CARPENTERS LOCAL NO. 491

HEALTH AND WELFARE PLAN

SUMMARY PLAN DESCRIPTION

July 2020

SUMMARY PLAN DESCRIPTION

OF THE

CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE PLAN

As Amended and Restated Effective as of January 1, 2014
As most recently amended effective April 1, 2020
Reprinted July 2020

CARPENTERS LOCAL NO. 491

HEALTH AND WELFARE PLAN

BOARD OF TRUSTEES
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For Vision, Dental, Death, or Disability Benefits Information or Claim Forms Call or Write:

Associated Administrators, LLC
911 Ridgebrook Road
Sparks, MD 21152-9451
Telephone: (888) 494-4443

For Medical Benefits Information or Claim Forms Call or Write:

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Eagan, MN 55121
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To All Covered Participants and Dependents:

The Carpenters Local No. 491 Health and Welfare Plan (the "Plan") was amended and restated previously, in part in order to comply with certain new laws, including the Patient Protection and Affordable Care Act ("PPACA") and the Health Care and Education Reconciliation Act of 2010 (the "Reconciliation Act"), and to continue to provide certain specified welfare benefits, for its eligible employees and their dependents. The Plan was amended and restated, effective January 1, 2014, to comply with the PPACA and the Reconciliation Act as well as to increase the deductible and coinsurance amounts and to remove grandfathered status. The Plan has been most recently amended effective April 1, 2020. The Plan intends to comply with the PPACA and the Reconciliation Act as a good faith compliance with such law.

The Plan is a self-funded plan and the administration is provided through a third-party Contract Administrator (referred to as the "Administrator"). Medical benefits and claims are administered by Independence Administrators. Vision, dental, death, and disability benefits and claims are administered by Associated Administrators. The funding for the benefits is derived from the funds of participating employers and contributions made by covered participants. The Plan is not insured. We have prepared this booklet to advise you of the benefits provided to eligible participants, retirees, and their dependents under the Plan. This booklet explains your benefits in a brief and simple way - how you become eligible, what benefits are provided, how to submit a claim, and how you may lose your eligibility. YOU MUST BE ELIGIBLE FOR BENEFITS BEFORE YOU CAN CLAIM THEM. Please read this booklet carefully so you know how the Plan can help you.

The Plan provides coverage for certain hospital, surgical, medical, and diagnostic expenses as well as prescription, vision, dental, death, accidental death and dismemberment, mental health, substance abuse and weekly disability benefits. It should be noted

that if you are injured while at your place of work or require medical care as a result of your employment, you should obtain care through the arrangements provided by your employer under workers' compensation laws.

This booklet is just a summary of plan provisions; it is not the governing instrument. It does not contain the detailed Agreement and Declaration of Trust, other plan documents under which the Plan is established and maintained, or the related Collective Bargaining Agreement, all of which govern the operation and administration of this Plan. The Plan must be interpreted in accordance with these documents which are available for your inspection at the Office of the Administrator. Whenever there is a conflict between this booklet and the formal plan documents, the documents will be controlling.

We urge you to read your Plan booklet carefully so that you are familiar with the benefits to which you are entitled and the Plan's eligibility requirements. We hope that you share our pride in your Plan and the measure of security it provides to those who work in the industry.

Sincerely,

BOARD OF TRUSTEES

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BENEFITS FOR ACTIVE PARTICIPANTS WHO SATISFY THE ELIGIBILITY REQUIREMENTS FOR FULL COVERAGE

Eligible Active Participants

Death Benefit	Up to $5,000
Accidental Death and Dismemberment Benefit	Up to $5,000
Weekly Accident and Sickness Benefit	$300

Eligible Active Participants and Eligible Dependents

Health Care Benefits

Deductible (per calendar year, combined annual deductible on all medical, surgical, mental health and substance abuse disorder benefits)

- Per exhibitor employee..... $250
- Per shop employee $500
- Per family (where employee works for an exhibitor)..... $500
- Per family (where employee works for a shop)..... $1,000

Coinsurance

- after deductible, Plan pays 80% up to a participant out-of-pocket maximum of $6,600 ($3,600 for medical and $3,000 for prescription) per individual per year where the employee works for an exhibitor and a maximum of $6,850 ($3,850 for medical and $3,000 for prescription) per individual per year where the employee works for a shop or $13,200 ($7,200 for medical and $6,000 for prescription) per family per year where the employee works for an exhibitor and $13,700 ($7,700 for medical and $6,000 for prescription) where the employee works for a shop, if applicable

Co-payment

- Non-Preventive Care Doctor Visits: $25.00 copayment for each doctor visit, which applies towards the out-of-pocket maximum (coinsurance limits)

Prescription Drugs

- Paid in Full, after a $5.00 co-payment for generic drugs for a 30-day supply
- $10 co-payment for generic drugs for a 90-day supply
- 25% co-payment for brand drugs. Maximum of $75.00 for a 30-day supply. Maximum of $150.00 for a 90-day supply
- 40% co-payment for compound drugs and non-formulary brand drugs
- There is a mandatory mail order for maintenance drugs. Three prescription fills are allowed at a pharmacy and the fourth fill must be through mail order. Maintenance drugs through mail order are for a three month supply for the price of two co-payments.

Vision Benefits (per person)

- 80% of incurred charges up to $250 per calendar year (annual maximum not applicable to vision benefits for children, however, vision benefits are limited to one eye examination and one pair of glasses per year per eligible child)

Dental Benefits

- up to $1,500 per person per calendar year (annual maximum not applicable to dental benefits for children)

Orthodontia Benefits

- $1,000 per person, per lifetime (lifetime maximum not applicable to orthodontia benefits for children)

Orthodontia Benefits

- $1,000 per eligible child, per year

BENEFITS FOR ACTIVE PARTICIPANTS WHO SATISFY THE ELIGIBILITY REQUIREMENTS FOR PARTIAL COVERAGE

Eligible Active Participants

Death Benefit	Up to $2,500
Accidental Death and Dismemberment Benefit	Up to $2,500

Eligible Active Participants and Eligible Dependents

Health Care Benefits

Deductible (per calendar year, combined annual deductible on all medical, surgical, mental health and substance abuse disorder benefits)

- Per exhibitor employee..... $250
- Per shop employee $500
- Per family (where employee works for an exhibitor)..... $500
- Per family (where employee works for a shop)..... $1,000

Coinsurance

- after deductible, Plan pays 40% up to a participant out-of-pocket maximum of $6,600 per individual, per year, where the employee works for an exhibitor and a maximum of $6,850 per individual, per year, where the employee works for a shop or $13,200 per family, per year, where the employee works for an exhibitor and $13,700 where the employee works for a shop, if applicable.

Co-payment

- Non-Preventive Care Doctor Visits: $25.00 co-payment for each doctor visit, which applies towards the out-of-pocket maximum (coinsurance limits)

BENEFITS FOR EMPLOYEES OF EMPLOYERS WHO ARE COVERED BY A PARTICIPATION AGREEMENT

Eligible Active Participants

Death Benefit	Up to $5,000
Accidental Death and Dismemberment Benefit	Up to $5,000
Weekly Accident and Sickness Benefit	$300

Eligible Active Participants and Eligible Dependents

Health Care Benefits

Deductible (per calendar year, combined annual deductible on all medical, surgical, mental health and substance abuse disorder benefits)

- Per exhibitor employee..... $250
- Per shop employee $500
- Per family (where employee works for an exhibitor)..... $500
- Per family (where employee works for a shop)..... $1,000

Coinsurance

- After deductible, Plan pays 80% up to a participant out-of-pocket maximum of $6,600 ($3,600 for medical and $3,000 for prescription) per individual, per year, where the employee works for an exhibitor and a maximum of $6,850 ($3,850 for medical and $3,000 for prescription) per individual, per year, where the employee works for a shop or $13,200 ($7,200 for medical and $6,000 for prescription) per family, per year, where the employee works for an exhibitor and $13,700 ($7,700 for medical and $6,000 for prescription) where the employee works for a shop, if applicable

Co-payment

- Non-Preventive Care Doctor Visits…….. $25.00

Prescription Drugs

- Paid in Full, after a $20 co-payment for generic drugs for a 30-day supply
- $10 co-payment for generic drugs for a 90-day supply
- 25% co-payment for brand drugs. Maximum of $75.00 for a 30-day supply. Maximum of $150.00 for a 90-day supply
- 40% co-payment for compound drugs and non-formulary brand drugs
- There is a mandatory mail order for maintenance drugs. Three prescription fills are allowed at a pharmacy and the fourth fill must be through mail order. Maintenance drugs through mail order are for a three-month supply for the price of two co-payments.

Vision Benefits (per person)

- 80% of incurred charges up to $250 per calendar year (annual maximum not applicable to vision benefits for children, however, vision benefits are limited to one eye examination and one pair of glasses per year per eligible child)

Dental Benefits

- up to $ 1,500 per person, per calendar year (annual maximum not applicable to dental benefits for children)

Orthodontia Benefits

- 1,000 per person, per lifetime (lifetime maximum not applicable to orthodontia benefits for children)

Orthodontia Benefits

- $1,000 per eligible child, per year

BENEFITS FOR RETIRED PARTICIPANTS

Eligible Retired Participants Under Age 65 (And Their Dependents Under Age 65) Who Continue Coverage Under The Self-Payment Provision

The same benefits are provided to eligible retired participants under age 65 and their dependents under age 65 as for the full coverage benefits for eligible active participants and their dependents except that the Weekly Accident and Sickness Benefits are not provided.

Eligible Retired Participants Age 65 And Over (And Their Dependents Age 65 And Over) Who Continue Under The Self-Payment Provision

The same benefits are provided to eligible retired participants over age 65 and their dependents over age 65 as for the full coverage benefits for eligible active participants and their dependents, except that the Weekly Accident and Sickness Benefits are not provided. In addition, Medicare becomes the primary insurer, with this plan of benefits supplementing Medicare. The Plan does not provide Prescription Drug Benefits to retirees over age 65.

Eligible Retired Participants Who Do Not Self-Pay (No Dependent Coverage)

A death benefit of $1,000 is provided.

ELIGIBILITY

Active Participants

Initial and Continuing Eligibility:

An employee becomes a participant in the Plan upon satisfying the eligibility requirements for benefits under categories of Full or Partial coverage as listed below:

Full Coverage:

In order to become eligible for Full Plan coverage during a coverage quarter (3 months), you must work in covered employment for a participating employer a minimum of 250 hours in the appropriate quarter, 450 hours in two calendar quarters, 700 hours in three calendar quarters, or 950 hours in four calendar quarters as shown in the chart below:

250 Hours Worked During the Period	**OR**	**450 Hours Worked During the Period**	**Eligible Period**
January 1 - March 31		October 1 - March 31	July 1 – September 30
April 1 - June 30		January 1 - June 30	October 1 – December 31
July 1 - September 30		April 1 - September 30	January 1 – March 31
October 1 – December 31		July 1 - December 31	April 1 – June 30
700 Hours Worked During the Period	**OR**	**950 Hours Worked During the Period**	**Eligible Period**
July 1 – March 31		April 1 – March 31	July 1 – September 30
October 1 – June 30		July 1 – June 30	October 1 – December 31
January 1 – September 30		October 1 - September 30	January 1 – March 31
April 1 – December 31		January 1 – December 31	April 1 – June 30

Effective April 1, 2020, if you are an active Employee, you will automatically be eligible for and will continue to receive full coverage on the first day of the April 1, 2020 – June 30, 2020,

Benefit Quarter, provided that you must have been working in covered employment for a participating employer in the October 1, 2019, - December 31, 2019, Work Period and that you have satisfied the required minimum hours worked in the appropriate quarter(s) in accordance with Plan terms.

Additionally, if you are an active Employee, you will automatically continue to receive full coverage in the July 1, 2020, - September 30, 2020, Benefit Quarter, if you were eligible for full coverage in the April 1, 2020, - June 30, 2020, Benefit Quarter, upon the terms stated above.

Partial Coverage:

In order to become eligible for Partial Plan coverage during a coverage quarter (3 months), you must work in covered employment for a participating employer a minimum of 175 hours in the appropriate quarter, or 350 hours in two calendar quarters as shown in the chart below:

175 Hours Worked During the Period	OR	350 Hours Worked During the Period	Eligible Period
January 1 - March 31		October 1 - March 31	July 1 – September 30
April 1 - June 30		January 1 - June 30	October 1 – December 31
July 1 - September 30		April 1 - September 30	January 1 – March 31
October 1 – December 31		July 1 - December 31	April 1 – June 30

Effective April 1, 2020, if you are an active Employee, you will automatically be eligible and will continue to receive partial coverage on the first day of April 1, 2020, - June 30, 2020, Benefit Quarter, provided that you must have been working in covered employment for a participating employer in the October 1, 2019, - December 31, 2019, Work Period and that you have satisfied the required minimum hours worked in the appropriate quarter(s) in accordance with Plan terms.

Additionally, if you are an active Employee, you will automatically continue to receive partial coverage in the July 1, 2020, - September 30, 2020, Benefit Quarter, if you were eligible for partial coverage in the April 1, 2020 – June 30, 2020, Benefit Quarter, upon the terms stated above.

Once an employee is determined to be eligible, the Plan will not impose a waiting period which exceeds 90 days.

Continued Eligibility While Disabled:

In the event a participant becomes **totally disabled** for at least six weeks in an eligibility quarter, upon written request to the Administrator, he will be credited with up to 250 hours for the quarter, provided he had worked at least 1,000 hours in the four eligibility quarters prior to the disability, and was eligible for benefits at the time his disability started. If he remains totally disabled beyond such quarter, he can apply for up to an additional three quarters of coverage by submitting a written request for continued coverage (the last two quarters of coverage require Trustee approval).

To qualify, you must send the Administrator satisfactory proof you cannot work because of a sickness or accident. For a workers' compensation case, the Administrator needs a letter from the commission or the insurance carrier stating the dates that disability was paid.

Termination of Eligibility:

Your coverage under the Plan automatically terminates on the first day of the month following the date on which you cease to satisfy the eligibility requirements for participants as described herein.

Your coverage may be continued after this date, however, under the circumstances described in the sections entitled "CONTINUATION OF COVERAGE" herein.

Military Service:

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), participants who enter military service are entitled to COBRA continuation rights as described herein. If you return to employment covered by this Plan within the time frame specified under the law after discharge from military service, you and your dependents are covered from the first day contributions are made to the Plan on your behalf only if you were eligible for coverage prior to entrance into the military service.

If you enter military service before you are eligible for coverage, you are credited with hours of employment accumulated prior to military service upon resuming employment with a contributing employer.

Dependents

Initial Eligibility:

Your eligible dependents are, except as otherwise provided herein:

- your spouse, until the date of legal separation;
- your children (including "adult children," legally adopted children, foster children and stepchildren) under the age of 26; or
- your unmarried dependent children, age 26 and older, who are incapable of self-sustaining employment because of mental retardation or physical handicap and (1) become incapable before attaining age 26, (2) are chiefly dependent on you for support and maintenance, and (3) furnish proof of such incapacity within 31 days prior to the date the dependent attains age 26.

The Plan does not offer coverage to a child of the dependent child or a spouse of the dependent child.

For your dependents to be eligible for coverage under the Plan, you must be an eligible participant. Coverage for your eligible dependents begins on the latest of:

- the effective date of the Plan;
- the date your coverage becomes effective; or
- the date you acquire the dependent.

In the case of marriage, however, coverage for your spouse begins on the date of your marriage. You must notify the Board of Trustees within 30 days from the date you acquire a new dependent unless there is a reasonable reason why you did not notify within 30 days. The Board of Trustees has the sole and absolute discretion as to the determination of what a reasonable reason is. You may obtain the proper forms from the Administrator.

Adopted/Foster Children:

Coverage for an adopted or foster child of an eligible employee will begin when the child is "placed," determined in accordance with the law, and not when the adoption becomes final. Please notify the Administrator if you intend to adopt a child or have a foster child to receive additional information on the procedures necessary to allow your child to be covered under the Plan.

Qualified Medical Child Support Orders:

The Plan shall recognize State court orders (including administrative) directing an eligible participant to provide health benefit coverage for dependent children even if the eligible participant does not have custody of these children, if a court order is a Qualified Medical Child Support Order ("QMCSO"). If the order is not a QMCSO, then the Plan will not honor the order. As is required by law, the Plan has adopted procedures to determine whether an order is a QMCSO. Participants and beneficiaries may obtain, without charge, a copy of such procedures by request to the Plan Administrator.

Termination of Eligibility:

In general, coverage for your dependent ends when either you or your dependent loses eligibility for coverage. If you lose eligibility, your dependent's coverage ends on the date you become ineligible for coverage. If your dependent ceases to be a dependent as defined by the Plan, his or her coverage terminates on the first day of the month following the date he or she ceases to be an eligible dependent. When your dependent's coverage terminates, no expenses incurred after the date eligibility ceases are payable, even if the condition which required treatment began before the termination of coverage.

In the case of a child who is incapacitated due to a mental or physical handicap, coverage automatically terminates on the earliest of:

- the end of such incapacity;
- the failure to provide required proof of the uninterrupted continuance of such incapacity or to submit to any required examination within 31 days after requested; or
- the termination of dependent coverage for reasons other than reaching the limiting age, as provided in the Plan.

