospitalized immediately prior to the start 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.

Hospice Care Agency

A Hospice Care Agency means a licensed agency or organization that:

- Keeps a medical record of each patient;
- Has hospice care available 24 hours a day, seven days a week;
- Provides skilled nursing services, medical social services, and psychological and dietary counseling primarily in a home setting using a hospice team;
- 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; and
- Has established policies governing the provision of hospice care.

Hospice Care Program

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

- Is established and periodically reviewed by a Physician attending the Terminally Ill Person or family participant and appropriate personnel of a Hospice Care Agency;
- Is designed to provide palliative and supportive care to Terminally Ill Persons and supportive care to their families; and
- Includes an assessment of the Terminally Ill Person's or family participant's medical and social needs and a description of the care to be rendered to meet those needs.

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

Hospital

A place that:

- Is licensed as a hospital (if licensing is required by law);
- Is operated for the care and treatment of resident inpatients; and
- 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 does the term "hospital" include an institution or that part of an institution principally used as a clinic, convalescent home, rest home, nursing home, home for drug addicts or alcoholics, rehabilitation hospital, or inpatient rehabilitation center.

For mental and nervous disorder treatment, a "hospital" also includes a place that has accommodations for resident bed patients, facilities for mental and nervous disorders treatment, a resident psychiatrist always on duty, and, as a regular practice, charges the patient for the Expense of confinement.

For alcoholism, chemical dependency, or drug addiction treatment (other than for non-residential treatment), a "hospital" also includes 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.

Injury

A bodily Injury that requires treatment by a Physician. It must result in a loss unconnected with a Sickness or other causes.

Medically Necessary or Medical Necessity

For purposes of this Plan, to be "Medically Necessary," a service or supply must be:

- Consistent with the symptoms, diagnosis, or treatment of the Person's Injury or Sickness;
- Appropriate with regard to accepted standards of good medical practice and recognized by an established medical society in the United States;
- Not primarily for the patient's convenience or that of the Physician, other licensed healthcare practitioner, or the facility at which treatment is received;
- It is not "Experimental or Investigative" as defined by this Plan; and
- Given as an inpatient only when the service cannot reasonably be provided on an outpatient basis.

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

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).

Morbid Obesity or Morbidly Obese

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

- 40; or
- 35 in conjunction with any of the following severe, diagnosed co-morbidities:
  - Coronary heart disease;
  - Type 2 diabetes mellitus;
  - Clinically significant obstructive sleep apnea; or
  - High blood pressure/hypertension (BP > 140 mmHg systolic and/or 90 mmHg diastolic).

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 website (**www.nhlbisupport.com/bmi**). For example, a person who weighs 200 pounds and is 70 inches (5'10") would have their BMI calculated as 200 ÷ 702 x 703 = 28.7 BMI.

Occurrence

With regard to mental health and substance abuse treatment, an Occurrence is measured as a continuous period of inpatient treatment in a Hospital. Treatment will be considered a new Occurrence if the eligible Person has been discharged from treatment or voluntarily discontinues treatment and is later readmitted to a Hospital for treatment.

Oral Surgery

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

Outpatient Services or Outpatient Care

With regard to mental health and substance abuse treatment, Outpatient Services or Outpatient Care means nonresidential services provided to a 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.

Outpatient Treatment Facility

With regard to mental health and substance abuse treatment, Outpatient Treatment Facility means a facility that is licensed and approved as such by the Wisconsin Department of Health and Social Services, or the applicable state licensing authority, and that provides Outpatient Services for the prevention and treatment of, but not limited to, mental and nervous disorders and alcohol, chemical and drug dependency.

Person

An active Employee, retired Employee, or a Dependent of an active or retired Employee, including Employees and their Dependents covered under the Bare Bones Plan.

Plan or Health Plan

The Plan Document adopted by the Trustees of the Wisconsin Laborers' Health Fund and as thereafter amended.

Physician or Surgeon

An individual licensed to prescribe and administer all drugs and to perform all surgery or any other licensed practitioner practicing within the scope of their license and performing services that would be payable under the Plan if performed by a Physician or Surgeon. For purposes of this definition of Physician or Surgeon, Dentists and oral surgeons are excluded.

Residential Treatment Facility

With regard to mental health and substance abuse treatment, a Residential Treatment Facility is 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 the Plan, a facility must be licensed as a Residential Treatment Facility (licensure requirements for this residential level of care may vary by state).

Sickness

A disease, disorder, or condition (including pregnancy) that requires treatment by a Physician.

Skilled Nursing Care Facility

An institution or that part of any institution that operates to provide Medically Necessary skilled nursing care or rehabilitation to patients on an inpatient basis. A Skilled Nursing Care Facility provides:

- Full-time supervision by at least one Physician or registered nurse;
- 24-hour nursing service by licensed professional nurses, and at least one registered professional nurse employed full time;
- Complete medical records for each patient; and
- Utilization review plans for all patients.

