OHIO LABORERS Benefits

Summary Plan Description

Effective May 1, 2022

Ohio Laborers' District Council - Ohio Contractors' Association Insurance Fund

Changes to the Summary Plan Description for the Ohio Laborers' District Council – Ohio Contractors' Association Insurance Fund since published on May 1, 2022…

Medical Deductibles

Effective January 1, 2027, For Active Members, Retirees NOT on Medicare, and Dependents (of retirees) NOT on Medicare:

	In Network		Out of Network	
	Current	2027	Current	2027
Individual	$400	$600	$800	$1,200
Family	$800	$1,200	$1,600	$2,400

Prescription Copays

Effective January 1, 2027, For Active Members, Retirees NOT on Medicare, and Dependents (of retirees) NOT on Medicare:

	Retail (1 month)		Mail Order (3 months)	
	Current	2027	Current	2027
Generic	$10	$20	$25	$50
Brand	$30	$60	$75	$150
Specialty	$50	$100	$125	$250

Maximum Out-Of-Pocket (MOOP) Limits

	2024 MOOP Limits (individual/family)	2025 MOOP Limits (individual/family)	2026 MOOP Limits (individual/family)	2027 MOOP Limits (individual/family)
Medical*	$4,425/$8,850	$4,300/$8,600	$4,300/$8,600	$4,500/$9,000
Prescription	$5,000/$10,000	$4,875/$9,750	$6,300/$12,600	$7,500/$15,000
Vision	$25/$50	$25/$50	N/A	N/A

Any future changes to the limits established in accordance with the ACA shall be determined by the Board of Trustees and communicated in the annual Summary of Benefits and Coverage.

*In-network. Out-of-network maximums are doubled.

Claims Administrator for Prescription Drug Benefits

Anthem-CarelonRx

Anthem changed their name from Anthem-IngenioRx to Anthem-CarelonRx.

Vision Benefits – Schedule of Benefits

Contact Lens Fitting Copayments

Daily Wear- $20
Extended Wear- $30
Specialty- $50

Claims Administrator for Hearing Benefits

HearUSA to Epic Hearing

Effective October 1, 2023, Epic Hearing is replacing HearUSA as our hearing aid administrator.

- Routine hearing exam: Once per calendar year
- Hearing aid benefit: $1,449 allowance per ear, every 3 years

To get started, visit EPICHearing.com or call 866-956-5400.

Eligibility – When Coverage Ends

Disenrolling Dependents

The following language was added to the plan, "*the Date you disenroll your Covered Dependent(s) by completing the applicable administrative forms used by the Fund for disenrolling Covered Dependents.*" A member must provide a written request to remove a dependent from their insurance. Forms are available at ohiolaborers.com and can be uploaded through the member's MemberXG account.

COVID-19 Tests

The COVID-19 national and public health emergencies ended effective April 10, 2023. With the end of the emergency, COVID-19 testing will no longer be covered at no cost. This testing includes At-home tests, Rapid tests, and PCR tests (including provider administered tests).

Moving forward, COVID-19 tests may be subject to cost-sharing. There may also be copays for lab work and other test-related services. The OLDC-OCA Insurance Fund Board of Trustees chose to continue to pay for the COVID-19 vaccine at 100%. Eligible members and dependents can continue to receive the COVID-19 vaccine at no cost.

Diabetes Supplies

Members and dependents can no longer get certain glucometers at no cost directly from the manufacturers through Anthem-CarelonRx.

Added Benefits

Sword Health

Sword Health is a suite of health services consisting of Thrive, Move, and Bloom. Sword Thrive is a digital physical therapy program to help members treat preventative, chronic, and post-surgical pain. Sword Move combines data from users' wearable devices with a dedicated personal trainer, to deliver personalized movement programs. Sword Bloom is a combination of individualized care from Pelvic Health Specialists, the Bloom Pod, and the Bloom app provides real-time progress and results.

Sword Health is available to eligible members and dependents through the OLD-OCA Insurance Fund. There are no out-of-pocket costs to participants. Visit enroll.swordhealth.com/OhioLaborers to sign up.

Anthem EAP

Anthem's Employee Assistance Program (EAP) provides immediate, confidential access to information, referrals, and crisis assistance for members and their dependents 24 hours a day, seven days a week. Call 800-865-1044 or visit anthemEAP.com and enter Ohio Laborers to log in. Everything you share is confidential. EAP is here to make sure you and your household members have the support you need for emotional well-being.

Cancer Study Group

A cancer diagnosis often brings one of the most difficult periods of a member's life, and members must make crucial decisions about where to go for care. To help members make these key decisions, OLDC-OCA Insurance Fund is proud to offer CancerNavigator, a no-cost benefit for all eligible members (including covered dependents), as well as Medicare members, effective October 1, 2023. If you are interested in learning more about the CancerNavigator service, call 614-812-0412 to connect with an Oncology Nurse Navigator today.