There are exceptions to these rules for dependents who elect to self-pay pursuant to "Continuation of Coverage (COBRA)".

Proof of Dependency:

In cases where eligibility of a dependent cannot be determined by the Administrator through standard enrollment procedures, you may be required to furnish additional proof of dependent status. Some examples of acceptable evidence are the following:

- a certified copy of the dependent's birth certificate;
- a certified copy of legal adoption papers or documents relating to the placement of a child;

- for incapacitated unmarried children age 26 or over, a statement by the dependent's doctor certifying incapacity; and
- a marriage certificate.

Additional Participation Requirements

The Trustees may adopt such additional requirements for participants in the Plan as they shall determine in their sole and absolute discretion.

Retired Participants

Self-Payment Provision

All retirees who retired either under a normal retirement or disability retirement as defined under the Carpenters Local No. 491 Pension Plan shall be entitled to make unlimited self-payments under the terms of the Plan. Such self-payment is for purposes of providing health care (supplementing Medicare once the retiree, or dependent, is Medicare eligible), vision, and dental coverage for retirees and eligible dependents. The Trustees have the right to change or eliminate this provision in the future to the extent they deem appropriate.

Retired participants and spouses over the age of 65 and disabled participants receiving an award from Social Security are entitled to Medicare, a broad federal program of health benefits which includes Hospital Insurance (Part A) and Voluntary Medical Insurance (Part B).

You must enroll and maintain enrollment in the hospital and voluntary medical insurance program of Medicare. Enrollment should be at the earliest opportunity available, since you will be considered to be insured under Part A (Hospitalization) and Part B (Voluntary Medical) of Medicare whether or not you have registered for Part A or enrolled for Part B.

In order for the Plan to avoid payment of benefits in a total amount greater than expenses incurred, benefits will first be paid under

Medicare, and if there are any expenses remaining unpaid, these expenses will be paid up to the maximum amounts payable under the Plan.

Eligibility for Employees of Employers Who are Covered by a Participation Agreement

Effective May 1, 2012, all employees of employers that contribute to the Collective Bargaining Agreement who are covered by a participation agreement shall be eligible for benefits under the Plan if they meet the eligibility requirements described in this section. The employee must be a full-time employee of an employer for which contributions are made by that employer to the Plan pursuant to a written agreement. For these purposes only, a full-time employee shall be an employee who works for that employer at least forty (40) hours per week. (Effective January 1, 2015, a full-time Employee shall be an Employee who works for that employer at least thirty (30) hours per week. Notwithstanding the forgoing, the contribution amounts will always be based on forty (40) hours per week.) Further, payments for such employee must be received by the Plan at least fifteen (15) days prior to the coverage for the next month in an amount equal to such rate as agreed upon by the Plan and that employer pursuant to a written agreement.

For illustrative purposes only, assume the Plan and employer B agreed (pursuant to a written agreement) to a $5.00 per hour contribution rate for employer B's employee, employee C, who works 40 hours per week. In order to have coverage for May for employee C, the Plan must receive employer B's contribution by April 15. The amount of the contribution shall be $5.00 x 40 hours x 52 weeks / 12 months = $866.67.

Further, the self-contribution provisions in this Plan shall not apply to employees covered in this section.

Opting-Out of Health Coverage

If eligible employees and/or their dependents have other group health coverage and therefore do not need health coverage through the Plan, they may suspend coverage and still be able to resume this health coverage at a later date.

Eligible employees may elect to opt-out by submitting a form and suspend coverage for the employees and their dependents, for the employee only, or for the employee's dependents only. Once the employee elects to opt out, he or she cannot re-enroll in the Plan for a minimum of six (6) months. To be eligible to opt-out and resume this coverage later, the employee and/or the employee's dependents must be covered under another group health plan, such as through the employee's spouse's employer.

If the employee elects to suspend coverage, coverage will be suspended as of the first day of the month following receipt of a properly completed form. An employee may resume coverage at any time after having suspended coverage for at least six (6) months. To resume coverage, the employee must file a written application with the Plan Office within 60 (sixty) days following the date the other coverage ends and provide proof of continuous coverage (such as a Certificate of Creditable Coverage) from the other health plan from the date coverage under this Plan was suspended (if proof of continuous coverage is not provided, the employee and/or the employee's dependents will not be eligible for coverage). Beginning January 1, 2015, Certificates of Creditable Coverage may not be required.

Coverage will resume as of the first day of the month after the employee's application for coverage is approved, provided the employee otherwise meets the Plan's eligibility requirements.

SELF-PAYMENT PROVISIONS—ACTIVE PARTICIPANTS

The self-payment rules are as follows:

- In order to be eligible to make a self-payment, you must be eligible in the previous coverage quarter;
- You must work at least 100 hours for the current work quarter in order to be eligible for self-pay;
- If you worked less than 175 hours in that work quarter, you can supplement your hours up to 175 hours by multiplying the current hourly health and welfare contribution rate times the hours that you are short;
- If you were eligible in the previous quarter as a result of hours worked, and if you worked greater than 175 hours in that work quarter, you can supplement your hours up to 250 hours by multiplying the current hourly health and welfare contribution rate times the hours that you are short;
- If you were eligible in the previous quarter as a result of making a COBRA payment, and if you worked greater than 175 hours in that work quarter, you can make a self-payment in the following amount: the COBRA rate less an amount equal to the current hourly health and welfare contribution rate times the hours that you worked;
- In all cases a minimum payment of $25.00 per quarter must be made by you;
- Provided you work at least 175 hours in each work quarter, there is no maximum period of time during which you may make self-payments. If you are working between 100 and 175 hours and making self-payments, you may do so for a maximum of three consecutive quarters;

- You must make payment under the self-payment rules within 30 days after the date of the mailing of the quarterly status report by the Administrator;
- The self-payment quarters are included as part of the maximum period (18 months, 29 months or 36 months as the case may be) when considering COBRA; and
- Beginning January 1, 2017, you can supplement your hours if you worked: (a) 175 hours or more in one calendar quarter, (b) 350 hours or more in two calendar quarters, (c) 525 hours or more in three calendar quarters; or , (d) 700 hours or more in four calendar quarters. If you are not eligible to make a self-contribution under this provision, you may still be eligible to make a self-contribution to maintain medical benefits in effect under the provisions of COBRA.

CONTINUATION OF COVERAGE (COBRA)

You and your dependents may be able to continue your health care coverage temporarily in certain circumstances where coverage would otherwise end. This extended health care coverage is called **"COBRA continuation coverage**," named for the law that sets forth the rules for it. COBRA continuation coverage is identical to the health care coverage provided under this Plan and is available to you and your dependents. However, it does not include death benefits, accidental death and dismemberment benefits, or weekly disability benefits. You must pay the premium for this coverage, not to exceed 102%, as determined by the Administrator. In the event the participant or a dependent is determined to be disabled for Social Security purposes, the cost shall not exceed 150% for the period after the first 18 months.

Maximum Period of Coverage

As a covered participant, you have the right to continue coverage for yourself and your spouse and dependent children for 18 months if it otherwise would end because of the following:

- You leave covered employment for reasons other than gross misconduct on your part; or
- Your hours of employment are reduced.

If you lose coverage for any one of the above reasons and you and/or one of your dependents becomes disabled (as determined by Social Security) at any time during the first 60 days of the continuation coverage, you have the right to continue coverage for the disabled individual(s) for a maximum of 29 months. This extension only applies if you notify the Plan within 60 days of the determination by Social Security and before the 18-month maximum coverage period expires. 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 continuation coverage. This special 11-month extension does not apply to non-disabled dependents.

Your spouse and dependent children also may continue health care coverage for themselves for 36 months if their health coverage otherwise would end as a result of:

- your death;
- your divorce or legal separation;
- your becoming entitled to (that is covered by) Medicare;
- for a dependent child, no longer qualifying as a dependent under this Plan; or
- your employer filing for reorganization under Chapter 11 of the Bankruptcy Code.

Even if two or more of the events just described occur, the maximum period of COBRA continuation coverage for your spouse and dependent children is 36 months.

Note: If you were enrolled in Medicare prior to your termination of employment or reduction in hours, your dependents may be eligible to continue coverage for up to 36 months after the date on which you become entitled to Medicare, or 18 months (29 months if there is a disability extension) from the date your coverage ceased, whichever is later.

Notification Requirements

You or your dependent must inform the Administrator in writing of a divorce, legal separation or loss of dependent status of a child within 60 days after the event occurs. Your employer must notify the Administrator of your death, termination of employment or reduction in hours within 30 days after such event occurs.

Within 14 days of receipt of notice that a qualifying event has occurred, the Administrator will notify you and any eligible dependents, including those not living with you (whose address is

known to the Administrator), of the right to elect COBRA continuation coverage. The Administrator also will provide instructions about how to elect and pay for COBRA continuation coverage.

Election of Continuation Coverage

To elect COBRA continuation coverage, you must complete an election form (provided by the Administrator) and submit it to the Administrator within 60 days of the later of the date coverage would be lost as a result of the event or the date of the notice sent to you by the Administrator of your right to elect COBRA continuation coverage.

Payment of Continuation Coverage

Timely payment of the initial premium is 45 days after the election is made, and every 30 days after that.

Termination of Continuation Coverage

Your COBRA continuation coverage may terminate earlier than the maximum period described above if:

- all health care coverage offered by the Plan terminates;
- the required premium is not paid on time;
- for each person, he or she becomes covered by another group plan (after the date of election) that does not contain any exclusion or limitation with respect to any pre-existing condition (or the exclusion or limitation does not apply to or would be satisfied by, the participant because of HIPAA rules);
- for each person, he or she becomes entitled to Medicare; or
- an individual who receives extended coverage for up to 29 months due to disability, has been determined for Social Security purposes to be no longer disabled.

You or one of your eligible dependents may be eligible to continue COBRA continuation coverage with another group coverage if your other group plan has a limitation or exclusion, which applies to pre-existing conditions for you and/or other enrolled dependents. Only the person who is affected by the limitation or exclusion remains eligible to continue coverage until the maximum COBRA continuation coverage period (18 or 36 months, whichever is applicable) has expired. Once COBRA continuation coverage terminates, it cannot be reinstated.

PLAN PARTICIPANT BENEFITS

(EMPLOYEE PARTICIPANTS ONLY—NO DEPENDENT COVERAGE)

Death Benefits

When you die, the beneficiary named by you will receive the full amount of your death benefit when proof of your death is received by the Administrator. Your beneficiary is the person you want to receive your benefits when you die. You may name anyone as your beneficiary, but you must have his or her name on file with the Administrator, as stated on the most recent enrollment form. If you do not name a beneficiary, your benefits will be paid to the first living person as follows:

- your legal spouse
- your children
- your parents
- your brothers and sisters
- executors and administrators

If your named beneficiary shows proof that they have paid for your funeral expenses, the Plan will reimburse that individual, or funeral service provider, up to $1,000, which is then deducted from the total benefit amount payable.
If you are eligible in the coverage quarter in which your death occurs, your beneficiary will be paid a death benefit.

Accidental Death and Dismemberment Benefits

In addition to your death benefit, your Plan provides an equal amount of accidental death and dismemberment (AD&D) coverage.

If you die as the result of an accident, not related to your work and not occurring while moonlighting, your beneficiary will receive an additional benefit equal to your death benefit. AD&D benefits will

not be paid in case of any of the Plan limits explained under the section labeled “General Limitations and Exclusions.”

For purposes of the Plan, an accident shall mean an unexpected and sudden event which is not foreseen.

If you lose a limb, or your sight, within 90 days of an accident (as a direct result of said accident) dismemberment benefits will be paid to you as follows:

The full amount of AD&D benefits will be paid if you lose any of the following:

- your life;
- two limbs;
- sight of both eyes; or
- one limb and sight of one eye.

You will receive one half of AD&D benefits if you lose either:

- one limb; or
- sight of one eye.

No payment will be made for death or dismemberment which is caused by or results from intentional self-destruction or intentionally self-inflicted injury, or is sustained as the result, directly or indirectly, of insurrection, war or any act of war, or of travel or flight in any type of aircraft except as a fare-paying passenger on a licensed aircraft piloted by a licensed passenger pilot on a scheduled air service regularly offered between specified airports.

There are no AD&D benefits if you are eligible by reason of self-payments.

Other Special Death Benefits

Funeral Expenses and Last Illness of a Spouse:

The Plan shall pay to each eligible participant whose spouse shall die in a coverage quarter during which such eligible participant is eligible for full benefits, $1,000 to cover funeral expenses and the expenses of last illness, provided, however, that such participant shall prove that he has actually incurred such funeral expenses.

Death Benefits in the Event of Total and Permanent Disability:

Under 60 Years Old:

If an eligible participant is less than 60 years old while covered for death benefits, and becomes permanently and totally disabled, his death benefit will be continued without cost, provided (1) he has been continuously eligible for at least one year preceding the date of total permanent disability, (2) he makes the necessary application in writing within one year immediately following the date of total permanent disability, and (3) each year thereafter he submits a doctor's certificate of continuing permanent and total disability.

60 Years Old or Older:

If an eligible participant 60 years or older becomes permanently and totally disabled during a coverage quarter in which he is eligible for benefits, and if the worker has been continuously eligible for at least one year preceding the date of total permanent disability, the Plan shall thereafter assume liability for a death benefit in the amount of $500 on the life of such worker, starting when the death benefit to which he was entitled under the Plan expires, provided that each year thereafter, such worker submits a medical doctor's certificate of continuing permanent and total disability.

Weekly Accident and Sickness Benefits
(ALSO CALLED NON-OCCUPATIONAL "LOSS-OF-TIME" OR "WEEKLY DISABILITY")

How To Receive Benefits:

This benefit is payable to you while you are under the care of a doctor which includes medical doctors (M.D.s), podiatrists (D.P.M.s), osteopaths (D.O.s), optometrists (O.D.s) and doctors of dental medicine (D.M.D.s or D.D.S.s), to the extent practicing within the scope of their license.

If you are injured on the job, or while moonlighting, you must contact your employer, as the Plan does not cover work-related injuries. If you are injured off the job, payment is made from the first day, if your disability is the result of an illness, you are paid from the eighth day (unless you are hospitalized for three (3) or more days, at which time payment will commence from the first day).

Perhaps the greatest area of difficulty is caused by what may be termed an "estimated duration". Often a member will see his doctor for an ailment, such as the flu and he will be told to remain home for two weeks without a return visit. Unfortunately, this is an "estimated period" and the Plan does not make payment. There must be at least two visits, the first for certification and the last for release. Long term disability operates in the same manner and checks are paid from visit to visit. However, in the case of long term disability, you must submit a form which indicates a medical visit at least once every three weeks.

Certain key items on the doctor form must be completed in order to properly apply for weekly disability.

<u>Important Notes:</u>

- Since the Plan pays disability from the first to the last medical visit, at least two (2) doctor visits are necessary.

- Only a medical doctor, podiatrist, osteopath, optometrist and doctor of dental medicine, to the extent practicing within the scope of their license can certify a disability.
- You must submit a doctor form to the Administrator, showing medical visits at least once every three weeks, and intervals between medical visits can be no more than three (3) weeks apart.
- You must be totally disabled.

Commencement Of Benefits:

- **Sickness**: In the case of sickness or disease, benefits will begin on the eighth day following your first medical visit provided you are properly certified. To be certified, you must be deemed by your medical doctor to be totally disabled.
- **Accident**: The weekly benefit to which you are entitled will begin on the first day if you are seen by a medical doctor or at a hospital within 72 hours of the accident, provided you are properly certified.
- **Hospitalization**: In the event you are hospitalized for three or more days, you will be paid from the first day of your hospitalization. If you are not in the hospital for three or more days, payment will be made as set forth in the first item above ("Sickness").

Limitations:

- No disability benefits are provided under the Plan if you are eligible by reason of self-payments, or you are only eligible for partial coverage.
- No person will be entitled to this weekly benefit in an amount to exceed thirteen (13) weeks of disability payments during any twelve consecutive month period except in the case of continued hospitalization or total and permanent disability.
- This is a maximum limitation regardless of the number of illnesses or accidents, and regardless of whether related or unrelated to previous disabilities. In order to be eligible again

for a new disability benefit, the member must be eligible as of the date the claim arises.

- In any six (6) year period you cannot receive more than 52 weeks of disability payments for the same or related accident, injury or illness.
- Successive periods of disability separated by less than two weeks of continuous active employment shall be considered as one continuous period of disability and no waiting period will be deducted unless they arise from different and unrelated causes.
- No person shall be entitled to this benefit if the disease or accident is the result of work for which the member or dependent receives compensation. Further, no person shall be entitled to this benefit if he is eligible for State Unemployment Compensation. If you are receiving Social Security benefits for benefits from any pension plan, you are not eligible for disability benefits.
- The Plan may refuse recognition of this benefit unless the member has exhausted his remedies under the State Unemployment or Workers' Compensation Laws. A written formal denial of the claim from the aforementioned sources can be required by the Administrator.
- No person who is disabled outside of the State of Maryland, District of Columbia or Commonwealth of Virginia will be entitled to benefits unless he is seen and certified by his attending medical doctor at least once every 10 days. Failure to be so seen limits payment to 10 days regardless of the time interval between medical visits.