A Skilled Nursing Care Facility must also have:

- Policies that are developed with the advice of a group of professional personnel;
- Medical staff responsible for the execution of such policies;
- A requirement that the healthcare of every patient be under the supervision of a Physician or Surgeon;
- A Physician or Surgeon available to provide necessary medical care in case of emergency;
- Appropriate methods and procedures for the dispensing and administering of drugs and biologicals; and
- A license from any state or local law when required.

Spouse

A legal Spouse, which includes same-sex Spouses.

Subrogation or Reimbursement

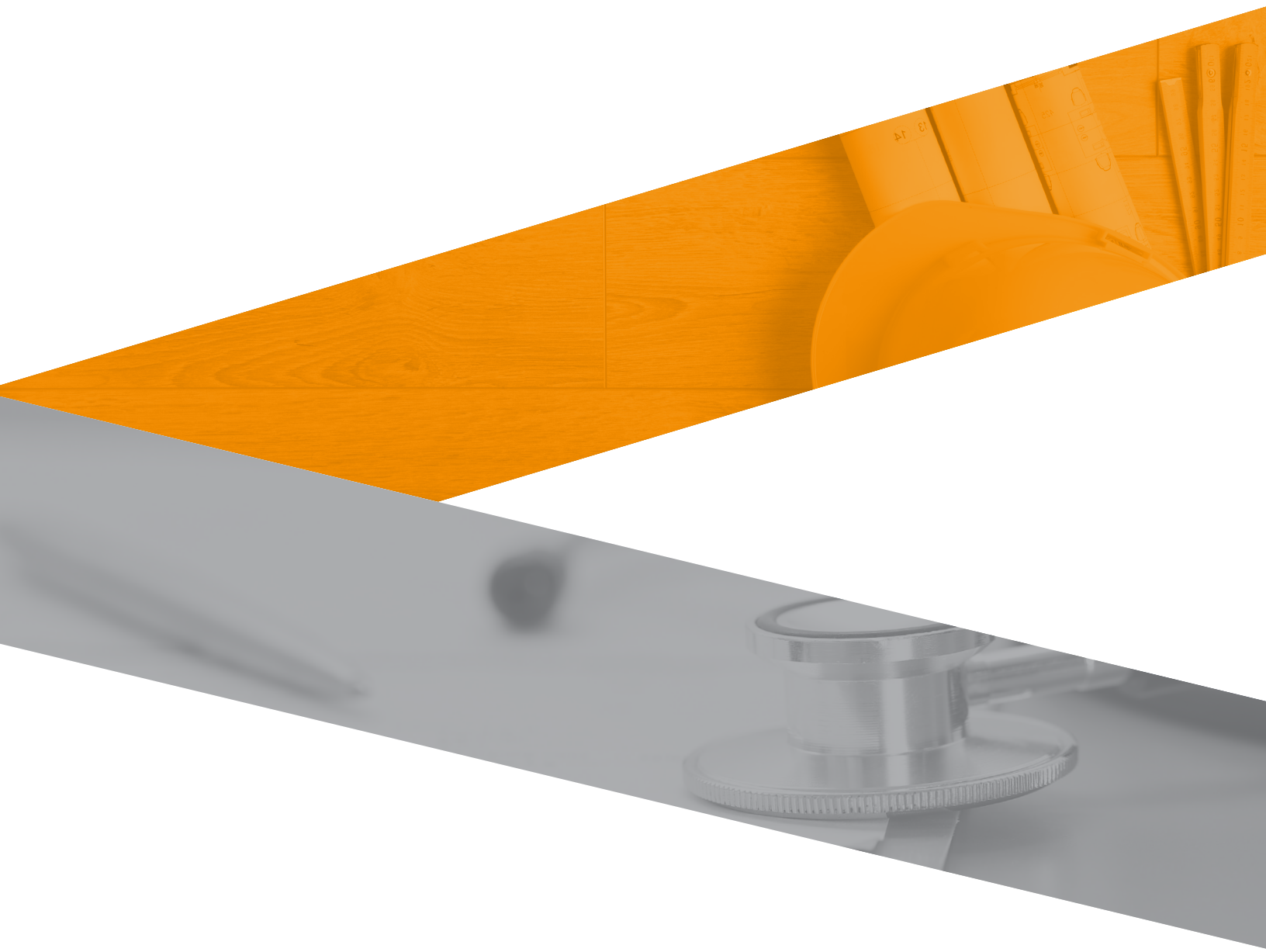
The Fund's right to recover Plan benefits from another party, the participant, or a Dependent of the participant.

Terminally Ill Person

An individual whose medical records indicate a life expectancy of six months or less.

Union

Any Wisconsin local Union affiliated with the Laborers International Union of North America or Operative Plasterers' and Cement Masons' International Association.



LiUNA!

Feel the Power