Ohio Laborers' District Council – Ohio Contractors' Association Insurance Fund
800 Hillsdowne Road
Westerville, OH 43081-3302

(614) 898-9006 or (800) 236-6437

Fax: (614) 898-9176

www.ohiolaborers.com

insurance@ohiolaborers.com

Dear Member:

We are pleased to provide you with this Plan Document/Summary Plan Description ("SPD") effective as of May 1, 2022. This booklet describes all the benefits provided to you by the Ohio Laborers' District Council – Ohio Contractors' Association Insurance Fund ("Fund"). Please read this booklet carefully, share it with your family, and reference it when you have questions regarding your health and welfare (insurance) benefits.

If you have any questions about the information contained in this booklet or about your insurance benefits in general, please don't hesitate to contact Ohio Laborers Benefits.

Sincerely,

Ohio Laborers Benefits and the Board of Trustees

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Medical Benefits

Schedule of Benefits

Claims Administrator: **Anthem Blue Cross Blue Shield** (855) 878-0128		
Medicare Eligible Retirees and Medicare Eligible Dependents of Retirees (Medical and Rx) Plan details not in this booklet, will be mailed separately by Anthem Medicare (833) 848-8730.		
	Network Coverage	**Out-of-Network Coverage**
Benefit Period	January 1st through December 31st	
Pre-Existing Condition Waiting Period	No Pre-Existing Rules	
Annual Deductible All claims will be subject to the annual Deductible, unless otherwise noted. Before the Fund pays for most Covered Expenses, you pay:	$400 per person $800 family maximum	$800 per person $1,600 family maximum
Maximum Out-Of-Pocket (MOOP) Limit The Fund pays 100% for the remainder of the year once you reach your MOOP Limit. MOOP Limit includes Deductibles, Copayments, and Coinsurance, but does not include penalties or balance billings or claims denied as not medically necessary. Any future increases in the limits established in accordance with the ACA shall be split evenly between the medical and prescription limits.	$4,250 per person $8,500 family maximum *Rates subject to change annually.*	$8,500 per person $17,000 family maximum *Rates subject to change annually.*
Coinsurance All claims will be subject to the Coinsurance, unless otherwise noted. Once you meet your annual Deductible, the Fund pays:	80%, then 100% after the annual Out-of-Pocket Maximum is reached	60%, then 100% after the annual Out-of-Pocket Maximum is reached
Office Visit – LiveHealth Online Visit a doctor for free on your smartphone, tablet, or computer with webcam.	100% Not Subject to Copayment or Deductible	Not Covered
Office Visit – Primary Care Providers Applies to the cost of Office Visit only (including consultation and telemedicine services). All other covered charges are subject to Deductible and Coinsurance.	$20 Copayment, then Fund pays 100%	$20 Copayment, then Fund pays 60%
Office Visit - Specialists Applies to the cost of Office Visit only (including consultation and telemedicine services). All other covered charges are subject to Deductible and Coinsurance.	$30 Copayment, then Fund pays 100%	$30 Copayment, then Fund pays 60%
Urgent Care Applies to the cost of Office Visit only.	$50 Copayment, then Fund pays 100%	$50 Copayment, then Fund pays 60%

Emergency Room Applies to room charges only. All other covered charges are subject to Coinsurance, but not subject to Deductible.	$150 Copayment, Copayment Waived if Admitted Fund pays 100% for room charges, 80% for all other covered charges	
Routine Physical Exam – Office Visit Once per Calendar Year.	100% Not Subject to Copayment or Deductible	$20 Copayment, then Fund Pays 60%
Routine Tests EKG, Chest X-ray, Complete Blood Count, Digital Rectal Exam, Cholesterol Screening, Prostate Specific Antigen (PSA), Comprehensive Metabolic Panels, and Urinalysis. Tests covered once per Calendar Year.		60%
Preventive Services Services include evidence-based services that have a rating of "A" or "B" in the United States Preventive Services Task Force, routine immunizations, and other screenings as provided for in the Patient Protection and Affordable Care Act. **Age and other restrictions apply to certain services. Examples: Colonoscopies only covered for ages 45 to 75, Bone Density Testing only covered for women age 60 and older, Herpes Zoster (shingles) Vaccine covered age 50 and older, HPV Vaccine covered under age 27.**		
Well Child Care Plan pays for Preventive Services covered under the Affordable Care Act for children through age 20. Age and other restrictions apply to certain services.		
Birth Control for Women All contraceptive methods for women approved by the FDA. Certain restrictions may apply.		
Routine PAP Smear Test		
Routine Mammogram – Age 40 and Older Once per Calendar Year.		
Routine Mammogram – Under Age 40 Once per Calendar Year.	80%	60%
Influenza Virus Vaccine (Flu Shots) and COVID-19 Vaccine	100%	
Behavioral Health Care & Substance Abuse – Inpatient You must obtain approval before Hospital admission, except for Emergency Admission.	80%	60%
Behavioral Health Care & Substance Abuse – Outpatient	$20 Copayment 100%	$20 Copayment 60%
Speech Therapy Up to 32 visits per year, Facility and Professional.	80%	60%