Additional Thirteen (13) Weeks Disability Payments:

You may receive up to a maximum of 13 additional weeks disability if you are:

- Continually hospitalized in excess of 13 weeks (but only for the period you are continually hospitalized after your first 13 weeks disability have been paid); or
- Deemed to be totally and permanently disabled to the satisfaction of the Trustees for a period of 12 or more months following the termination of your first 13 weeks payment. After receiving the first 13 weeks payment you must obtain special forms from the Administrator for your medical doctor to complete in order to qualify for the extended 13 weeks.

Vacation Benefits

You become eligible for Vacation benefits as soon as any payments are made to the Plan on your behalf. If you are working under the Show Site Agreement between the Trade Show Contractors Association of Washington, D.C. and Vicinity and the Mid-Atlantic Regional Council of Carpenters, United Brotherhood of Carpenters and Joiners of America, a specified amount per hour will be deducted from your paycheck and paid to the Plan. The amount deducted per hour is set forth in your employer's collective bargaining agreement. Keep in mind that all hourly deduction rates are subject to change when new collective bargaining agreements are negotiated in the future. These funds are deducted from your paycheck on an "after-tax" basis. This means income and Social Security taxes are withheld from your gross wages before the Vacation plan deduction is made.

Vacation funds are collected by the Plan and Vacation payments are made based on the money collected for a "Distribution Year". A Distribution Year runs from October 1 through the following September 30. At the end of each Distribution Year, the Plan adds

up the funds that were collected on your behalf. The Trustees of the Plan then determine how much earnings, if any, you receive on the funds. The amount of earnings is based on how much the Plan is able to earn by investing the funds received during the year.

During the first week of December, the funds collected during the Distribution Year ending on the prior September 30, plus earnings (if applicable), will be distributed to you by mail. The funds you paid in are not taxable when they are paid to you, but the earnings paid to you by the Plan are taxable.

It is extremely important that you keep the Administrator advised of your current mailing address. If the Administrator does not have your current mailing address, it cannot mail you your Vacation check.

If a participant who is entitled to receive a Vacation check dies before it is paid to him, the Vacation check will be paid to the participant's beneficiary for death benefits as named in the records of the Plan. That beneficiary designation can be changed at any time.

Effective April 1, 2020, unless expressly renewed or modified by the Trustees in writing, exclusively for the calendar year of 2020, the money collected during the Distribution Year ending on September 30, 2019, plus earnings (if applicable), will be distributed to eligible employees by mail, and shall be evenly divided between two separate payments during the 2020 calendar year. The first payment shall be issued during the first week of April 2020, and the second payment shall be issued during the first week of December 2020. The money paid in this 2020 calendar year is not taxable when it is paid out, but the earnings paid by the Plan are taxable.

Limitations:

Failure to receive your Vacation payment: If for any reason you do not receive your Vacation payment for any Distribution Year, you only remain entitled to receive that payment for three years. The amount of the payment will not earn any additional earnings after the Distribution Year to which it relates. If, after five (5) years from that Distribution Year, you do not claim your Vacation payment or the Administrator cannot locate you to send you your payment, you will forfeit your payment. In other words, after five (5) years, you will lose your payment if you have not claimed it. If you make sure the Administrator always has your current address, you should not have this problem.

Pre-Existing Condition Limitation

As of January 1, 2014, the Plan will not impose a pre-existing condition limitation.

HEALTH CARE BENEFITS

The Plan pays for or reimburses you for **"covered medical expenses**" at a specific percentage of the amount which exceeds the "Plan Deductible" and the "Plan Coinsurance," if any.

Plan Deductible and Plan Coinsurance

The "**Plan Deductible**" and the "**Plan Coinsurance**" are the amounts of charges incurred for "covered medical expenses" which you must pay before the Plan pays any benefits. The Deductible must be satisfied each calendar year. The Deductible for each eligible exhibitor employee is $250. The Deductible for each eligible shop employee is $500. However, there is a $500 maximum family deductible where the Employee works for an exhibitor and a $1,000 maximum family deductible where the Employee works for a shop. The family deductible is met by at least two members or a combination of the remaining dependents. Furthermore, covered medical expenses incurred during the last three months of a calendar year and used to satisfy that year's Deductible are applied towards the Deductible for the following year. This Deductible amount is the combined annual deductible on all covered medical expenses. There is not a separate annual deductible amount for mental health and substance abuse disorder benefits.

Further, an eligible person must pay 20% coinsurance of all covered medical expenses after the deductible has been satisfied, up to a yearly maximum of $6,600 ($3,600 for medical and $3,000 for prescription) where the Employee works for an exhibitor and a yearly maximum of $6,850 ($3,850 for medical and $3,000 for prescription) where the Employee works for a shop. The family coinsurance amount is 20% of all covered medical expenses after the deductible has been satisfied, up to a yearly maximum of $13,200 ($7,200 for medical and $6,000 for prescription) where the Employee works for an exhibitor, and a yearly maximum of $13,700

($7,700 for medical and $6,000 for prescription) where the Employee works for a shop.

Annual Maximum
There may be an annual maximum benefit which represents the most the Plan will pay per person per year. However, there will not be any maximums on the dollar value of Essential Health Benefits (as defined herein) under the Plan.

Patient Protections

Pursuant to the PPACA, the Plan provides certain patient protections. You have the right to designate any primary care provider who is available to accept you or your family members. For help locating a primary care provider, you are encouraged to use Independence Administrator's online provider directory located at www.MyIBXTPAbenefits.com, or you may contact Independence Administrators at (833) 242-3330 or via U.S. mail at PO Box 21974, Eagan, MN 55121 (Payor ID 54763).

Further, you do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of health care professionals who specialize in obstetrics or gynecology visit www.MyIBXTPAbenefits.com. You may also contact Independence Administrators at (833) 242-3330 or via U.S. mail at PO Box 21974, Eagan, MN 55121 (Payor ID 54763).

Mental Health and Substance Abuse Benefits

Treatment of Mental Health Conditions. The treatment or diagnosis of mental health conditions is a covered service and as such is eligible for reimbursement subject to the following special provisions:

Inpatient Treatment:

Coverage is provided for mental health benefits at the same level as provided for medical and surgical benefits.

Outpatient Treatment:

Coverage is provided for mental health benefits at the same level as provided for medical and surgical benefits.

Treatment of Substance Abuse. The treatment of substance abuse is a covered service and as such is eligible for payment subject to the following special provisions:

Inpatient Treatment:

Coverage is provided for substance abuse benefits at the same level as provided for medical and surgical benefits.

Outpatient Treatment:

Coverage is provided for substance abuse benefits at the same level as provided for medical and surgical benefits.

Referral Required. The Plan will cover treatments performed by any licensed mental health/substance abuse provider. If services are performed by a provider who is not a doctor, however, such treatment requires a referral from a doctor.

Covered Medical Expenses

"**Covered Medical Expenses**" are the usual, customary and reasonable charges for services and supplies that are rendered or prescribed by a legally qualified doctor or surgeon. A charge is usual, customary and reasonable if the level charged does not

exceed the fees a doctor charges most of his or her patients for a similar service, and if the level is within the range of fees charged by doctors with similar training and experience for the same or similar services within the locality. Also taken into account is your condition and any additional time or skills needed by your doctor to treat you. The decision of whether a charge is usual, customary and reasonable is made by the Trustees, and is conclusive and binding. Under the Plan, preventive care benefits are not subject to cost-sharing when provided by an in-network provider.

Covered Medical Expenses include the following charges:

- **hospital room and board:** hospital charges for semi-private or intensive care room and board accommodations, inpatient expenses for newborns are covered on the same basis as for any other admission, room and board charges include any charges for other hospital services, such as general nursing services, which are made by the hospital as a result of confinement or on a regular daily or weekly basis;
- **hospital miscellaneous expenses:** benefits for necessary hospital charges to the extent usual, customary and reasonable, in addition to charges for room and board, made by the hospital, hospital charges for an operating room, anesthesia, X-ray examinations in hospital (excluding X-ray of teeth), laboratory analysis, drugs, medications, dressings and blood transfusions are covered. Generally, a hospital must charge for room and board for hospital miscellaneous expenses to be covered by the Plan. However, if the only charges are for a surgical operation, diagnostic procedure, or for emergency treatment of a non-occupational accident or illness, a room and board charge is not required. To be recognized as a "hospital" for Plan purposes, an institution regularly must keep patients overnight, have full diagnostic, surgical and therapeutic facilities under the supervision of a staff of physicians who are doctors of medicine and regularly provide 24-hour nursing service by registered, graduate nurses, unless they fully meet this definition,

institutions such as clinics, nursing homes, and places of rest for the aged, drug-addicts or alcoholics do not qualify as hospitals, hospital charges for physical therapy will be covered, hospital charges, however, are not paid for the following: special nurses, form completion charges, companion charges, telephone, or television; interpretation of X-ray and diagnostic lab tests is an eligible expense, hospital benefits are payable to the hospital only, payment cannot be made to you unless appropriate evidence that the bill has been paid by you personally is submitted to the Plan Administrator, and anesthesia charges by a licensed anesthesiologist will be covered, subject to the PPO fee maximum;

- **extended care facility benefit:** charges incurred for room and board and routine nursing services for confinement in an extended care facility, such facility shall be considered a "hospital" for the purposes of this Plan if it is an institution duly licensed to keep patients overnight and regularly provides 24 hour skilled nursing care by a licensed nurse under the direction of a registered nurse or doctor, the institution must keep full medical records on their patients and, if part of the institution meets this definition, that part will be considered an eligible institution, further, the institution must provide a review committee as outlined under the appropriate provisions of the Social Security Act effective July 1, 1973, institutions which provide solely custodial care or institutions such as clinics, nursing homes, places of rest for the aged or for drug addicts or alcoholics do not qualify as extended care facilities;
- **emergency illness and accident expense benefit:** the usual, customary, and reasonable charges for facility expenses incurred as a result of an accident provided the expenses are incurred within 72 hours of the accident, for facility expenses incurred as a result of an emergency illness benefits are payable only if the expenses are incurred within 72 hours of the onset of the illness. The Plan does not require pre-authorization for emergency services, further, the Plan will not increase coinsurance or co-

payment requirements for out-of-network emergency services, for an illness, emergency care is defined as the sudden onset of a medical condition resulting in: (i) placing the patient's health in danger, (ii) causing other serious medical problems, (iii) causing serious impairment to bodily functions, or (iv) causing serious and permanent damage to any body part, if the patient arrives at the hospital unconscious or in acute pain, this will be considered an emergency, however, visits for colds, flu, childhood diseases and nausea would not be considered emergency care within the intent of the Plan and if a visit is not considered an emergency, it will be paid as a doctor office visit only;

- the usual, customary and reasonable fees of a doctor or surgeon for diagnosis and treatment in connection with a medical visit, limited to the difference, if any, between the PPO fee maximum and the amount paid under the Plan;
- **outpatient physical therapy:** an amount per visit for physical therapy treatments, payments may be made either to a legally qualified doctor or a licensed physical therapist, if paid to a licensed physical therapist, such treatments must be prescribed by a doctor and in addition to the maximum payment, there is a maximum duration per illness or injury of six months; ;
- **surgical expense benefit**: benefits are payable whether a surgical procedure is performed in a hospital, doctor's office or elsewhere, but the procedure must be performed by a legally qualified doctor while coverage is in force, **multiple surgical procedures:** when two or more surgical procedures are performed during the same operation through the same incision or in the same operative area, they are considered one procedure and the maximum benefit payable is the largest of the benefits payable for the individual procedures based on the PPO fee maximum, if multiple or bilateral procedures, which add significant time or complexity to patient care, are performed at the same operative session, the total payment available shall be the amount payable for the procedure for which the largest amount is payable plus fifty percent (50%) of the amount payable

for the procedure for which the smaller amount is payable, **definition of surgical procedure:** the term "surgical procedure" means any of the following: (i) the incision, excision, or electrocauterization of any organ or part of the body; (ii) the manipulative reduction of a fracture or dislocation; (iii) the suturing of a wound; and (iv) the removal by endoscopic means of a stone or other foreign object from the larynx, bronchus, trachea, esophagus, stomach, urinary bladder or ureter, **second surgical opinion:** the Plan will pay charges for second opinions, limited to the PPO fee maximum, **reconstructive breast surgery:** as specified in the Women's Health and Cancer Rights Act of 1998, the Plan provides benefits for mastectomy-related services for an employee (and his or her dependents) including: (i) all stages of reconstruction of the breast on which the mastectomy was performed, (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, (iii) prostheses, and (iv) treatment of physical complications at all stages of the mastectomy, including lymphedemas, these benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits under the Plan, the Plan will provide this coverage in a manner determined in consultation with the attending doctor and patient;

- **diagnostic X-ray and laboratory expense benefit:** the usual, customary and reasonable charges for expenses incurred for diagnostic X-ray or laboratory examinations (including interpretation of same) for the diagnosis of an illness;
- X-ray, radium and radioactive therapy and administration of chemotherapy;
- casts, splints, trusses, braces, artificial limbs and crutches and surgical dressings, rental of hospital-type equipment, including wheelchair, hospital bed, and other mechanical equipment for the treatment of respiratory paralysis and equipment for the administration of oxygen;

- **anesthesia and/or oxygen in a doctor's office:** when anesthesia and/or oxygen is administered in a doctor's office in connection with a surgical procedure or an emergency, the Plan will pay, limited to the PPO maximum;
- professional ambulance service when used to transport an individual from the place where he or she is injured in an accident or stricken by an illness to the first hospital where treatment is given;
- hospital and other medical services rendered while confined in a hospital in connection with necessary dental work for the repair of natural teeth or other body tissues and required as a result of a non-occupational accidental bodily injury occurring while the individual is covered, such covered dental expenses must be incurred within 90 days of the accident;
- services of a licensed home health care provider;
- allergy injections when performed in a doctor's office;
- **doctor visits:** all doctor's office visits for preventive wellness exams for eligible employees and dependents are permitted, there is no cost-sharing if a doctor's visit is for preventive care services when provided by an in-network provider, **non-preventive care doctor visits:** the Plan will pay for doctor's office visits, however, eligible employees and dependents must pay a co-payment of $25.00 for each doctor visit, with such co-payment applying towards the out-of-pocket maximum (coinsurance limits), "doctor" means a person licensed and acting within the scope of his or her practice;
- **maternity benefit:** provided to the eligible dependent spouse of an eligible active or retired employee as well as to the active or retired employee; unless otherwise provided by law, dependent children are not eligible for maternity benefits outside of those prenatal services that are considered preventative services under the PPACA, all hospital charges for room and board and miscellaneous services are covered the same as for any other illness, the fee charged by the doctor for any obstetrical

procedures is reimbursed up to the PPO fee maximum, services of a licensed midwife are paid, limited to the PPO fee maximum, the Plan does not offer this coverage to the child of the dependent child or the spouse of the dependent child, pursuant to the NMHPA, the Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods, the attending provider, after consulting with the mother, may discharge the mother or newborn earlier than 48 hours following a vaginal delivery or 96 hours following a cesarean section;

- **elective abortion:** expenses in connection with an elective abortion are covered as any other illness;
- **outpatient cancer treatment:** expenses relating to outpatient cancer treatments will be paid;
- **preventive care benefits:** all required preventive care benefits are provided under the Plan with no cost-sharing when provided by an in-network provider;
- **approved clinical trials:** coverage is provided for individuals participating in approved clinical trials if provided to a qualified individual, a qualified individual for this purpose is an employee or dependent who is eligible to participate in an approved clinical trial according to trial protocol with regard to the treatment of cancer or another life-threatening disease and either: the referring medical professional is a participating provider and has determined that participation in the trial is appropriate; or the employee or dependent provides medical and scientific information verifying that participation in the trial is appropriate, the Plan will not deny the qualified individual participation in an approved clinical trial with regard to the treatment of cancer or another life-threatening disease, will not deny the coverage of routine patient costs for services furnished in connection with participation in the trial; and will

not discriminate against the individual due to participation in the clinical trial; and

- **Coronavirus (COVID-19):** pursuant to the Families First Coronavirus Response Act ("Response Act"), effective March 18, 2020, coverage is provided for eligible employees and dependents for in vitro diagnostic products for the detection of SARS-CoV-2 (Coronavirus) or the diagnosis of the virus that causes COVID-19 that are approved, cleared, and authorized by the U.S. Food and Drug Administration (FDA); and items and services furnished to individuals during healthcare provider office visits (including telehealth visits), urgent care center visits, and emergency room visits that result in an order for an administration of the in vitro diagnostic products described in this paragraph, but only to the extent that those items and services provided during said visit(s) relate to the furnishing of the FDA approved, cleared, and authorized diagnostic product(s) or evaluating the individual for determining if he or she needs such a product. These products and services described in this paragraph are to be provided without prior authorization or any other medical management requirements.
- **Telehealth**: Online doctor visits 24/7 provided by MDLIVE. To register, please visit www.mdlive.com/levelcarehealth, or call MDLIVE at 888-921-0313.

PREFERRED PROVIDER ORGANIZATION

The Plan retains the services of a "**Preferred Provider Organization**" (PPO). A PPO is a group of select doctors, specialists, hospitals, and other treatment centers which have agreed to provide their services to Plan participants for a discount. A PPO can be used for routine or emergency medical problems. It is not mandatory, so you do not need to change your doctor or the hospital you use, even if the doctor or hospital does not participate in the PPO program. However, if you use the PPO, both you and the Plan will save money, as explained below.

By using the PPO, there are considerable savings for both you and the Plan. The PPO has special arrangements with health care providers, such as doctors and hospitals, to substantially discount their normal fees. Because you usually pay a portion of billed charges, this will result in your paying a portion of a much smaller amount. Use of a PPO doctor or hospital for medical benefits means a direct **out-of-pocket** cost savings to you.

Of course, the Plan's costs are reduced as well, which means that your contribution dollars will be used more efficiently.

When PPO providers are used, the Plan will not reimburse such providers for billed charges which exceed the negotiated PPO fee for such service.

Participating PPO doctors and hospitals can be located by calling Independence Administrators at (833) 242-3330 or by logging onto the website www.MyIBXTPAbenefits.com. Using the "locate a provider" feature on the website, you can enter your zip code and the radius that you would like to locate in-network providers. You can also locate providers based on specialty. Check to see if your current doctor already participates. In fact, there is a good possibility that you are already using a PPO doctor. New doctors

are added frequently so if you do not find your doctor listed, call the number of the PPO which is on your identification card.

Your identification card verifies your participation in the PPO. When you go to a participating hospital or doctor, identify yourself as a PPO participant by presenting the identification card. The hospital or doctor will submit your claim directly to the PPO which will discount the bill and forward it to the Administrator for payment. You should let your current doctor know that the Plan is participating in the PPO.

ADDITIONAL BENEFITS

Vision, Dental and Prescription Drug Benefits

Eligibility

If you are eligible for full coverage, you are then eligible for vision, dental and prescription drug benefits. If you are eligible for partial coverage, then you are not eligible for vision, dental and prescription drug benefits.

Prescription Drug Benefit

The prescription claims are administered by a Pharmacy Benefit Manager ("PBM") chosen by the Plan Trustees. Eligible participants and dependents will automatically receive a prescription identification card which will entitle you to obtain drugs at participating pharmacies.

In order to use your card, present it to the pharmacist along with your prescription. When you receive your drugs, you generally pay only the co-payment amount (see the Summary Schedule of Benefits).

Co-payment Required:

You will be required to pay a co-payment amount per prescription filled (see the Summary Schedule of Benefits for specifics).

What is Covered:

Drugs prescribed by a medical doctor which are required by law to be sold only by prescription or a compounded prescription if at least one of the ingredients is a prescription requiring drug.

As a cost-saving measure, the Board of Trustees has adopted a generic drug policy. Generic drugs are pharmaceutical equivalents to brand name drugs. They are approved by the Federal Food and Drug Administration and are considered to contain the same active ingredients and are identical in strength or concentration, dosage

form, and type of administration, as brand name drugs. They may differ in characteristics such as color, shape, packaging, preservations, expiration time, and within certain limits, labeling.

Under the generic drug policy, you should note the following:

- If there is no generic equivalent, then the pharmacy will dispense the brand name drug and be reimbursed by the Plan.
- If you insist upon a brand name drug and there is a generic equivalent, then you must pay the difference in price in addition to the co-payment amount.

As an additional cost savings measure, the Board of Trustees has adopted a Step Therapy program whereby you benefit from using generic medications or lower cost brand alternatives ("Front Line Therapies") as opposed to brand name drugs ("Back-up Drugs"). This program is designed for those who take prescription drugs on a regular basis to treat ongoing medical conditions. Under this program, the first time you submit a prescription for a Back-up Drug the pharmacist will notify you of the Plan's use of the Step Therapy program and you will be required to either proceed in having the Front Line Therapy filled or paying full price for the Back-up Drug. The use of a Back-up Drug will be covered by the Plan to the extent you have (i) already tried the Front Line Therapy covered in the Step Therapy program, (ii) you cannot take the Front Line Therapy, or (iii) your doctor decides, for medical reasons, that a Back-up Drug is needed.

Similarly, as an additional cost savings measure, the Board of Trustees has adopted a $0 Co-pay Program whereby you will be entitled to relief, on a one-time only basis, from the co-pay associated with filling a prescription, to the extent you choose a generic prescription as opposed to a brand name prescription. The waived co-pay will only apply to specific targeted prescriptions as the Plan shall determine from time to time, and will be restricted to a six (6) month supply.

Covered Injectable Prescriptions:

Generally injectable drugs are not covered. The following are covered by the Plan, however, with some requiring prior approval from the PBM:

No Prior Approval

- Epipen
- Imitrex
- Insulin

Prior Approval Required

- Interferon
- Depo-Provera
- Heparin
- Botox (for treatment of Cerebral Palsy only)
- Lovenox

If your doctor prescribes a drug which requires prior approval, please contact the Administrator immediately.

What Is Not Covered:

- any non-legend drug, except insulin;
- vitamins, minerals, dietary supplements, cosmetics or beauty aids;
- any medication which is to be taken by or administered while you or your dependent is confined in a hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution;
- more than a 34-day supply unless specifically authorized by a doctor;
- any drug labeled "Caution - Limited by Federal Law to Investigational Use" or experimental drugs whether or not a charge is made to the patient;
- smoking cessation drugs; or

- unless otherwise required by law, contraceptive drugs or devices, with the following exception: oral contraceptives may be covered if your doctor prescribes them for medical (not contraceptive) purposes **and** is able to document their medical necessity. Such contraceptives will be covered at 50% up to a maximum plan payment of $15 per 34-day supply, unless otherwise required by law.

Should you or an eligible dependent patronize a non-participating pharmacy you can be reimbursed by the PBM (contact the Administrator for details).

In Order To Be Reimbursed Directly - You Must:

- Obtain reimbursement drug forms from the Administrator.
- Ensure that the forms are properly completed by the pharmacy; this includes:
- Name of the drug and quantity dispensed,
- Date dispensed,
- Name and address of the pharmacy,
- Authorizing doctor's name,
- Patient's name,
- Eligible participant's signature of acceptance, and
- Participant's name, social security number, and group number.
- Following completion, the form should then be submitted to the PBM together with your paid receipt.
- In order to get a prescription card, you need an enrollment form on file at the Administrator.

As an additional cost savings measure, the Board of Trustees has adopted a Prior Authorization Program under which the Plan will monitor certain prescription drugs to ensure that covered drugs are used for medical problems rather than for other purposes (i.e. cosmetic, etc.). Through the use of the Prior Authorization Program, you will be notified by the pharmacist if a specific

prescription requires prior authorization. If prior authorization is required, you can (i) ask your doctor to contact the PBM to explain the use of the prescription, (ii) ask your doctor whether another covered medication could be used for this purpose, or (iii) simply pay the full price for the prescription at the pharmacy.

As an additional cost savings measure, the Board of Trustees has adopted a mail order drug program for maintenance types of drugs, up to a 90-day supply for two co-payments. Prescriptions filled through non-mail order retail locations will be limited to a 30-day supply.

Vision Benefit

Vision benefits are provided to eligible participants and their eligible dependents. Vision benefits are based upon 80% of charges incurred, to a maximum of $250 per person per year, which may be applied for by contacting the Administrator for a form. The annual maximum of $250 does not apply to vision benefits for children, however, vision benefits are limited to one eye examination and one pair of glasses per year per eligible child. You may use the provider of your choice or request information concerning providers offering a special discount to the Plan.

Dental Benefit

Eligible participants and their dependents may receive up to $1,500 of dental benefits per person per year, excluding orthodontia. The annual maximum per person of $1,500 does not apply to dental benefits for children. Unless otherwise required by law, orthodontia is covered up to a lifetime limit of $1,000 per person. The lifetime limit of $1,000 per person does not apply to orthodontia benefits for children. Notwithstanding any other provisions in the Plan, orthodontia is covered up to an annual limit of $1,000 per eligible child. The Plan has contracted with CIGNA for discounts from dentists; the Plan will be administered by the Administrator, who will continue to process the claims. You will get

the best benefit if you use a dentist who participates in the CIGNA Dental Preferred Provider Organization (PPO) network. The allowed amount for each dental procedure will be based on a schedule determined by CIGNA. The Plan benefit will depend on the type of procedure. The benefit schedule is listed below. If you use an In-Network Provider, you will be responsible for the percentage of the allowed amount that the Plan does not pay. For instance, for a filling (Basic Restorative Procedure) the Plan will pay 75% of the allowed amount and you will be responsible for the remaining 25%. If you use an Out-of-Network Provider, you will be responsible for the remaining percentage of the allowed amount for that procedure **plus** any difference between the allowed amount and what the provider charges.

Benefits are not provided:

- for dentures, bridges, and crowns delivered more than 60 days after your coverage ends;
- for engraving of dentures, or any other charges for services and supplies that are partially or wholly cosmetic in nature;
- for professional fees to someone who is not a registered dentist or medical physician;
- for replacements of covered dentures, partials, or crowns more often than once every two years;
- for damage due to war;
- resulting from any injury which is work related;
- paid for or furnished by, or at the direction of any government agency or plan, but only to the extent so paid or furnished; or
- for charges for the replacement of lost or stolen dentures.

You may use the dentist of your choice. The benefit will be maximized if you use an In-Network-Provider. The Dental Schedule below shows the benefit provided and how the benefit differs depending on whether you choose an In-Network Provider or an Out-of-Network Provider.

The Plan reserves the right to determine reasonable allowances for services not listed.

Dental Schedule (what the Plan will pay as a percentage of the PPO allowed amount)

For an In-Network Provider:

Diagnostic/Preventative	Dental Benefits Paid at 100%
Basic Restorative	Dental Benefits Paid at 75%
All other Services	Dental Benefits Paid at 40%

For an Out-of-Network Provider:

Diagnostic/Preventative	Dental Benefits Paid at 80%
Basic Restorative	Dental Benefits Paid at 60%
All other Services	Dental Benefits Paid at 30%

A partial list of services by category is included below:

DIAGNOSTIC AND PREVENTIVE SERVICES

- Oral Evaluations (periodic; comprehensive)
- Prophylaxis (cleanings)
- Topical fluoride applications
- General x-rays – bitewing limit once every six months
- Panorex or full mouth x-rays – limit one per calendar year
- Space maintainers
- Sealants

BASIC RESTORATIVE SERVICES

- Restorations/fillings (amalgams/composite resins)

ALL OTHER SERVICES

- Oral surgery (e.g., extractions; removal of impacted teeth)
- Periodontics (e.g., gingivectomies; root planning)
- Endodontics (e.g., root canals; apicoectomies)

- Dentures
- Bridges
- Crowns

Effective December 1, 2014, the Plan covers the use of a hospital facility and anesthesia where impacted wisdom teeth are removed. Additionally, effective January 1, 2019, the Plan will cover the use of a hospital facility and anesthesia for dental services provided to eligible children 12 years of age or younger when recommended or deemed necessary by the eligible child's dentist. However, any dentists' fees relating to the removal of impacted wisdom teeth or dental services provided to Dependent children 12 years of age or younger will apply towards the annual maximum for these dental benefits and based upon the dental fee schedule.

RETIREE BENEFITS NOT REQUIRING A SELF-PAYMENT

If you are receiving early, normal or disability retirement payments under Carpenters Local No. 491 Pension Plan, you are eligible for certain retiree benefits. Retirees who are eligible for these benefits are eligible for themselves only. Benefits are coordinated with Medicare and are as follows:

Death Benefit $1,000.00

GENERAL LIMITATIONS AND EXCLUSIONS

The following charges are not covered under this Plan; therefore, the amount of benefits payable under the Plan is determined after these charges are deducted from covered expenses:

- charges incurred while not covered under this Plan;
- charges that would not have been made if coverage did not exist;
- charges that you or your dependents are not required to pay;
- charges for services or supplies which are furnished, paid or otherwise provided for by reason of the past or present service of any person in the armed forces unless otherwise required by law;
- charges for nursing or other services performed by a person who ordinarily resides in the patient's home or is a member of your family or your spouse's family;
- charges for services or supplies which are paid for or otherwise provided for under any laws of the government unless required by federal law;
- charges for services or supplies which are not medically necessary for treatment of an injury or illness or are not provided, recommended or prescribed by a legally-qualified surgeon or doctor;
- charges to the extent that they are not usual, customary and reasonable, as defined in the Plan;
- charges for an injury or illness covered by workers' compensation laws;
- charges for the purchase or fitting of a hearing aid;
- charges for blood plasma or whole blood;
- charges by an intern of a hospital;

- charges for transportation or travel except as otherwise covered under the Plan;
- medicines which may be purchased without a prescription or are not prescribed to treat an illness or injury;
- charges for custodial care;
- charges for or in connection with experimental procedures or treatment methods not approved by the American Medical Association or the appropriate medical specialty society;
- charges for telephone consultations, for failure to keep a scheduled visit, for completion of forms, or other non-medical or administrative services;
- charges for dependent child maternity benefits outside of those prenatal services that are considered preventative services under the PPACA;
- charges for chiropractic care;
- charges incurred as a result of war, declared or undeclared, including armed aggression;
- charges incurred as the result of a commission of a crime (NOTE: if a copy of a police report is required, this will be obtained at the expense of the covered individual);
- cosmetic procedures (except as otherwise required by law) and associated expenses;
- the services of private duty registered and licensed practical nurses, unless medically necessary;
- physical or psychiatric examinations or psychological testing for purposes of obtaining or maintaining employment, licensure, legal proceeding, registration or insurance, or conducted for purposes of medical research, physical examinations for camp, school, sport, or other similar activities;
- any elective surgical procedure including all associated expenses, intended primarily for treatment of morbid obesity;

- any surgical procedure, including all associated health services, for the reversal of voluntary sterilization;
- speech therapy and evaluation, diagnosis and treatment of educable children diagnosed as having special learning disabilities;
- services related to sex transformations, sexual enhancement, or sexual dysfunction inadequacies, unless medically necessary;
- artificial insemination;
- in-vitro fertilization and embryo transplants;
- charges for services or supplies for the diagnosis or treatment of Temporomandibular Joint Dysfunction (TMJ) and any related disorders or procedures regardless of medical necessity;
- charges incurred or resulting from an injury caused by a third party in which you or your covered dependents have recovered by suit, settlement or otherwise;
- dental X-rays, except in the case of an accidental bodily injury;
- examinations that are not recommended or approved by a legally qualified doctor or surgeon;
- eye examinations, unless otherwise provided in the Plan;
- dental disorders, except as otherwise provided in the Plan
- eye refraction, eyeglasses or their fitting, except as provided under the Vision Benefits section of the Plan;
- hearing aids or their fittings;
- drugs and medicines, except as otherwise provided herein; or
- charges incurred due to psychiatric or personality disorders, drug abuse or alcohol abuse, except as otherwise required by the Mental Health Parity and Addiction Equity Act.

The term “custodial care” means services and supplies, including room and board and other institutional services, primarily to assist a person in the activities of daily living, whether or not he or she is disabled. However, room and board and skilled nursing care for a person in a hospital are not considered custodial care if they must

be combined with therapeutic services needed to improve his or her medical condition.

The Plan only covers treatments, services or supplies that are necessary, reasonable and recommended or approved by the attending doctor.

COORDINATION OF BENEFITS

If an eligible participant or any eligible dependents is eligible to receive benefits under another "plan" preceding the Plan in the "order of benefit determination" (as set forth below), the benefits otherwise payable for expenses incurred in each calendar year, or lesser period covered under the Plan, will not exceed the amount which, added to the benefits available from such other plans for such expenses, equals the individual's "allowable expenses" incurred in that period.

In this provision, a "plan" is considered to be any group coverage, or other arrangement of coverage for individuals in a group, which provides medical, vision or dental benefits or services on an insured or uninsured basis, and any governmental program providing benefits or services of a similar nature. An "allowable expense" is any necessary, reasonable and customary item of expense covered in full or in part under any one of the plans involved.

The "order of benefit determination" provides that:

- Any 'plan', which does not have a Coordination of Benefit ("COB") or similar provision will pay its benefits first.
- All 'plans' which have a COB or similar provision will pay benefits in the order determined by the following rules:
- A plan which covers a participant as a participant/member will be considered before a plan which covers a participant as a dependent.
- A plan which covers a participant as an active participant/member, or as the dependent of an active participant/member, will be considered before a plan which covers a participant as a laid-off or retired participant/member or as the dependent of a laid-off or retired

participant/member. If a plan which is being considered for COB does not have a provision regarding laid-off or retired participants/members, then this rule will not apply.

- For covered dependent children, the plan which pays first is determined by the parents' birthdays. The plan which covers the parent whose month and day of birth occurs earliest in the calendar year will be considered first. If a plan which is being considered for COB does not have a birthday rule for covered dependent children, then the COB rules in the other plan will be used and this rule will not apply.

Except that, as to the above rule, when the biological parents of a covered dependent child are divorced or legally separated, the following rules apply:

- If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a covered dependent of the parent with custody of the child will be considered first.
- If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a covered dependent of the parent with custody of the child will be considered before the benefits of a plan which covers the child as a covered dependent of his or her stepparent; and the benefits of a plan which covers the child as a covered dependent of the parent without custody of the child will be considered last.
- Except that, if there is a court decree which establishes financial responsibility for the medical or other health care expenses of the child, the above will not apply, and the plan which covers the parent with such financial responsibility will be considered before the benefits of any other plan which covers the child as a covered dependent.

- If the above rules do not establish an Order of Benefit Determination (such as when two plans cover a participant as a participant/member), the plan which has covered the participant for the longest continuous period of time will be considered first.