Physical Therapy, Outpatient Occupational Therapy, and Chiropractic Services Combined 50 visit maximum per calendar year. (Example: 20 visits of PT and 30 visits to Chiropractor or 50 visits all PT) Not subject to Copayments.	80% Not subject to Copayment	60% Not subject to Copayment
Dental Accident Care Impacted wisdom teeth, tooth extractions, TMJ, and expenses related to all facility services for dental procedures (even when deemed a medically appropriate setting) are not covered.	80%	60%
Home Health Care Services Up to 120 days per Calendar Year. Private Duty Nursing counts toward the visit maximum.	80%	60%
Skilled Nursing Facility Care You must obtain approval before admission. Up to 120 days per Calendar Year.	80%	60%
Hospice Care Services Limited to the last six months of life expectancy.	80%	60%
Additional Covered Items Allergy Testing and Treatments Ambulance Services (out-of-network covered at in-network level) Breast Cancer Care Breast Reconstructive Surgery Care Management Durable Medical Equipment (including Jobst/Compression Stockings) General Anesthesia Services Hospital Services (including Semi-Private Room and Board) Human Organ and Tissue Transplant Services Inpatient Physical Medical Rehabilitation (limited to 30 days per calendar year) Maternity Care, Infertility, and Abortion Services (including Initial Newborn Care Exams) Prosthetic Appliances Reconstructive Surgery Sterilization (services not covered under federal mandate) Surgical Care	80%	60%
Note: This is only a partial listing of benefits. Unless otherwise specified, Coinsurance is after Deductible.		
Please note General Plan Exclusions and Limitations beginning on page 109.		

Prescription Drug Benefits

Schedule of Benefits

Claims Administrator: **Anthem – CarelonRx** Pharmacy Member Service is available 24/7 by calling (844) 993-4314		
CarelonRx Home Delivery: (833) 236-6196		
Specialty Medications: **CarelonRx Specialty Pharmacy (833) 255-0645**		
Medicare Eligible Retirees and Medicare Eligible Dependents of Retirees (Medical and Rx) Plan details not in this booklet, will be mailed separately by Anthem Medicare (833) 848-8730.		
Copayments	Retail Pharmacy *(30 days)*	Home Delivery *(90 days)*
Tier 1	$10	$25
Tier 2	$30	$75
Tier 3	$50	$125
Maximum Out-Of-Pocket (MOOP) Limit The Fund pays 100% for the remainder of the calendar year once you reach your MOOP Limit. MOOP Limit does not include penalties or ingredient charges. Any future increases in the limits established in accordance with the ACA shall be split evenly between the medical and prescription limits.	$4,825 per person $9,650 family maximum *Rates subject to change annually.*	
Quantity Limits Taking too much medicine or using it too often isn't safe. And it may even drive up your health care costs. That's why this program limits the amount of medicine that's covered by your plan for a certain length of time. For example, a drug may have a limit of 30 pills per 30 days. You can always find the most current information about covered quantity limits when you log in at anthem.com or call Pharmacy Member Services.		
Mandatory Home Delivery You must use the Home Delivery pharmacy or a CVS retail pharmacy to fill prescriptions for maintenance medications (with limited exceptions). You are permitted to use a retail pharmacy three times (the original prescription, plus two refills) for a maintenance medication. Home Delivery refills require a 90-day prescription.		
Mandatory Generic Drugs The Fund will only pay the cost of the generic drug, if a generic is available. If you or your Physician request a brand name drug instead of a generic drug, you will be responsible for paying the cost difference between the generic and brand name drug in addition to the brand name drug Copayment.		
Specialty Medications You are required to use the Specialty Pharmacy to fill all your prescriptions for specialty medications.		

Step Therapy Certain medications may qualify for Step Therapy, which encourages doctors to first attempt to prescribe lower cost drugs to treat an ongoing condition.	
Smoking Cessation Prescription and over-the-counter FDA approved smoking cessation medications. To get the over-the-counter drugs at no cost, you must have a prescription.	Plan Pays 100%
Influenza Virus Vaccine (Flu Shots) and COVID-19 Vaccine Administration fees may not be covered.	Plan Pays 100%
Diabetic Supplies Insulin needles and syringes; lancets and devices (spring or powered); blood glucose testing strips for home glucose monitors; normal, low, and high calibrator solution/chips; and Alcohol wipes	Plan Pays 100% (coverage limited to listed items only)
Birth Control for Women All contraceptive methods for women approved by the FDA. (* Tier 2 and Tier 3 prescriptions are subject to Copayments when Tier 1 prescriptions are available.)	Plan Pays 100% (certain restrictions apply*)
Prior Authorization Certain medications that may have a risk of side effects, a risk of harmful effects when taken with other drugs, potential for incorrect use or abuse, better options that may cost you less and work better, and rules for use with certain health conditions require authorization from Anthem-CarelonRx before your prescription can be filled.	
Please note General Plan Exclusions and Limitations beginning on page 109.	