The Plan may exchange benefit information with other insurance companies, organizations and individuals, and has the right to recover any overpayment made to a participant.

The Coordination of Benefits provision applies to all benefits under the Plan.

In applying the rules for determining which plan is the primary carrier, the provisions of any plan which would attempt to shift the status of this Plan from secondary to primary by excluding from coverage under such other plan any participant or dependent eligible under this Plan shall not be considered.

In the event another plan is determined to be primary and such other plan is either not financially able or refuses to discharge its responsibility, such action shall not cause this Plan to assume primary status.

In the event an eligible participant or dependent fails or refuses to comply with the terms and conditions of another plan, thereby resulting in that other plan reducing or denying benefits, this Plan will only provide benefits under the Coordination of Benefits provision based upon the benefits which the other plan would have provided if the participant or dependent had fully and properly complied with the terms and conditions of the other plan.

Rights of States With Respect to Medicaid

Payments for benefits with respect to a participant under the Plan shall be made in accordance with any assignment of rights made by or on behalf of such participant or a dependent of the participant as required by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to section 1912(a)(1)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

In enrolling an individual as a participant or dependent or in determining or making any payments for benefits of an individual as a participant or dependent, the fact that the individual is eligible for or is provided medical assistance under a state plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account.

To the extent that payment has been made under a state plan for medical assistance approved under Title XIX of the Social Security Act in any case in which the Plan has a legal liability to make payment for items or services constituting such assistance, payment for benefits under the Plan shall be made in accordance with any state law which provides that the state has acquired the rights with respect to a participant to such payment for such items or services.

SUBROGATION

The Plan reserves the right to recover any monies paid in error to or on behalf of you or your eligible dependents, or to providers of health care. To the extent that payments are made by the Plan which are either in excess of the maximum amount necessary to satisfy the obligations of the Plan or are subsequently determined to have been incorrectly made, regardless of to whom such payments have been made, the Plan shall have the right to recover such excess or incorrect payments from any person or other entity to whom or for whom such payments were made (including the you and/or an eligible dependent), any insurance companies, or any other person or entity from whom repayment is appropriate as the Plan shall determine.

To the extent that benefits for covered services are provided or paid by the Plan, the Plan shall be subrogated and succeed to any and all rights of you or any eligible dependent for recovery of such paid expenses against any person, corporation, organization or other entity who may be liable for such expenses. You or an eligible dependent are required by the Plan to provide information with respect to other persons, corporations, organizations or other entities which may be liable for expenses paid by the Plan (Subrogation Agreement). Failure to provide such information or documents or failure to cooperate with the Plan in protection of its rights of subrogation, may result in cancellation of benefits and/or denial of the claim upon which the Plan's subrogation right is based, but such failure shall not affect the Plan's right of subrogation. The Plan's right to subrogation granted herein shall constitute a lien against any settlement of the proceeds of any judgment by you or any eligible dependent against a responsible third party.

Should you or an eligible dependent institute negotiations or a civil action to recover damages from a third party who may be liable for expenses paid by the Plan, you or an eligible dependent are required

to notify your legal counsel of the Plan's right of subrogation and subrogation lien. You or an eligible dependent and/or legal counsel may also be required to execute and deliver to the Plan a written confirmation and/or legal counsel of the lien granted herein and certain instruments that may be required to secure and protect the Plan's right of subrogation. Failure to provide such information or documents or failure to cooperate with the Plan in protection of its rights of subrogation, may result in cancellation of benefits and/or denial of the claim upon which the Plan's subrogation right is based, but such failure shall not affect the Plan's right of subrogation.

You, an eligible dependent and/or legal counsel shall pay the Plan all amounts recovered by suit, settlement or otherwise from any third party to the extent of the benefits provided or paid under the Plan without reduction for any legal fees, court costs, or expenses incurred by you or an eligible dependent, unless otherwise waived by the Trustees in their sole and absolute discretion. You and your legal counsel must sign, in the presence of a witness, the Subrogation Agreement distributed by the Plan Administrator agreeing to the provisions of the Plan.

CLAIMS AND APPEALS PROCEDURES

Obtaining and Completing Claim Forms for Medical Benefits
If you are treated for a covered accidental injury or illness at a medical facility or a participating doctor's office, present your Independence Administrators' identification card. Independence Administrators will pay the provider directly for covered expenses.

If you are required to pay the medical facility or the doctor, be sure to get a receipted, itemized bill. Besides the itemized charges it should show:

- your name and address
- patient's name and age
- doctor's or hospital's name and address
- medical provider or facility identification number
- date of admission or treatment

You can register for Independence Administrator's secure website to access personalized health benefit information and resources, 24 hours a day, 7 days a week. You can view benefits and claims, find network hospitals and doctors, access health tools & resources, download forms, and much more. Registration will allow you to take advantage of a number of online tools and resources that will help you manage your health. Access your health benefit information and resources using the website listed on the back of your ID Card or www.myibxtpabenefits.com

- *Medicare:* If payment is to be sent to you, only send your Explanation of Medicare Benefits that Medicare sends to you. If you do not receive the statement, you need to contact Medicare at (800) 633-4227 and request a "duplicate" copy. When you want payment made directly to the provider of

services, you need to have them complete a physician/supplier form and have them bill us directly.

Obtaining and Completing Claim Forms for Dental, Vision, Death, and Disability Benefits

- The prompt filing of any required claim form will result in faster payment of your claim.
- You may get the required claim forms from the Administrator. All fully completed claim forms and bills should be sent directly to the Administrator.
- Your claim must be submitted to the Administrator in writing. It must give proof of the nature and extent of the loss. All claims should be reported promptly.
- *Doctor's Bills*: Complete the "patient & insurer information" section. Then have the bottom portion completed by your doctor, or attach a bill/receipt to a completed form, making sure the following information is on the bill/receipt:
  1. employee's full name,
  2. patient's full name,
  3. diagnosis for each date,
  4. type of services or treatment,
  5. date of service or treatment,
  6. itemization of all charges,
  7. name of doctor, and
  8. other insurance coverage.

- All benefits are payable to you or your eligible dependents. For your convenience, the Plan may pay benefits directly to the provider of services. This will be done if you elect this option when you file the claim.

- Send all Completed Claim Forms for Vision, Dental, Death, and Disability benefit claims to the Administrator:

  Carpenters Local No. 491 Health and Welfare Plan
  c/o Associated Administrators, LLC
  911 Ridgebrook Road
  Sparks, MD 21152-9451
  Phone: (888) 494-4443

For information or assistance, contact the Administrator.

General Rules To Remember

- When to file a claim?

  File the completed claim form as soon as possible.

- Time for processing claims?

  Allow the Administrator time to process claims before making inquiries as to non-receipt of benefit checks. You will be notified in writing when the claim will be delayed for additional information or further review.

- Fraud.

  If a participant purposely supplies wrong information to the Plan or causes, or conspires with someone else to cause, wrong information to be supplied to the Plan, in connection with the filing of a claim, the participant may be subject to the loss of eligibility and other severe penalties.

REMEMBER:

The sooner your completed Claim Form is received by the Administrator, the sooner your claim may be paid.

Claims and Appeals Procedures

Proof of Loss

Claims must be filed with the Claims Administrator no later than two (2) years from the date that the treatment or service on which the claim is based is provided. Specifically, a completed claim form, corresponding itemized bills and other information necessary to process the claim, which represent proof of loss related to a Covered Medical Expenses incurred by a Participant must be received by the Claims Administrator or PPO no later than two (2) years from the date the service was rendered or otherwise provided.

The Plan reserves the right, at its discretion, to accept or to require verification of any alleged fact or assertion pertaining to any claim.

In the event of Plan termination, all claims incurred by an Employee must be received by the Claims Administrator within ninety (90) days of the date of termination of the Plan.

Claims for benefits under the Plan must be filed in the manner and within the time limits stated above. If an employee or an employee's spouse, dependent or beneficiary (hereinafter referred to as a "Claimant") is denied any benefit under this Plan, the Claimant may request review of the claims with the Plan. The claims procedures do not preclude an authorized representative of a Claimant from acting on behalf of such Claimant in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The Plan shall review the claim itself or appoint an individual or an entity to review the claim.

A Claimant is not required to follow more than the claims and appeals process described below prior to bringing a civil action under ERISA or under state law, as applicable.

If the Plan fails to adhere to the internal claims and appeals process required herein, a Claimant shall be deemed to have exhausted the internal claims and appeals process. Accordingly, the Claimant may initiate an external review under paragraph (e) of this section and is entitled to pursue any available remedies under ERISA section 502(a) or under state law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

The internal claims and appeals process will not be deemed exhausted based on minor violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan.

Initial Benefit Determination

1. Urgent Care Claims.

In the case of an Urgent Care Claim, the Plan shall notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan shall notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim.

The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to

provide the specified information. The Plan shall notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information; or (2) the end of the period afforded the Claimant to provide the specified additional information.

2. Concurrent Care Claims.

If the Plan has previously approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments shall constitute an Adverse Benefit Determination. In such a case, the Plan shall notify the Claimant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before reduction or termination of the benefit.

Any request by a Claimant to extend a course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the Plan shall notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Continued coverage for concurrent care shall be provided pending the outcome of an appeal.

3. Pre-Service Claims

In the case of a pre-service claim, the Plan shall notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical

circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim is considered a pre-service claim if the claim requires approval, in whole or in part, in advance of obtaining the health care in question.

In the case of a failure by a Claimant to follow the Plan's procedures for filing a pre-service claim, the Claimant shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the Claimant as soon as possible, but not later than five (5) days (24 hours in the case of a failure to file an Urgent Care Claim) following the failure. Notification may be oral, unless written notification is requested by the Claimant. The above shall apply only in the case of a failure that:

(i) Is a communication by a Claimant that is received by the person or organizational unit designated by the Plan that handles benefit matters; and

(ii) Is a communication that names a specific Claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

4. Post-Service Claims

In the case of a post-service claim, the Plan shall notify the Claimant of the Plan's Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to the failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A post-service claim is any claim for a benefit under the Plan that is not a pre-service claim, as defined above.

5. Calculation of Time Periods. For purposes of the time periods specified in this paragraph (b), the period of time within which a benefit determination shall be made begins at the time a claim is filed in accordance with Plan procedures, without regard to whether all the information necessary to make a benefit determination accompanies the claim. If a period of time is extended due to a Claimant's failure to submit all information necessary to decide the claim, the period for making the benefit determination shall be tolled from the date the notification of the extension is sent to the Claimant until the date the Claimant responds to the request for additional information.

6. Manner and Content of Notification of Adverse Benefit Determination. The Plan shall provide a Claimant with written or electronic notification of any Adverse Benefit Determination. The notification shall set forth, in a manner calculated to be understood by the Claimant:

(i) The specific reason(s) for the adverse determination;

(ii) A reference to the specific Plan provisions on which the determination is based;

(iii) A description of any additional information or material necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA section 502(a) or under state law, as applicable, following an Adverse Benefit Determination on review **plus a statement that the Claimant has one year from the date of the Adverse Benefit Determination to bring suit under ERISA**;

(v) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request; or

(vi) If the Adverse Benefit Determination is based on a medical necessity or Experimental or Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's

medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(vii) In the case of an Adverse Benefit Determination concerning an Urgent Care Claim, a description of the expedited review process applicable to such claims.

In the case of an Adverse Benefit Determination concerning an Urgent Care Claim, the information described above may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this section is furnished to the Claimant not later than three (3) days after the oral notification.

Appeal of Adverse Benefit Determinations

The Plan provides two levels of internal appeals. A Claimant has the right to file an appeal to the Plan within 180 days from the date of the initial Adverse Benefit Determination notice and within 30 days of the date of a second Adverse Benefit Determination notice. The Claimant's appeal request must include the patient's name, identification number, and any additional documentation to be reviewed.

(1) A Claimant has the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(2) A Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits. For purposes of this section, such information will be considered "relevant" if it:

(i) Was relied on in making the benefit determination;

(ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied on in making the benefit determination;

(iii) Demonstrates compliance with the Plan's administrative processes and consistency safeguards required in making the benefit determination; or

(iv) Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

(3) The Plan shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(4) The Plan shall allow a Claimant to review the claim file and to present evidence and testimony as part of the internal claims and appeals process. Specifically:

(i) The Plan shall provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided, to

give the Claimant a reasonable opportunity to respond prior to that date; and

(ii) Before the Plan issues a Final Internal Adverse Benefit Determination based on a new or additional rationale, the Claimant shall be provided, free of charge, with the rationale; the rationale shall be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided, to give the Claimant a reasonable opportunity to respond prior to that date.

(5) The Plan shall ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits;

(6) The Plan shall provide for a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

(7) In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental or Investigational, or not medically necessary or appropriate, the

appropriately named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall be an individual who was neither consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;

(8) The Plan shall identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination; and

In the case of an Urgent Care Claim, a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant. All necessary information, including the Plan's determination on review, may be transmitted between the Plan and the Claimant by telephone, facsimile, or other available similarly expeditious methods.

Deadline for Review Decisions

1. Urgent Care Claims. This Plan has two levels of internal appeals. In case of Urgent Care Claims, the Plan shall notify the Claimant of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an Adverse Benefit Determination by the Plan.

2. Pre-Service Claims. This Plan has two levels of internal appeals. In the case of a pre-service claim, the Plan shall notify the

Claimant of the Plan's benefit determination on review, with respect to any one of such two appeals, within a reasonable time appropriate to the medical circumstances but not later than 15 days after receipt of the Claimant's request for review of the Adverse Benefit Determination.

3. Post-Service Claims. This Plan has two levels of internal appeals. In the case of a post-service claim, the Plan shall notify the Claimant of the Plan's benefit determination on review, with respect to any one of such two appeals, within a reasonable period but not later than 30 days after receipt of the Claimant's request for review of the Adverse Benefit Determination.

4. Calculation of Time Periods. For purposes of the time periods specified in this paragraph (d), the period of time within which a benefit determination on review shall be made begins at the time an appeal is filed in accordance with the Plan procedures, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. If a period of time is extended due to a Claimant's failure to submit all information necessary to decide the appeal, the period for making the benefit determination on review shall be tolled from the date the notification requesting the additional information is sent to the Claimant until the date the Claimant responds to the request for additional information.

5. Manner and Content of Notice of Appeal Determinations. The Plan shall provide the Claimant with written or electronic notification of its benefit determination on review. In the case of an Adverse Benefit Determination, the notification shall set forth, in a manner calculated to be understood by the Claimant:

(i) The specific reason(s) for the adverse determination;

(ii) A reference to the specific Plan provisions on which the benefit determination is based;

(iii) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits;

(iv) A statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring an action under ERISA section 502(a) or under state law, as applicable **plus a statement that the Claimant has one year from the date of the Adverse Benefit Determination to bring suit under ERISA**;

(v) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;

(vi) If the Adverse Benefit Determination is based on a medical necessity or Experimental or Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(vii) A statement that the Claimant may have other voluntary alternative dispute resolution options, such as mediation.

Federal External Review Process

1. Request for External Review. The Plan shall allow a Claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination). If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following receipt of the notice. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

The external review process applies only to an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by the Plan that involves:

(i) Medical judgment, which includes, but is not limited to, determinations based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is Experimental or Investigational, as determined by the external reviewer; and

(ii) A rescission of coverage, whether or not the rescission has any effect on any particular benefit at that time.

2. Preliminary review. Within five (5) business days after receiving a Claimant's external review request, the Plan shall

complete a preliminary review of the request to determine whether:

i) The Claimant is (or was) covered under the Plan when the health care item or service was requested or, in the case of a retrospective review, whether the Claimant was covered under the Plan when the health care item or service was provided;

ii) The Adverse Benefit Determination does not relate to the Claimant's failure to meet the Plan's eligibility requirements;

iii) The Claimant has exhausted the Plan's internal claims and appeals process, unless the Claimant is not required to do so, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim; and

iv) The Claimant has provided all the information and forms required to process the external review.

Within one (1) business day after completion of the preliminary review, the Plan shall issue a written notice to the Claimant. If the request is complete but not eligible for external review, the notice shall include the reasons for its ineligibility, as well as contact information for the Employee Benefits Security Administration (866) 444-EBSA (3272). If the request is incomplete, the notice shall describe the information or materials needed to complete the request, which must be received by the Plan within the four-month filing period or within 48 hours after receipt of the notice, whichever is later.

3. Referral to Independent Review Organization. The Plan shall assign an Independent Review Organization (IRO) that is accredited by URAC or by a similar nationally recognized

accrediting organization to conduct the external review. Moreover, the Plan shall take action against bias and ensure independence. Accordingly, the Plan shall contract with at least three IROs for assignments under the Plan and incorporate an independent unbiased method for IRO selection. The IRO shall not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The agreement between the Plan and the assigned IRO shall include the following:

i) The IRO shall utilize legal experts where appropriate to make coverage determinations under the Plan.

ii) The IRO shall provide the Claimant with written notice of the request's eligibility and acceptance for external review. The notice must inform Claimants that they may submit additional information in writing to the IRO within 10 business days following receipt of the notice and that the IRO must consider such additional information in its external review. The IRO may also accept and consider additional information that is submitted after 10 business days, but it is not required to do so.

iii) Within five (5) business days after the date the IRO is assigned, the Plan shall provide to the IRO the documents and any information considered in making the Adverse Benefit Determination. The Plan's failure to timely provide such documents and information shall not delay the external review. If the Plan fails to timely provide the documents and information, the IRO may terminate the external review and reverse the Adverse Benefit Determination. If the IRO does so, it

shall notify the Claimant and the Plan within one (1) business day after making the decision.

iv) Upon receipt of any information submitted by the Claimant, the IRO shall forward the information to the Plan within one (1) business day. The Plan may then reconsider its Adverse Benefit Determination, but such reconsideration shall not delay the external review. If the Plan decides, on reconsideration, to reverse its Adverse Benefit Determination and provide coverage or payment, then the external review can be terminated. The Plan must provide written notice to the Claimant and IRO within one (1) business day after making this decision. On receiving the Plan's notice, the IRO must terminate its external review.

v) The IRO shall review all of the information and documents timely received. In reaching a decision, the IRO shall review the claim anew and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

vi) In addition to documents and information provided by the Claimant, the IRO shall consider the following items in reaching a decision (to the extent the information or documents are available and the IRO considers them appropriate):

(A) The Claimant's medical records;

(B) The attending health care professional's recommendation;

(C) Reports from appropriate health care professionals and other documents submitted by the Plan, Claimant, or the

Claimant's treating provider;

(D) The terms of the Claimant's Plan, to ensure that the IRO's decision is not inconsistent with the Plan's terms, unless the terms are contrary to applicable law;

(E) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(F) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or applicable law; and

(G) The opinion of the IRO's clinical reviewer(s).

vii) Within 45 days after receiving the external review request, the IRO shall provide written notice of the final external review decision to both the Claimant and the Plan. The IRO's notice shall contain:

(A) A general description of the reason for the external review request, including information sufficient to identify the claim: date(s) of service, health care provider, claim amount (if applicable), diagnosis and treatment codes (and their corresponding meanings), and the reason for the previous denial;

(B) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(C) References to the evidence or

documentation considered in reaching the decision, including specific coverage provisions and evidence-based standards;

(D) A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards that the IRO relied on;

(E) A statement that the IRO's determination is binding on the Plan and the Claimant, unless other remedies are available under state or federal law; therefore, the Plan must provide any benefits (including paying the claim at issue) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise. This requirement shall not preclude the Plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits;

(F) A statement that judicial review may be available to the Claimant; and

(G) Current contact information and phone number for any applicable office of health insurance consumer assistance or ombudsman established under PHSA section 2793.

viii) After a final external review decision, the IRO shall maintain records of all claims and

notices associated with the external review process for six years. The IRO shall make such records available for examination by the Claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

4. Request for Expedited External Review. The Plan shall permit a Claimant to request an expedited external review when the Claimant receives:

i) An Adverse Benefit Determination involving a Claimant's medical condition where the timeframe for completing an expedited *internal* appeal would seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function, and the Claimant has filed an expedited internal appeal request; or

ii) A Final Internal Adverse Benefit Determination involving (1) a Claimant's medical condition where the timeframe for completing a standard *external* review would seriously jeopardize the life or health of the Claimant or the Claimant's ability to regain maximum function, or (2) an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services but has not been discharged from a facility.

Immediately upon receiving the expedited external review request, the Plan shall complete a preliminary review to assess whether the request meets the reviewability requirements applicable under the standard external review process set forth above. The Plan shall immediately send the Claimant a notice regarding the Plan's

reviewability assessment; this notice must meet the requirements applicable under the standard external review process set forth above.

Following a preliminary review determination that a request is eligible for external review, the Plan shall assign an IRO based on the standard external review process set forth above. The Plan shall provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the IRO. The documents and information can be provided electronically, by telephone or facsimile, or any other expeditious method available.

The IRO shall consider the documents and information according to the procedures for standard external review set forth above, to the extent the documents or information are available and the IRO considers them appropriate. In reaching a decision, the IRO shall review the claim anew and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The agreement between the Plan and the IRO shall require the IRO to provide notice of its final external review decision; this notice must meet the requirements applicable under the standard external review process set forth above. The notice must be provided as expeditiously as the Claimant's medical condition or circumstances require, but not more than 72 hours after the IRO receives the expedited external review request. If the notice is not in writing, the IRO shall provide written confirmation of the decision to the Claimant and the Plan within 48 hours after the date it provides the non-written notice.

Definitions

(1) Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on a determination of a Claimant's eligibility to participate in the Plan. An Adverse Benefit Determination includes determinations based on utilization review, Experimental or Investigational exclusions, and medical necessity, in addition to any rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at the time. A rescission means a cancellation or discontinuance of coverage that has retroactive effect, unless attributable to a failure to timely pay required contributions toward the cost of coverage.

(2) Final Internal Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

(3) Urgent Care Claim means a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function; or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether a claim is an Urgent Care Claim is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any claim that a physician with knowledge

of the Claimant's medical condition determines is an Urgent Care Claim shall be treated as an Urgent Care Claim for purposes of this claims and appeals process.

Information on Claim Forms

For information on claim forms call or write:

For Medical:

Independence
Administrators
PO Box 21974
Eagan, MN 55121
(Payor ID 54763)
Telephone: 1 (833) 242-3330

For Vision, Dental, Death, and Disability:

Associated Administrators, LLC
911 Ridgebrook Road
Sparks, MD 21152-9451
Telephone: (888) 494-4443

When to Notify the Administrator

You should notify the Administrator whenever:

- You change your mailing address;
- You are receiving workers' compensation benefits or are eligible to recover damages from, or settle for damages with, a person or organization which caused you expenses paid for by the Plan;
- You enter, or are discharged from, the Armed Services;
- Your dependency status changes - you marry or are divorced, a new dependent is added, etc.;
- You apply for retirement benefits with the Carpenters Local No. 491 Pension Plan;
- You become disabled or return to employment after ceasing to be disabled;
- You or your spouse reach age 65;
- You desire to make a self-payment into the Health and Welfare Plan;
- Your spouse changes employment; or
- You or your spouse become eligible for Medicare.

Utilization Review

The health benefits provided by the Plan are limited to charges for services which are necessary to the care and treatment of an illness or accident. The Plan Administrator may from time to time utilize a hospital admission review program to review and reduce costs associated with unnecessary and excessive medical treatment. Further, the Plan requires pre-certification for hospital admissions. The Plan does not require pre-authorization for emergency services. The Plan will not increase coinsurance and co-payment requirements for out-of-network emergency services.

Action of the Trustees

Wherever in the Plan the Trustees are given discretionary powers, the Trustees shall exercise such powers in a uniform and non-discriminatory manner. The Trustees shall process a claim for benefits as speedily as is administratively feasible, consistent with the need for adequate information and proof necessary to establish the claimant's benefit rights and to commence the payment of benefits. However, the Trustees shall have the power to interpret, apply and construe all provisions of the Plan in their sole and absolute discretion, and any construction, interpretation and application adopted by the Trustees in good faith shall be binding upon the Union, the employers, any employers' association and the employees.

Notwithstanding anything herein to the contrary, the Trustees shall have sole and absolute discretion in determining eligibility and benefits and in interpreting the terms of the Plan. The Trustees also have authority to make factual findings and the Trustees' decision cannot be overturned unless it is determined to be arbitrary and capricious. Arbitrary and capricious for purposes herein under the Plan shall mean "having no foundation."

GENERAL PROVISIONS

Family and Medical Leave Act, as amended

Participating employees on leave under the Family and Medical Leave Act ("FMLA") are entitled to have health benefits maintained while on leave. The plan costs will be paid in the same manner customarily used. The Plan will continue to pay its share of the plan costs throughout the leave, while the participating employee will be expected to pay according to a signed agreement, which will be executed prior to the leave, as long as the participating employer pays its costs.

The Trustees will expect the employee to reimburse it within 30 days of return for all withholdings that were covered by the Plan during the FMLA leave. If a participating employee does not make the full payment within the 30-day period after return, the Trustees will immediately deduct it from the employee's vacation pay.

The Trustees will recover costs it paid for maintaining Plan coverage if the employee fails to return to work after the leave entitlement has expired, unless the reason the employee does not return to work is due to:

- The continuation, recurrence or onset of a serious health condition affecting the employee or an immediate family member;
- A sudden change in the employee's circumstance during leave; or
- An employee on FMLA was laid off.

In the absence of any of these conditions, the Trustees reserve the right to recover its share of health costs by deducting the amount due from any sums owed to the employee in vacation pay. An employee who does not return to work within 30 calendar days

after leave expires is considered to have failed to "return" to work under FMLA guidelines. The Plan will comply with the Maryland Flexible Leave Act to the extent it is not preempted by the FMLA.

Mental Health Parity and Addiction Equity Act

To the extent that the Plan covers mental health and substance abuse treatment for eligible employees and their dependents, the Plan will provide mental health and substance abuse benefits at the same level as it provides for medical and surgical benefits pursuant to the Mental Health Parity and Addiction Equity Act ("MHPAEA").

Michelle's Law

To the extent applicable, the Plan will comply with Michelle's Law.

Genetic Information Nondiscrimination Act

The Plan will comply with the Genetic Information Nondiscrimination Act ("GINA") by not discriminating against you or your dependents based on genetic information. In general, the Plan will not adjust premium or contribution amounts on the basis of genetic information, the Plan will not request or require you or your dependents to undergo genetic tests and the Plan will not request, require or purchase genetic information for underwriting purposes or collect genetic information about you or your dependent before you are enrolled in the Plan.

However, the Plan is not prevented from obtaining and using the results of a genetic test when making payment determinations under the HIPAA privacy regulations as well as requesting genetic testing for research purposes, if certain criteria are met. Further, if you or any dependent seeks a benefit under the Plan, the Plan can limit or exclude the benefit based on whether the benefit is medically appropriate.

(a) Genetic Information: Notwithstanding anything herein to the contrary, for purposes of GINA, genetic information means information about your genetic tests, the genetic tests of your family members, family medical history, genetic information about a fetus carried by an Employee or family member or of an embryo legally held by the Employee or family member using assisted reproductive technology and the manifestation of a disease or disorder in your family members. It also includes any request for, or receipt of, genetic services or participation in clinical research that includes genetic services. However, genetic information does not include your gender or age.

(b) Family Member: Notwithstanding anything herein to the contrary, for purposes of GINA, family member means an individual who may become eligible for coverage because of his or her relationship to you or any other person who is a 1st, 2nd, 3rd or 4th degree relative of you or your dependent (including relatives by marriage or adoption).

Children's Health Insurance Program Reauthorization Act

If applicable, the Plan will comply with the special enrollment rights under the Children's Health Insurance Program Reauthorization Act ("CHIPRA"). The Plan will allow you and your dependents who become eligible, but are not enrolled, to enroll, as long as CHIPRA is in effect, if either of the following two conditions are met: (i) you or your dependent is covered under Medicare or a State child health plan and coverage of you or your dependent under such plan is terminated as a result of the loss of eligibility for such coverage and you request coverage under the Plan no later than 60 days after the termination of such coverage; or (ii) you or your dependent becomes eligible for financial assistance, with regard to coverage under the Plan or a State child health plan, if you request coverage under the Plan no later than 60 days after you or your dependent is determined to be eligible for assistance.

Patient Protection and Affordable Care Act and the Health Care Education and Reconciliation Act of 2010

The Plan will comply with the Patient Protection and Affordable Care Act ("PPACA") and the Health Care and Education Reconciliation Act of 2010 (the "Reconciliation Act"). To the extent mandated by law, the Plan will provide the necessary "Essential Health Benefits." Coverage will not be rescinded except in the case of fraud and intentional misrepresentation of material facts. However, the Plan Administrator has the sole and absolute discretion to rescind coverage for those reasons.

Subject to future requirements mandated by law, Essential Health Benefits shall include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Pursuant to the PPACA and the Reconciliation Act, there are no lifetime limits or annual limits on the dollar value of Essential Health Benefits under the Plan.

Use and Disclosure of Protected Health Information

Protected Health Information (PHI) is individually identifiable health information that is maintained, created or transmitted by a covered entity, such as the Plan. Individually identifiable health information is health information that relates to an individual's past, present or future physical or mental health or condition, or to the provision of health care to that person, or to the past, present or future payment for that person's health care. Examples of PHI held, created, or maintained by the Plan include claims information

and claims payment history as well as enrollment and disenrollment information.

The Plan will use PHI to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Privacy Rules (Privacy Rules), as revised, and the regulations thereunder, as well as the Health Information Technology for Economic and Clinical Health Act ("HITECH"). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

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

- Determination of eligibility, coverage and cost-sharing amounts (for example, cost of a benefit, Plan maximums and co-payments as determined for an individual's claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefits claims;
- Establishing employee contributions;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- Medical necessity review or reviews of appropriateness of care or justification of charges;
- Utilization review, including precertification, preauthorization, concurrent review and retrospective review;
- Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
- Reimbursement to the Plan.

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

- Quality assessment;
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;
- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development or improvement of payment methods or coverage policies;
- Business management and general administrative activities of the Plan, including, but not limited to, (a) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or (b) customer services, including the provision of data analyses for policyholders, plan sponsors or other customers;
- Resolution of internal grievances; and
- Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

The Plan will use and disclose PHI as required by law and as permitted by written authorization of the participant or beneficiary. The Plan will disclose PHI to the personal representative of the participant or beneficiary only upon receiving adequate written verification.

With written authorization, the Plan will disclose PHI to pension plans, disability plans, reciprocal benefit plans, and workers' compensation insurers, for purposes related to administration of this Plan.

The Plan will disclose PHI to the Plan Administrator only upon receipt of a certification from the Plan Administrator that the Plan

documents have been amended to incorporate the following provisions:

With respect to PHI, the Plan Administrator agrees to certain conditions. The Plan Administrator agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
- Ensure that any agents, including subcontractors, to whom the Plan Administrator provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Administrator with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual in writing;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Administrator unless authorized in writing by an individual;
- Report to the Plan's designee any PHI use or disclosure that it becomes aware of which is inconsistent with the uses or disclosures provided for;
- Make PHI available to an individual in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- Make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the U.S. Department of Health and Human Services Secretary for the purposes of determining the Plan's compliance with HIPAA;

- Ensure that adequate separation between the Plan and the Plan Administrator is established as required by HIPAA;
- Ensure that the Plan will comply with the privacy and security rules which were extended so that business associates of the Plan are now required to comply with the security rule;
- If feasible, return or destroy all PHI received from the Plan that the Plan Administrator maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible);
- Ensure that reasonable steps are taken to limit uses, disclosures or requests of PHI to the minimum necessary ("Minimum Necessary Standard") to accomplish the intended purposes (with an exception for disclosures to or requests by a health care provider for treatment purposes, or to disclosures to the individual who is the subject of the information);
- Mitigate, to the extent possible, any harmful effects that become known to the Plan Administrator of a use or disclosure of an individual's PHI in violation of the Plan, HIPAA, HITECH or other related law;
- Require that requests for disclosures of PHI from the individual's spouse, family member or friends are fulfilled only after receiving appropriate written authorization;
- In the event of a breach of PHI, follow the HITECH Breach Notification Rules for informing affected individuals, the Department of Health and Human Services and the media, as required by law; and
- Ensure that executed business associate agreements are in place with all business associates and/or subcontractors that have access to PHI.

Adequate separation between the Plan and the Plan Administrator will be maintained.

In accordance with HIPAA, only the Plan office employees and employees of the third-party administrator, if any, may be given access to PHI.

The persons above described can only have access to and use and disclose PHI for Plan administration functions that the Plan Administrator performs for the Plan.

The persons above described may only use or disclose PHI when it is necessary to satisfy a particular purpose or to carry out a necessary function and in compliance with the Minimum Necessary Standard.

If the persons above described do not comply with this Plan document, the Plan Administrator shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's Privacy Notice, which follows immediately and is also available from the Plan Administrator.

This Plan and the Plan Administrator will not use or further disclose information that is protected by HIPAA (PHI) except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Administrator. In accordance with HIPAA and any other applicable law, in the event there are any unauthorized disclosures of PHI, the Plan will promptly notify those affected of the breach through proper notification.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a Privacy Notice, as follows, which provides a complete description of your rights under HIPAA's privacy rules. For another copy of the Privacy Notice, please contact the Plan Administrator. If you have questions about the privacy of your health information, please contact the Plan Administrator. If you

wish to file a complaint under HIPAA, please contact the Plan Administrator.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Plan is required by applicable federal and state law to maintain the privacy of an employee's PHI. The Plan is also required to give each employee a notice about its privacy practices, its legal duties, and his rights concerning PHI. The Plan must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2004, and will remain in effect until the Plan replaces it.

The Carpenters Local No. 491 Health and Welfare Plan (the Plan) uses health information about each employee for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that he receives. The health information is contained in a medical record that is the physical property of the Plan.

How Your Health Information May be Used or Disclosed

For Treatment. The Plan may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a doctor, nurse, or other person providing health services to you, will be recorded as it relates to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you will respond to the actions.

For Payment. The Plan may use and disclose your health information to others for purposes of receiving payment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment of supplies used in the course of treatment. The Plan may also review information from a doctor about a treatment you have received or are going to receive to decide if the Plan will cover the treatment.