Vision Benefits

Schedule of Benefits

Claims Administrator: **National Vision Administrators (NVA)** (800) 672-7723		
	Participating Provider	**Non-Participating Provider**
Examination Once every two calendar years * Higher copayment may apply for Contact Lenses Eye Examination.	100% After $5 Copayment*	Up to $30
Lenses Once every two calendar years *Lens options will be priced by NVA Providers at their wholesale price plus 25%.*	100% Standard Glass or Plastic	Single Vision – Up to $25 Bifocal – Up to $35 Trifocal – Up to $45 Lenticular – Up to $75
Frame Once every two calendar years *Provider will charge the difference between the wholesale cost and the plan allowance plus 20%.*	Wholesale Allowance Up to $40	Up to $25
Maximum Out-Of-Pocket (MOOP) Limit The Fund pays 100% for the remainder of the year once you reach your MOOP Limit. MOOP Limit includes Examination Copayment and purchase of standard frames and lenses, but does not include additional costs for upgraded frames, lenses, and contacts.	$25 per person $50 family maximum	
Contact Lenses Once every two calendar years *In lieu of Lenses & Frame* *Pre-approval required from NVA for Medically Necessary*	Elective – Up to $105, plus routine eye exam Medically Necessary – Up to $150 including routine eye exam	

Fixed Prices on Lens Options Lens options purchased from a participating NVA Provider will be provided to the Member at the amounts listed: *Options not listed will be priced by participating NVA Providers at their wholesale cost plus 25%.*	$10 Solid Tint $12 Fashion / Gradient Tint $10 Standard Scratch-Resistant Coating $12 Ultraviolet Coating $40 Standard Anti-Reflective $20 Glass Photogrey (Single Vision) $30 Glass Photogrey (Multi-Focal) $75 Polarized $50 Progressive Lenses Standard * $65 Transitions Single Vision Standard $70 Transitions Multi-Focal Standard $25 Polycarbonate (Single Vision) $30 Polycarbonate (Multi-Focal) $30 Blended Bifocal (Segment) $55 High Index $100 Progressive Lenses Premium * *Fixed Pricing not available on certain brands.
Discounts In addition to your funded benefit, you are eligible to access the EyeEssential® Plan discount (in network only) on additional purchases during the plan period. Please contact NVA for details.	
Please note General Plan Exclusions and Limitations beginning on page 109.	

Hearing Benefits

Schedule of Benefits

Claims Administrator: **HearUSA*** (800) 442-8231	
	Network Coverage
Hearing Screening One per calendar year	100%
Hearing Aids	$1,200 per ear every 36 months
Additional Hearing Aid Supplies/Services	Unlimited visits during the first year of purchase for adjustments, cleaning, and programming 3-year warranty including loss and damage on all hearing aids 2-year supply of hearing aid batteries with purchase
** Additional hearing benefits noted below covered through Anthem Blue Cross Blue Shield, not HearUSA.*	

Short Term Disability *(Class 1 Members Only)*

Schedule of Benefits

Weekly Benefit *Net after standard FICA and Medicare withholdings*	$400
Maximum Benefit Period	26 weeks
Day Benefit Begins	
Accident	Day 1
Sickness (one week waiting period)	Day 8
Please note General Plan Exclusions and Limitations beginning on page 109.	

Death Benefits *(Members Only)*

Schedule of Benefits

Class 1	$14,000
Class 2, Class 3, Class 4	$2,500
The amount of Death Benefits continued under Waiver of Premium is $5,000 and will be reduced to $2,500 at Early Retirement age with the Laborers' District Council and Contractors' Pension Fund of Ohio or entry into Class 2, 3, or 4, whichever occurs first.	
Please note General Plan Exclusions and Limitations beginning on page 109.	

Accidental Death & Dismemberment *(Class 1 Members Only)*

Schedule of Benefits

Accidental Death	$10,000
Dismemberment Quadriplegia or loss of one of the following: • Both Hands • Both Feet • Sight in Both Eyes • One Hand and One Foot • One Hand or Foot and Sight in One Eye • Speech and Hearing	$10,000
Paraplegia or Hemiplegia	$7,500
Loss of one of the following: • Hand • Foot • Sight in One Eye • Speech • Hearing	$5,000
Loss of Thumb and Index Finger of the Same Hand	$2,500
No more than $10,000 will be paid for all losses suffered due to the same accident.	
Please note General Plan Exclusions and Limitations beginning on page 109.	