For Health Care Operations. The Plan may use and disclose health information about you for operational procedures. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

- Evaluate the utilization and effectiveness of benefits under the Plan;
- Evaluate the performance of staff;
- Assess the business management and general admission of the Plan, including but not limited to legal services, audit services, fraud and abuse detection programs and cost management;
- Assess the quality of care and outcomes in your case and in similar cases;
- Learn how to improve facilities and services; and
- Determine how to improve the quality and effectiveness of the provided health care.

Appointments. The Plan may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest.

Required by Law. The Plan may use and disclose information about you as required by law. For example, the Plan may disclose any information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority;
- To report information related to victims of abuse, neglect or domestic violence; and
- To assist law enforcement officials in their official duties.

Public Health. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Decedents. Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation. Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

Research. The Plan may use your health information for research purposes when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Health and Safety. Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions. Specialized government functions, such as protection of public officials or reporting to various branches of the armed services, may require use or disclosure of your health information.

Workers' Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to workers' compensation.

The Plan Sponsor. The Plan may disclose PHI to the Plan Sponsor for plan administrative purposes. The Plan Sponsor may need your PHI to administer benefits under the Plan. The Plan Sponsor agrees not to use or disclose PHI other than as permitted or required by the documents governing the Plan and by law. The Plan Sponsor cannot and will not use PHI obtained from the Plan for any employment-related actions. The Plan may also disclose your PHI to the Plan Sponsor to enable it to perform enrollment and disenrollment functions and to make decisions about the structure of the Plan, among other things.

To, From and Between Business Associates. The Plan contracts with business associates to provide certain services, such as the review of elements of participants' care and to administer claims. The Plan may disclose PHI to its business associates, receive PHI from its business associates and its business associates may share PHI between themselves. For example, the Plan may disclose your PHI to the Plan's third-party administrators or other service providers. To protect PHI, however, the Plan requires business associates to sign contracts agreeing to appropriately safeguard PHI.

For Health-Related Benefits and Services. The Plan may use and disclose PHI to tell you about or recommend possible treatment options or alternatives and to provide appointment reminders.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, the Plan may disclose PHI in response to a court or administrative order.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement officer, the Plan may release PHI

to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Genetic Information. The Plan is prohibited from using or disclosing genetic information for underwriting purposes under the Genetic Information Nondiscrimination Act as described herein.

Your Health Information Rights

You have the right to:

- Request a restriction on certain uses and disclosures of your information; however, the Plan is not required to agree to a requested restriction;
- Obtain a paper copy of the Notice of Privacy Practices upon request;
- Inspect and obtain a copy of your health record;
- Amend your health record;
- Request communications of your health information by alternative means or at alternative locations;
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken; and
- Receive an accounting of disclosures made of your health information.

Authorization: You may give the Plan a written authorization to use your PHI or to disclose it to anyone for any purpose. If you give the Plan an authorization, you may revoke it in writing at any time unless the Plan has taken action relying on the authorization or if you signed the authorization as a condition of obtaining insurance coverage. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give a written authorization, the Plan cannot use or disclose your

medical information for any reason except those described in this notice.

The following disclosures will be made only after receiving your written authorization:

- disclosure of psychotherapy notes;
- disclosure of PHI for marketing purposes, including subsidized treatment conditions;
- disclosures that constitute a sale of PHI; and
- other uses and disclosures not described in the Notice of Privacy Practices.

A valid authorization to use or disclose your PHI must contain the following:

- description of the information to be disclosed;
- identification of person(s) authorized to use or disclose your medical information and to whom your medical information may be disclosed;
- purpose of the requested disclosure;
- expiration date or event that would terminate the authorization;
- signatures by individuals whose information will be disclosed; and
- statements regarding your right to revoke authorization and the Plan's inability to condition treatment, payment, enrollment or eligibility for benefits on authorization and potential for redisclosure.

You will receive a signed copy of the authorization if an authorization was requested by an individual or entity other than yourself.

The Plan will not disclose your medical information for any employment purpose without your authorization. The Plan will not

condition treatment or payment on an authorization, except in very limited circumstances.

Disclosure to Your Family or Person Designated by You: The Plan may disclose your PHI to a family member or other person designated by you to the extent necessary to help with your health care or with payment for your health care, with your verbal permission and in circumstances where it is impracticable to get your written permission. The Plan may use or disclose your name, location, and general condition or death to notify, or assist in the notification of (including identifying or locating), a person involved in your care.

Before the Plan discloses your medical information to a person involved in your health care or payment for your health care, the Plan will provide you with an opportunity to object to such uses or disclosures. If you are not present, or in the event of your incapacity or an emergency, the Plan will disclose your medical information based on its professional judgment on whether the disclosure would be in your best interest.

Access: You have the right to look at or get copies of your medical information, with limited exceptions. You must make a request in writing to obtain access to your medical information. You may obtain a form to request access by contacting the Plan Administrator. Where appropriate, the Plan may provide you with a summary of, rather than access to, PHI. If you request copies, the Plan may charge you reasonable cost-based photocopying and postage costs.

The Plan will respond to your request within 30 days for medical information that the Plan maintains on site or within 60 days if the medical information is not on site.

The Plan may deny access to your medical information in certain specified circumstances. If the Plan denies your request, it will

provide you with a written denial that includes the reason for the denial, a statement about your right to review the denial (if applicable), and a description of the Plan's complaint procedures, including the name, title and telephone number of the Plan's contact person. In certain very limited circumstances, the Plan's denial will be unreviewable. Ordinarily, however, you may request within a reasonable period of time that the denial be reviewed. Except for unusual circumstances, 90 days will be deemed a reasonable period of time in which to review a request.

Disclosure Accounting: You have the right to receive a list of instances in which the Plan or its business associates disclosed your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities, beginning April 14, 2004. This right to an accounting extends to disclosures made by the Plan at any time in the last six years (but not including any time prior to April 14, 2004). This right does not include disclosures:

i. To you or persons involved in your health care or payment for that care.
ii. Pursuant to your written authorization.
iii. For the purpose of carrying out treatment, payment or health care operations.
iv. That are incidental to another impermissible use or disclosure.
v. For disaster relief, national security or intelligence purposes.
vi. To correctional institutions or law enforcement officers who have you in custody at the time of the disclosure.
vii. As a part of a limited data set.
viii. To a health oversight agency or law enforcement.

The Plan will provide you with the date on which it made the disclosure, the name of the person or entity to which the Plan

disclosed your medical information, a description of the medical information the Plan disclosed, the reason for the disclosure, and certain other information. The Plan will respond to an accounting request within 60 days.

You must state the time period for the request, which may not be longer than six years. If you request this accounting more than once in a twelve-month period, the Plan may charge you a reasonable, cost-based fee for responding to these additional requests. The Plan will notify you of the cost involved and you may then choose to withdraw or modify the request at that time before any costs are incurred. You may request a disclosure accounting by contacting the Plan Administrator.

The Plan must act on your request for an accounting of disclosures of PHI no later than 60 days after receipt of the request. The Plan may extend the time for providing you with an accounting by no more than 30 days, but it must provide you with a written explanation for the delay. You may request one accounting in any 12-month period, free of charge.

Restriction: You have the right to request that the Plan place additional restrictions on its use or disclosure of your medical information for treatment, payment or health care operations. You also have the right to request a limit on the health information that the Plan discloses to someone who is involved in your care or the payment of your care, such as a family member or friend. You may request a restriction by contacting the Plan Administrator.

The Plan is required to grant your request or limit the PHI the Plan uses or discloses about you for payment and/or health care operations if such PHI relates only to a health care item or service for which you paid the health care provider in full, out-of-pocket. Under such circumstances, any agreement to additional restrictions must be in writing signed by a person authorized to make such an agreement on the Plan's behalf, and the request

should identify (i) the information to be restricted; (ii) the type of restriction being requested (i.e., on the use of information, the disclosure of information or both); and (iii) to whom the limits should apply. In all other circumstances, the Plan is not required to agree with your request.

If the Plan is required to grant your request, or elects to do so, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for PHI created or received after you are notified that the restriction has been removed. The Plan may disclose your PHI if you need emergency treatment, even if the Plan has provided for a restriction.

Any request for a restriction must indicate what information you want to limit, whether you want to limit the Plan's use, disclosure or both and to whom you want the limits to apply.

Confidential Communication: You have the right to request that the Plan communicates with you about your medical information by alternative means or to alternative locations. You must make your request in writing. The Plan must accommodate your request if it is reasonable and specifies the alternative means or location. The Plan will accommodate reasonable requests that must clearly state that disclosure of all or part of the medical information could endanger your health or safety. Please contact the Plan Administrator for the forms necessary to process your request.

Amendment: You have the right to request that the Plan amend your PHI for as long as the information is kept by or for the Plan. Your request must be in writing, and it must explain why the information should be amended. The Plan may deny your request if the Plan did not create the information you want amended. The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny the request if the information:

i. Is not part of the PHI kept by or for the Plan;
ii. Was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
iii. Is not part of the information which you would be permitted to inspect or copy; or
iv. Is not accurate and/or not complete.

If the Plan denies your request, the Plan will provide you with a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If the Plan accepts your request to amend the information, the Plan will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

The Plan maintains a process to track and timely respond to individual requests for amendments, the Plan's denials of the amendment, the individual's statement of disagreement, and the Plan's rebuttal, as applicable. The Plan will respond to an amendment request within 60 days, and it may extend this period by 30 days, if it gives you notice within the original 60-day period.

Please contact the Plan Administrator for the forms necessary to process your request.

Obligations of the Plan

The Plan is required to:

- Maintain the privacy of protected health information;
- Provide you with this notice of its legal duties and privacy practices with respect to your health information;
- Abide by the terms of this Notice;
- Notify you if the Plan is unable to agree to a requested restriction on how your information is used or disclosed;
- Accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations; and
- Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

The Plan reserves the right to change its health information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you within 60 days of any change.

Questions and Complaints

The Plan has designated a Privacy Officer responsible for implementation of policies and procedures regarding the Privacy Rules and for handling complaints. The contact person for receiving complaints and providing additional information regarding the Plan's privacy procedures is:

Plan Administrator
The Board of Trustees of Carpenters Local No. 491 Health and Welfare Plan
c/o Carpenters Local No. 491 Health and Welfare Plan
911 Ridgebrook Road
Sparks, Maryland 21152-9451
Telephone: (888) 494-4443

If you are concerned that the Plan may have violated your privacy rights, or you disagree with a decision the Plan made about access to medical information or in response to a request to amend or restrict the use or disclosure of medical information or to have the Plan communicate by alternative means or at alternative locations, you may contact the Plan Administrator or the Privacy Officer. You also may submit a written complaint to the U.S. Department of Health and Human Services Office for Civil Rights. The Office for Civil Rights provides further information on its website about how to file a complaint: www.hhs.gov/ocr/hipaa.

Missing Persons

The Trustees shall make a reasonable effort to locate all persons entitled to benefits under the Plan; however, notwithstanding any provision in the Plan to the contrary, if, after a period of five (5) years from the date such benefit shall be due, any such persons entitled to benefits have not been located, their rights under the Plan shall stand suspended. Before this provision becomes

operative, the Trustees shall send a certified letter to all such persons at their last known address advising them that their interest or benefits under the Plan shall be suspended. Any such suspended amounts shall be held by the Trustees for a period of three (3) additional years (or a total of eight (8) years from the time the benefits first became payable). Provided, however, that if a person subsequently makes a valid claim with respect to such suspended benefits, his right to benefits shall be reinstated. Any such suspended amounts shall be handled in a manner not inconsistent with regulations issued by the Internal Revenue Service and U.S. Department of Labor.

GENERAL INFORMATION

Board of Trustees' Discretion

The Board of Trustees has full and exclusive authority and discretion to determine all questions of coverage, eligibility for and entitlement to benefits, methods of providing or arranging for benefits, and other related matters.

Amendment or Termination of the Plan

Neither this Plan nor any of its benefits is guaranteed. Although the Plan is intended to be permanent, the Board of Trustees may amend or terminate the Plan, in whole or part, as it finds necessary. The nature and amount of Plan benefits always are subject to the actual terms of the Plan as it exists at the time the claim occurs.

Name, Address and Telephone Number of the Plan

Carpenters Local No. 491 Health and Welfare Plan
911 Ridgebrook Road, Sparks, MD 21152-9451, (888) 494-4443

Type of Administration of the Plan

The Plan is administered by a Joint Board of Trustees. The daily administrative duties are performed under a contract with Associated Administrators, LLC. Notwithstanding anything herein or the Plan or Trust Agreement to the contrary, the Administrator shall have sole and absolute discretion in determining eligibility and benefits and in interpreting the terms of the Plan. The Administrator also has authority to make factual findings and the Administrator's decision cannot be overturned unless it is determined to be arbitrary and capricious. Arbitrary and capricious for purposes herein shall mean "having no foundation."

Names and Addresses of the Trustees

Ken Bisch
Carpenters Local No. 491
Health and Welfare Plan
911 Ridgebrook Road
Sparks, MD 21152-9451

Robert Tarby
Carpenters Local No. 491
Health and Welfare Plan
911 Ridgebrook Road
Sparks, MD 21152-9451

Mike Goodwin
Carpenters Local No. 491
Health and Welfare Plan
911 Ridgebrook Road
Sparks, MD 21152-9451

Sandra Forstner
Carpenters Local No. 491
Health and Welfare Plan
911 Ridgebrook Road
Sparks, MD 21152-9451

Bill Sproule
Carpenters Local No. 491
Health and Welfare Plan
911 Ridgebrook Road
Sparks, MD 21152-9451

Todd Weitzman
Carpenters Local No. 491
Health and Welfare Plan
911 Ridgebrook Road
Sparks, MD 21152-9451

Legal Process

The name and address of the person designated as agent for the service of legal process is as follows:

The Board of Trustees of the Carpenters Local No. 491
Health and Welfare Plan
c/o Associated Administrators, LLC
911 Ridgebrook Road
Sparks, MD 21152-9451

Service may also be made on any Trustee at the address shown above.

IRS Plan Identification Number

The Employer Identification Number (EIN) issued to the Plan by the IRS is 52-1252611.

Plan Number

The Plan Number assigned by the Board of Trustees is 501.

Type of Plan

This is a health and welfare benefit plan which provides from time to time, death benefits, weekly disability benefits, medical benefits, vision benefits, dental benefits and prescription drug benefits.

Plan Year

January 1 - December 31

Funding Medium

Benefits under the Plan are provided from the Plan's assets, which are accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement. These assets are invested and held in a Trust Fund for the purpose of providing benefits to covered participants and paying reasonable administrative expenses.

Sources of Contributions

Contributions are 100% employer paid pursuant to the terms of the collective bargaining agreements, other than any self-payments. A complete list of contributing employers and employee organizations sponsoring the Plan is available for examination by participants and their beneficiaries upon written request to the Plan Administrator. If you wish to examine the list of contributing employers, you may do so at the business office of the Union during normal business hours. For information as to whether a particular employer participates in the Plan, you may contact the Plan Trustees. The Plan Trustees will inform you whether such employer participates in the Plan and, if so, the address of such employer.

PLAN DOCUMENTS AND REPORTS

Participants and Beneficiaries may examine the following documents at the Office of the Administrator during regular business hours, Monday through Friday, except holidays:

- Trust Agreement
- Collective Bargaining Agreements (may be examined at the Office of the Union)
- Plan documents and all amendments
- Form 5500, a Full Annual Report filed with the U.S. Department of Labor
- Form 990
- Form 1024

ACKNOWLEDGMENT OF RECEIPT

I hereby acknowledge receipt of the SPD for Carpenters Local No. 491 Health & Welfare Plan. I will review the SPD and understand that any conflict between it and the Plan will be resolved by reference to the Plan and I understand that the Plan may be changed from time to time.

_____ _____

Signature of Participant Date

APPENDIX A

SAMPLE DOCUMENTS

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE PLAN

Introduction

You are receiving this notice because you have recently become covered under the Carpenters Local No. 491 Health and Welfare Plan (the "Plan"). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

(1) Your hours of employment are reduced, or
(2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

(1) Your spouse dies;
(2) Your spouse's hours of employment are reduced;
(3) Your spouse's employment ends for any reason other than his or her gross misconduct;
(4) Your spouse becomes entitled to Medicare benefits (Part A, Part B, or both); or
(5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

(1) The parent-employee dies;
(2) The parent-employee's hours of employment are reduced;
(3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
(4) The parent-employee becomes entitled to Medicare benefits (Part A, Part B or both);
(5) The parents become divorced or legally separated; or
(6) The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to a participating employer and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA coverage 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer or the employee's becoming entitled to Medicare benefits (part A, Part B or both), the employer must notify the Plan Administrator of the qualifying event following the date that coverage ends.

You Must Give Notice of Some Qualifying Events

For the 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 Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to the Board of Trustees, Carpenters Local No. 491 Health and Welfare Plan, c/o Associated Administrators, LLC, 911 Ridgebrook Road, Sparks, MD 21152-9451, Telephone: (888) 494-4443, Facsimile: (410) 683-7796.

How is COBRA Coverage Provided?

Once the Plan Administrator 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (Part A, Part B or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and

children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage.