Introduction

Contact Information

It is important to know who to contact when you need information about your insurance benefits. You can contact Ohio Laborers Benefits for most general insurance questions; however, for certain claims information you may need to contact one of the various organizations that provide services under the OLDC-OCA Insurance Fund. Please review the following to determine the proper organization to contact.

Contact Organization	Topics	Contact Information
Ohio Laborers Benefits 800 Hillsdowne Road Westerville, OH 43081-3302	Eligibility, Enrollment, Death Benefits, Accidental Death & Dismemberment, Short-Term Disability Benefits, Legal Issues, and General Benefit Information	(614) 898-9006 (800) 236-6437 Fax: (614) 898-9176 www.ohiolaborers.com
Anthem Blue Cross Blue Shield PO Box 105187 Atlanta, GA 30348-5187	Medical Claims, Precertification, Network Providers, Nurse Line	Member Services: (855) 878-0128 24/7 Nurseline: (888) 249-3820 Precertification: (866) 776-4793 Coverage while traveling: (800) 810-2583 Emergency International Coverage: (804) 673-1177 www.anthem.com
Anthem Medicare PO Box 105187 Atlanta, GA 30348-5187 Claims Dept Part D Services PO Box 52077 Phoenix, AZ 85072-2077	Medical Claims and Prescription Drug Benefits for Medicare Eligible Retirees and Medicare Eligible Dependents of Retirees	Member Services: (833) 848-8730 Pharmacy questions: (833) 360-3662 Pre-Enrollment: (833) 848-8729 www.anthem.com
Anthem - CarelonRx PO Box 105187 Atlanta, GA 30348-5187	Prescription Drug Benefits, Retail Network Pharmacies, Home Delivery Pharmacy, and Specialty Pharmacy	Member Services: (844) 993-4314 Home Delivery: (833) 236-6196 Specialty Medications: (833) 255-0645 www.anthem.com
National Vision Administrators PO Box 2187 Clifton, NJ 07015	Vision claims, list of Network Providers for Vision Benefits	(800) 672-7723 www.e-nva.com
HearUSA 11400 N. Jog Road Palm Beach Gardens, FL 33418	Hearing Aid Benefits, Network Providers for Hearing Aids and Exams	(800) 442-8231 http://members.hearusa.com/olfbp

Legal

This booklet serves as the Plan Document and Summary Plan Description ("SPD") booklet as provided in Section 102 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). This booklet and supplemental documents such as the Plan's HIPAA'S Privacy Policies and Procedures serve as the Fund's controlling legal documents. These documents are used by the Trustees of the Fund to determine the eligibility of Active Members and retirees for benefits provided by the Insurance Fund and to prescribe the amount, extent, conditions, and methods of payment of such benefits.

Only the Board of Trustees is authorized to interpret the Plan described in this booklet. In addition, the Board of Trustees has maximum discretionary authority to determine participation and benefit eligibility, to interpret and construe the terms of the Plan, and to otherwise perform functions under or relating to the Plan herein. No Contractor, union, or any representative of any Contractor or union, is authorized to interpret the Plan nor can any such person act as agent of the Trustees. You may only rely on information regarding the Fund that is communicated to you in writing and signed on behalf of the Board of Trustees either by the Trustees, or, if authorized by the Trustees, signed by the Claims Administrator or Ohio Laborers Benefits.

The Board of Trustees reserves the right and has the discretion to amend, modify, or discontinue all or part of the Fund whenever, in its sole judgment, conditions so warrant.

Benefits under the Fund will only be paid when the Trustees or persons delegated by them decide, in their discretion, that the Member or beneficiary is entitled to benefits in accordance with the terms of the Fund.

If English is not your first language and you have any difficulty understanding any part of this booklet, contact Ohio Laborers Benefits by:

- Calling (614) 898-9006 or (800) 236-6437,
- Emailing insurance@ohiolaborers.com, or
- Writing to or visiting Ohio Laborers Benefits at 800 Hillsdowne Road, Westerville, Ohio 43081-3302.

Your Responsibility

It is important to remember that the Fund is not designed to cover every health care expense. The Fund pays charges for eligible expenses, up to the limits and under the conditions established by the rules of the Fund. The decisions about how and when you receive medical care are up to you and your doctor, not the Fund. The Fund and any insurer described herein determine how much it will pay; you and your doctor must decide what medical care is best for you.

Updating Your Address

You should always keep your mailing address current with Ohio Laborers Benefits to receive important information from the Fund in a timely manner. You (member only) can update your address in writing or via the phone. A written change of address must be signed by the Member. Changing your address at your Local Union is not sufficient; you must change it with Ohio Laborers Benefits. Your benefits may be suspended if Ohio Laborers Benefits is notified your address is incorrect.

Filing Deadline

There is a 15-month filing time limit for submitting all claims. Any claims which are filed after the filing deadline will be denied as untimely.

Reciprocity – Contributions Made to Multiple Health and Welfare Funds

If you work as a laborer both in and outside the jurisdiction of the OLDC-OCA Insurance Fund, you may be able to have your hours/contributions transferred to your Home Fund. You should contact Ohio Laborers Benefits prior to

working outside this Fund's jurisdiction to discuss your options. There are two types of reciprocity provided by the Laborers' International Union of North America National Reciprocal Agreement for Health and Welfare Plans in the United States (NRA):

1. By signing the NRA, all participating funds agree to the **Point-of-Claim Reciprocity** rules. Generally, these rules provide that when you work outside the jurisdiction of your Local Union's health and welfare fund ("Home Fund") and are not eligible for benefits from the health and welfare fund in whose jurisdiction the work is performed ("Local Fund"), you would continue to participate in and file benefit claims with your Home Fund. If you lose eligibility for benefits from your Home Fund, the Home Fund would obtain a transfer of contributions made to the Local Fund on your behalf if such a transfer would restore your eligibility for benefits.
2. The **Transfer-of-Contributions Reciprocity** rules are optional (but more common with this Fund) and apply only to and between those participating Funds, which have expressly agreed to adopt them. These rules allow you to work in the jurisdiction of a Local Fund which has a reciprocal agreement with your Home Fund and have all your contributions transferred to your Home Fund. You must complete and submit a Reciprocal Transfer Request form to one of the Funds to initiate the transfer. Many of these forms can be found at www.ohiolaborers.com. This type of reciprocity could allow you to continue to participate in and file all benefit claims with your Home Fund.

Pre-existing Conditions Exclusion

The Fund does not have a pre-existing condition exclusion.

Non-Assignment of Health Care Benefits

Other than payments made directly to a provider, you cannot assign your benefits or other rights to which you are entitled under the Fund. The prohibition against assignment of rights includes rights such as the right to:

- Receive benefits
- Claim benefits in accordance with Fund procedures and/or federal law
- Begin legal action against the Fund Trustees, the Fund, its agents, or Members
- Request Fund documents or other instruments under which the Fund is established or operated
- Request any other information that a participant or beneficiary, as defined in ERISA Section 102, may be entitled to receive upon written request to a Plan Administrator
- Any and all other rights afforded a participant or beneficiary under the Fund, the trust agreement, federal law, and state law

Additionally, benefit payments are exempt from execution, attachment, garnishment, or other legal or equitable process for the debts of the Covered Individual.

Eligibility

Before you can start using the benefits the OLDC-OCA Insurance Fund offers, you must first become eligible. The Fund offers four separate classes of insurance, with different eligibility rules for each. The four classes are designed for different times in your life, from your initial employment as a laborer through retirement. Before reviewing the eligibility rules, you should first understand the differences between the classes:

- **Class 1** – Active Members *(page 18)*
- **Class 2** – Members disabled due to End Stage Renal Disease (ESRD) prior to Early Retirement age with the Laborers' District Council and Contractors' Pension Fund of Ohio and not eligible for Medicare *(page 26)*
- **Class 3** – Retired Members who are age 53 or older, but not eligible for Medicare *(page 28)*
- **Class 4** – Retired Members who are eligible for Medicare *(page 31)*

In addition to covering you, as an eligible Member or retiree, the OLDC-OCA Insurance Fund may also cover your Dependents. Please review the **Dependent Eligibility** section *(starting on page 34)* for details. If you lose your eligibility, you may qualify to extend your eligibility by making payments. See the **COBRA** section *(starting on page 40)* for details. Furthermore, if you get called to active duty in the U.S. Armed Forces, you may qualify for certain eligibility provisions. See the **USERRA Continuation Coverage** section *(starting on page 44)* for details.

Class 1 Eligibility – Active Members

Initial Eligibility

Generally, once you have worked at least **450 hours in a six-consecutive month period,** you are Eligible for Insurance Benefits on the first day of the following month. *(For example, if you worked 450 hours or more in the months of April, May, and June; you would generally become eligible for Insurance Benefits starting in July.) (Please note: Contractors may report monthly hours based on week ending dates, pay dates, or calendar dates.)*

Additional requirements for Initial Eligibility include:

- You work for a Contractor within the jurisdiction of the Fund.
- You work in employment covered by a collective bargaining agreement or participation agreement that requires participation in the Fund.
- An hour of contributions counts as an hour only if your Contractor contributes at the Standard Hourly Rate. If contributions are made at less than the Standard Hourly Rate, then your hours will be credited downward on pro rata basis. In contrast, the Fund will not credit you more than one hour worked for each hour worked, even if a Contractor pays the Fund a contribution in excess of the Standard Hourly Rate. The Standard Hourly Rate is the contribution rate appearing in the Ohio Highway-Municipal-Utility State Construction Agreement, negotiated by Laborers' District Council of Ohio and the Ohio Contractors' Association, as in effect now or in the future.
- Payment for hours is received and accepted for the hours worked. All hours are subject to audit. Audits may result in reduction of hours that may reduce benefits, including retroactive changes.