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

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

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

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

Board of Trustees of the Carpenters Local No. 491
Health and Welfare Plan
c/o Associated Administrators, LLC
911 Ridgebrook Road
Sparks, MD 21152-9451
Telephone: (888) 494-4443
Facsimile: (410) 683-7796

COBRA CONTINUATION COVERAGE ELECTION NOTICE
CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE PLAN

[enter date of notice]

Dear *[identify the qualified beneficiary(ies), by name or status]:*

This notice contains important information about your right to continue your health care coverage in the Carpenters Local No. 491 Health and Welfare Plan (the "Plan"), as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace. Please read the information contained in this notice very carefully.

To elect COBRA continuation coverage, follow the instructions on the next page to complete the enclosed Election Form and submit it to us.

If you do not elect COBRA continuation coverage, your coverage under the Plan will end on *[enter date]* due to *[check appropriate box]:*

❏ End of Employment
❏ Death of Employee
❏ Entitlement to Medicare
❏ Reduction in hours of employment
❏ Divorce or legal separation
❏ Loss of dependent child status

Each person ("qualified beneficiary") in the category(ies) checked below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for up to _____ *[Enter 18 or 36, as appropriate and check appropriate box or boxes; names may be added]*

❏ Employee or former employee
❏ Spouse or former spouse of employee
❏ Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
❏ Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

If elected, COBRA continuation coverage will begin on *[enter date]* and can last until *[enter date].* [Add, if appropriate: You may elect any of the following options for COBRA continuation coverage: *[list available coverage options]*

COBRA continuation coverage will cost: *[enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods.]*You do not have to send any payment with the Election Form. Important additional information about payment for COBRA continuation coverage is included in the pages following the Election Form.

There may be other coverage options for you and your family. When key parts of the health care law take effect, you may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, individuals may be eligible for a new kind of tax credit that lowers monthly premiums right away, and individuals can see what the premiums, deductibles, and out-of-pocket costs will be before a decision to enroll is made. Being eligible for COBRA does not limit one's eligibility for coverage for a tax credit through the Marketplace. Additionally, individuals may qualify for a special enrollment opportunity for another group health plan for which they are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if they request enrollment within 30 days.

If you have questions about your rights to COBRA continuation coverage, you should contact the Board of Trustees of the Carpenters Local No. 491 Health and Welfare Plan, c/o Associated Administrators, LLC, 911 Ridgebrook Road, Sparks, MD 21152-9451; Telephone: (888) 494-4443; Facsimile: (410) 683-7796.

COBRA CONTINUATION COVERAGE ELECTION FORM
CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE PLAN

INSTRUCTIONS: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you must have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to: **Board of Trustees of the Carpenters Local No. 491**
Health and Welfare Plan,
c/o Associated Administrators, LLC
911 Ridgebrook Road
Sparks, MD 21152-9451

This Election Form must be completed and returned by mail [*or describe other means of submission and due date*]. If mailed, it must be post-marked no later than [*enter date*].

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.

I/We elect COBRA continuation coverage in the Carpenters Local No. 491 Health and Welfare Plan (the "Plan") as indicated below:

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)

a. _____
[*Add if appropriate*: Coverage option elected: _____]

b. _____
[*Add if appropriate*: Coverage option elected: _____]

c. _____
[*Add if appropriate*: Coverage option elected: _____]

_____ _____
Signature Date

_____ _____
Print Name Relationship to individual(s) listed above

_____

_____ _____
Print Address (Phone Number)

IMPORTANT INFORMATON ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What is continuation coverage?

Federal law requires that most group health plans (including the Carpenters Local No. 491 Health and Welfare Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of "qualifying event," "qualified beneficiaries" can include the employee covered under the group health plan, a covered employee's spouse, and dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including special enrollment rights.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the Plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified

beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid on time,
- a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusions for a pre-existing condition of the qualified beneficiary (note: there are limitations on plans' imposing a pre-existing condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act (PPACA)),
- a covered employee becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of continuation coverage?

If you elect continuation coverage, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Fund Office of a disability or a second qualifying event in order to extend the period of continuation coverage.

Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started 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 continuation coverage. [Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination.

Second qualifying event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lost coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage, even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage The required payment for each continuation coverage period is described in this notice.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the Fund Office at 1 (888) 494-4443 to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the [*enter due date for each monthly payment*] for that coverage period. The Plan will not] send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic

payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to:

Board of Trustees
Carpenters Local No. 491 Health and Welfare Plan
c/o Associated Administrators, LLC
911 Ridgebrook Road
Sparks, MD 21152-9451
Telephone: (888) 494-4443
Facsimile: (410) 683-7796

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have any questions concerning the information in this notice or your rights to coverage, you should contact:

Board of Trustees of the Carpenters
Local No. 491 Health and Welfare Plan
c/o Associated Administrators, LLC
911 Ridgebrook Road
Sparks, MD 21152-9451
Telephone: (888) 494-4443
Facsimile: (410) 683-7796

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at (866) 444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of

information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0123.

OMB Control Number 1210-0123 (expires 09/30/2013)

ANNUAL NOTICE

CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE PLAN

Coverage Under the Women's Health and Cancer Rights Act of 1998:

This Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications at all stages of the mastectomy including lymphedemas (swelling that sometimes happens after treatment for breast cancer).

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits under the Plan. The Plan will provide this coverage in a manner determined in consultation with the attending doctor and patient.

If you would like more information on WHCRA, contact your Plan Administrator at:

Plan Administrator
The Board of Trustees of Carpenters Local No. 491
Health and Welfare Plan
c/o Carpenters Local No. 491 Health and Welfare Plan
911 Ridgebrook Road
Sparks, MD 21152-9451
Telephone: (888) 494-4443

Model Notice of Adverse Benefit Determination

Date of Notice:
Carpenters Local No. 491 Health and Welfare Plan **(888) 494-4443/(410) 683-7796 (fax)**
c/o Associated Administrators, LLC
911 Ridgebrook Road
Sparks, Maryland 21152-9451

This document contains important information that you should retain for your records.

This document serves as notice of an adverse benefit determination. We have declined to provide benefits, in whole or in part, for the requested treatment or service described below. If you think this determination was made in error, you have the right to appeal (see the back of this page for information about your appeal rights).

Case Details:

Name:	**ID Number:**
Claim #:	**Date of Service:**
Provider:	

Reason for Denial (in whole or in part):

Amt. Charged	**Allowed Amt.**	**Other Insurance**	**Deductible**	**Co-pay**	**Coinsurance**	**Other Amts. Not Covered**	**Amt. Paid**

YTD Credit toward Deductible:	**YTD Credit toward Out-of-Pocket Maximum:**
Diagnosis:	
Diagnostic Codes:	**Requested Service(s)/ Treatment Code:**
Treatment Category (Subcategory):	**Denial Codes:**

[If denial is not related to a specific claim, only name and ID number need to be included in the box. The reason for the denial would need to be clear in the narrative below.]

Explanation of Basis for Determination:

If the claim is denied (in whole or in part) and there is more explanation for the basis of the denial, such as the definition of a plan or policy term, include that information here.

Important Information about Your Appeal Rights

What if I need help understanding this denial? Contact us at Associated Administrators, LLC, 911 Ridgebrook Road, Sparks, Maryland, 21152-9451, (888) 494-4443, if you need assistance understanding this notice or our decision to deny you a service or coverage.

What if I don't agree with this decision? You have a right to appeal any decision not to provide you or pay for an item or service (in whole or in part).

How do I file an appeal? Detach and send in the bottom of this form within [insert timeframe, for example, X days from the date of this notice]. [If electronic notice, insert alternate submission instructions.]

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will be conducted within 24 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by [insert instructions for filing internal appeals (and, if applicable, simultaneous external review)].

Who may file an appeal? You or someone you name to act for you (your authorized representative) may file an appeal. [Insert information on how to designate an authorized representative.]

Can I provide additional information about my claim? Yes, you may supply additional information. [Insert any applicable procedures for submission of additional information.]

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge) by contacting us at Associated Administrators, LLC, 911 Ridgebrook Road, Sparks, Maryland, 21152-9451, (888) 494-4443.

What happens next? If you appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Other resources to help you: For questions about your appeal rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). [Insert, if applicable in your state: Additionally, a consumer assistance program may be able to assist you at [insert contact information].]

Appeal Filing Form

[Insert Name and ID Number] [Insert Claim #]
[Insert Patient Name]

Detach this form and send to: [Insert name and contact information]
NAME OF PERSON FILING APPEAL: _____
☐Covered person ☐Patient ☐Authorized Representative

Model Notice of Final Internal Adverse Benefit Determination

Date of Notice:
Carpenters Local No. 491 Health and Welfare Plan
c/o Associated Administrators, LLC
911 Ridgebrook Road
Sparks, Maryland 21152-9451

(888) 494-4443/(410) 683-7796 (fax)
Website/Email Address

This document contains important information that you should retain for your records.

This document serves as notice of a final internal adverse benefit determination. We have declined to provide benefits, in whole or in part, for the requested treatment or service described below. If you think this determination was made in error, you may have the right to appeal (see the back of this page for information about your appeal rights).

Case Details:

Name:	**ID Number:**
Claim #:	**Date of Service:**
Provider:	

Reason for Denial (in whole or in part):

Amt. Charged	**Allowed Amt.**	**Other Insurance**	**Deductible**	**Co-pay**	**Coinsurance**	**Other Amts. Not Covered**	**Amt. Paid**

YTD Credit toward Deductible:	**YTD Credit toward Out-of-Pocket Maximum:**
Diagnosis:	
Diagnostic Codes:	**Requested Service(s)/ Treatment Code:**
Treatment Category (Subcategory):	**Denial Codes:**

[If denial is not related to a specific claim, only name and ID number need to be included in the box. The reason for the denial would need to be clear in the narrative below.]

Background Information: *Describe facts of the case including type of appeal and date appeal filed.*

Final Internal Adverse Benefit Determination: *State that adverse benefit determination has been upheld. List all documents and statements that were reviewed to make this final internal adverse benefit determination*.

Findings: *Discuss the reason or reasons for the final internal adverse benefit determination*.

Important Information about Your Rights to External Review

What if I need help understanding this denial? Contact us at Associated Administrators, LLC, 911 Ridgebrook Road, Sparks, Maryland, 21152-9451, (888) 494-4443, if you need assistance understanding this notice or our decision to deny you a service or coverage.

What if I don't agree with this decision? For most types of claims, you are entitled to request an independent, external review of our decision. Contact us at Associated Administrators, LLC, 911 Ridgebrook Road, Sparks, Maryland, 21152-9451, (888) 494-4443, with any questions on your rights to external review.

How do I file a request for external review? [Insert instructions in place of detachable form at the bottom of this page. If there are no current procedures applicable, insert: Detach and send in the bottom of this form within [insert timeframe].]

What if my situation is urgent? If your situation meets the definition of urgent under the law, the external review of your claim will be conducted as expeditiously as possible. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe your situation is urgent, you may request an expedited external review by [insert instructions to begin the process (such as by phone, fax, electronic submission, etc.)].

Who may file a request for external review? You or someone you name to act for you (your authorized representative) may file a request for external review. [Insert information on how to designate an authorized representative.]

Can I provide additional information about my claim? Yes, once your external review is initiated, you will receive instructions on how to supply additional information.

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge) by contacting us Associated Administrators, LLC, 911 Ridgebrook Road, Sparks, Maryland, 21152-9451, (888) 494-4443.

What happens next? If you request an external review, an independent organization will review our decision and provide you with a written determination. If this organization decides to overturn our decision, we will provide coverage or payment for your health care item or service.

Other resources to help you: For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). [Insert, if applicable in your state: Additionally, a consumer assistance program may be able to assist you at [insert contact information].]

Appeal Filing Form

[Insert Insurer Name] [Insert Name and ID Number]
[Insert Phone Number/ Mailing Address] [Insert Claim #]

Detach this form and send to: [Insert name and contact information]
NAME OF PERSON FILING APPEAL: _____
☐Covered person ☐Patient ☐Authorized Representative

Model Notice of Final External Review Decision

Date of Notice

Carpenters Local No. 491 Health and Welfare Plan
Address

This document contains important information that you should retain for your records.

This document serves as notice of a final external review decision. We have **[upheld/overturned/modified]** the denial of your request for the provision of, or payment for, a health care service or course of treatment.

Historical Case Details:

Name:			**ID Number:**				
Claim #:			**Date of Service:**				
Provider:							
Reason for Denial (in whole or in part):							
Amt. Charged	**Allowed Amt.**	**Other Insurance**	**Deductible**	**Co-pay**	**Coinsurance**	**Other Amts. Not Covered**	**Amt. Paid**
YTD Credit toward Deductible:			**YTD Credit toward Out-of-Pocket Maximum:**				
Diagnosis:							
Diagnostic Codes:			**Requested Service(s)/ Treatment Code:**				
Treatment Category (Subcategory):			**Denial Codes:**				

[If denial is not related to a specific claim, only name and ID number need to be included in the box. The reason for the denial would need to be clear in the narrative below.]

Background Information: *Describe facts of the case including type of appeal, date appeal filed, date appeal was received by IRO and date IRO decision was made.*

Final External Review Decision: *State decision. List all documents and statements that were reviewed to make this final external review decision.*

Findings: *Discuss the principal reason or reasons for IRO decision, including the rationale and any evidence-based standards or coverage provisions that were relied on in making this decision.*

Important Information about Your Appeal Rights

What if I need help understanding this decision?
Contact us [insert IRO contact information] if you need assistance understanding this notice.

What happens now? If we have overturned the denial, your plan or health insurance issuer will now provide service or payment. If we have upheld the denial, there is no further review available under the appeals process. However, you may have other remedies available under State or Federal law, such as filing a lawsuit.

Other resources to help you: For questions about your appeal rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). [Insert, if applicable in your state: Additionally, a consumer assistance program may be able to assist you at [insert contact information].]

Addendum
Certification

WHEREAS the CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE PLAN ("Plan Sponsor") is the sponsor of an employee welfare benefit plan for participating employees and their dependents;

WHEREAS Plan Sponsor's employee welfare benefit plan is a "group health plan" within the meaning of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and

WHEREAS the CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE PLAN ("Health Plan") provides health insurance coverage to the participants and beneficiaries in the Plan Sponsor's group health plan; and

WHEREAS Health Plan and Plan Sponsor desire to exchange health information protected under HIPAA ("protected health information" or "PHI") for purposes related to the administration of the group health plan;

THEREFORE BE IT RESOLVED, that Plan Sponsor hereby certifies to Health Plan the following, as required by Section 45 CFR 164.504(f) of HIPAA:

The Plan documents that govern the Plan Sponsor's group health plan have been amended to incorporate the following provisions and Plan Sponsor agrees to:

- not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law;

- not use or disclose an individual's genetic information for underwriting purposes under the Genetic Information Nondiscrimination Act;
- not disclose psychotherapy notes or other forms of PHI for marketing purposes without express written authorization;
- ensure that any agents, including subcontractors, to whom it provides PHI received from Health Plan agree to the same restrictions and conditions that apply to Plan Sponsor with respect to such PHI, as set forth in an executed business associate agreement;
- not use or disclose PHI for employment-related actions and decisions unless authorized by the affected individual;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of Plan Sponsor, unless authorized by the affected individual;
- report to Health Plan's designee any PHI use or disclosure that it becomes aware of which is inconsistent with the uses or disclosures provided for and implement all necessary breach notification procedures under the HIPAA Privacy Act and as required by law;
- make PHI available to an individual based on HIPAA's access requirements;
- make PHI available for amendment and incorporate any PHI amendments based on HIPAA's amendment requirements;
- make available the information required to provide an accounting of disclosures;
- accommodate a reasonable and specific request to make PHI available by an alternative means of confidential communication;
- make its internal practices, books and records relating to the use and disclosure of PHI received from the Health Plan available to the Secretary of the U.S.

Department of Health and Human Services to determine the Health Plan's compliance with HIPAA;

- ensure that adequate separation between the Health Plan and the Plan Sponsor is established as required by HIPAA (45 CFR 164.504(f)(2)(iii));
- ensure that the Plan will comply with the privacy and security rules which were extended so that business associates of the Plan are now required to comply with both rules; and
- if feasible, return or destroy all PHI received from the Health Plan that Plan Sponsor maintains in any form and retain no copies of such PHI when no longer needed for the specified disclosures to those purposes that make the return or destruction infeasible.

IN WITNESS WHEREOF, this Certification is hereby executed this

_____ day of _____, 2020.

_____

Privacy Officer

Enclosure

STATEMENT OF YOUR RIGHTS UNDER ERISA

As a participant in the CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE PLAN, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974.

1. ERISA provides that all Plan participants shall be entitled to:

a. Examine without charge at the Plan Office and at other specified locations, such as worksites and the Union office, all Plan documents including: insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

b. Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

c. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. 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.

3. 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.

a. 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 any benefit, to which you may be entitled, or exercising your rights under ERISA.

b. If your claim for a benefit is denied, in whole or part, you must receive written explanation of the reason for the denial.

c. You have the right to have the Plan review and reconsider your claim.

4. Under ERISA, there are steps you can take to enforce the above rights.

a. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, the court may require the Plan Administrator to pay a fine for the delay, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

b. If you have a claim for benefits which is denied, in whole or in part, you may file suit in a state or federal court.

5. 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.

a. 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.

b. If you lose the court may order you to pay these costs and fees, if it finds your claim is frivolous.

6. If you have any questions about your Plan, you should contact the Plan Administrator.

7. 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 Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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