Continuing Eligibility

Once you meet the Initial Eligibility requirements for Insurance Benefits, your continued eligibility is determined using three different calculations. Each and every month is looked at individually when determining future eligibility. If you meet the minimum hours criteria of any of the three calculations for a given month, you will be eligible for that month. *(Please note: Contractors may report monthly hours based on week ending dates, pay dates, or calendar dates.)* **In general, the more hours you work, the longer you will be eligible.** Your eligibility will continue if you work at least:

- 250 hours in the first 3 months of the 4 months immediately preceding the month of coverage; or
- 500 hours in the first 6 months of the 7 months immediately preceding the month of coverage; or
- 1,000 hours in the first 12 months of the 13 months immediately preceding the month of coverage.

Please refer to the Monthly Eligibility Calculation Tables on next five pages to determine how long your insurance eligibility will continue based on your work history. You can also go to ohiolaborers.com and click the member login link to track of your eligibility.

2022 Monthly Eligibility Calculation Table

To be Eligible for the following Month	You need 250 Hours or more in these Months, or	You need 500 Hours or more in these Months, or	You need 1,000 Hours or more in these Months
January 2022	September 2021 through November 2021	June 2021 through November 2021	December 2020 through November 2021
February 2022	October 2021 through December 2021	July 2021 through December 2021	January 2021 through December 2021
March 2022	November 2021 through January 2022	August 2021 through January 2022	February 2021 through January 2022
April 2022	December 2021 through February 2022	September 2021 through February 2022	March 2021 through February 2022
May 2022	January 2022 through March 2022	October 2021 through March 2022	April 2021 through March 2022
June 2022	February 2022 through April 2022	November 2021 through April 2022	May 2021 through April 2022
July 2022	March 2022 through May 2022	December 2021 through May 2022	June 2021 through May 2022
August 2022	April 2022 through June 2022	January 2022 through June 2022	July 2021 through June 2022
September 2022	May 2022 through July 2022	February 2022 through July 2022	August 2021 through July 2022
October 2022	June 2022 through August 2022	March 2022 through August 2022	September 2021 through August 2022
November 2022	July 2022 through September 2022	April 2022 through September 2022	October 2021 through September 2022
December 2022	August 2022 through October 2022	May 2022 through October 2022	November 2021 through October 2022

2023 Monthly Eligibility Calculation Table

To be Eligible for the following Month	You need 250 Hours or more in these Months, or	You need 500 Hours or more in these Months, or	You need 1,000 Hours or more in these Months
January 2023	September 2022 through November 2022	June 2022 through November 2022	December 2021 through November 2022
February 2023	October 2022 through December 2022	July 2022 through December 2022	January 2022 through December 2022
March 2023	November 2022 through January 2023	August 2022 through January 2023	February 2022 through January 2023
April 2023	December 2022 through February 2023	September 2022 through February 2023	March 2022 through February 2023
May 2023	January 2023 through March 2023	October 2022 through March 2023	April 2022 through March 2023
June 2023	February 2023 through April 2023	November 2022 through April 2023	May 2022 through April 2023
July 2023	March 2023 through May 2023	December 2022 through May 2023	June 2022 through May 2023
August 2023	April 2023 through June 2023	January 2023 through June 2023	July 2022 through June 2023
September 2023	May 2023 through July 2023	February 2023 through July 2023	August 2022 through July 2023
October 2023	June 2023 through August 2023	March 2023 through August 2023	September 2022 through August 2023
November 2023	July 2023 through September 2023	April 2023 through September 2023	October 2022 through September 2023
December 2023	August 2023 through October 2023	May 2023 through October 2023	November 2022 through October 2023

2024 Monthly Eligibility Calculation Table

To be Eligible for the following Month	You need 250 Hours or more in these Months, or	You need 500 Hours or more in these Months, or	You need 1,000 Hours or more in these Months
January 2024	September 2023 through November 2023	June 2023 through November 2023	December 2022 through November 2023
February 2024	October 2023 through December 2023	July 2023 through December 2023	January 2023 through December 2023
March 2024	November 2023 through January 2024	August 2023 through January 2024	February 2023 through January 2024
April 2024	December 2023 through February 2024	September 2023 through February 2024	March 2023 through February 2024
May 2024	January 2024 through March 2024	October 2023 through March 2024	April 2023 through March 2024
June 2024	February 2024 through April 2024	November 2023 through April 2024	May 2023 through April 2024
July 2024	March 2024 through May 2024	December 2023 through May 2024	June 2023 through May 2024
August 2024	April 2024 through June 2024	January 2024 through June 2024	July 2023 through June 2024
September 2024	May 2024 through July 2024	February 2024 through July 2024	August 2023 through July 2024
October 2024	June 2024 through August 2024	March 2024 through August 2024	September 2023 through August 2024
November 2024	July 2024 through September 2024	April 2024 through September 2024	October 2023 through September 2024
December 2024	August 2024 through October 2024	May 2024 through October 2024	November 2023 through October 2024

2025 Monthly Eligibility Calculation Table

To be Eligible for the following Month	You need 250 Hours or more in these Months, or	You need 500 Hours or more in these Months, or	You need 1,000 Hours or more in these Months
January 2025	September 2024 through November 2024	June 2024 through November 2024	December 2023 through November 2024
February 2025	October 2024 through December 2024	July 2024 through December 2024	January 2024 through December 2024
March 2025	November 2024 through January 2025	August 2024 through January 2025	February 2024 through January 2025
April 2025	December 2024 through February 2025	September 2024 through February 2025	March 2024 through February 2025
May 2025	January 2025 through March 2025	October 2024 through March 2025	April 2024 through March 2025
June 2025	February 2025 through April 2025	November 2024 through April 2025	May 2024 through April 2025
July 2025	March 2025 through May 2025	December 2024 through May 2025	June 2024 through May 2025
August 2025	April 2025 through June 2025	January 2025 through June 2025	July 2024 through June 2025
September 2025	May 2025 through July 2025	February 2025 through July 2025	August 2024 through July 2025
October 2025	June 2025 through August 2025	March 2025 through August 2025	September 2024 through August 2025
November 2025	July 2025 through September 2025	April 2025 through September 2025	October 2024 through September 2025
December 2025	August 2025 through October 2025	May 2025 through October 2025	November 2024 through October 2025

2026 Monthly Eligibility Calculation Table

To be Eligible for the following Month	You need 250 Hours or more in these Months, or	You need 500 Hours or more in these Months, or	You need 1,000 Hours or more in these Months
January 2026	September 2025 through November 2025	June 2025 through November 2025	December 2024 through November 2025
February 2026	October 2025 through December 2025	July 2025 through December 2025	January 2025 through December 2025
March 2026	November 2025 through January 2026	August 2025 through January 2026	February 2025 through January 2026
April 2026	December 2025 through February 2026	September 2025 through February 2026	March 2025 through February 2026
May 2026	January 2026 through March 2026	October 2025 through March 2026	April 2025 through March 2026
June 2026	February 2026 through April 2026	November 2025 through April 2026	May 2025 through April 2026
July 2026	March 2026 through May 2026	December 2025 through May 2026	June 2025 through May 2026
August 2026	April 2026 through June 2026	January 2026 through June 2026	July 2025 through June 2026
September 2026	May 2026 through July 2026	February 2026 through July 2026	August 2025 through July 2026
October 2026	June 2026 through August 2026	March 2026 through August 2026	September 2025 through August 2026
November 2026	July 2026 through September 2026	April 2026 through September 2026	October 2025 through September 2026
December 2026	August 2026 through October 2026	May 2026 through October 2026	November 2025 through October 2026

Reinstating Eligibility

If you lose eligibility under Class 1, the rules to reinstate your eligibility depend on the length of time you are without coverage.

- If you lose your eligibility for 12 or more consecutive months, you must meet the Initial Eligibility requirements again *(450 hours in a six-consecutive month period)*.
- If you lose your eligibility for less than 12 consecutive months, you may regain your eligibility by meeting the minimum hours requirements for continued eligibility for a given month.
- If you are receiving pension benefits from the Laborers' District Council and Contractors' Pension Fund of Ohio, the Laborers' International Union of North America National (Industrial) Pension Fund, the Laborers' Local #265 Pension Fund, or other Laborers' affiliated pension fund as determined by the Trustees, you must work at least 1,000 hours in a 12-consecutive-month period to regain your Class 1 eligibility. Your hours must be reported and paid by a Contractor. Class 1 coverage begins on the first day of the month following the month in which you meet the 1,000-hour requirement.

Termination

The reasons your coverage under Class 1 may end are described in the When Coverage Ends section *(on page 38)* and may include the following:

- Insufficient working hours contributed to maintain eligibility.
- Non-payment of the COBRA/Self-Contribution billing.
- A current address is not on file; therefore, the COBRA notice cannot be mailed to you or is returned by the Post Office. You can update your address in writing or via the phone. A written change of address must be signed by the Member. Changing your address at your Local Union is not sufficient; you must change it with Ohio Laborers Benefits.
- The COBRA/Self-Contribution payment is not received by the due date, unless postmarked on or before the due date. Mail is not always postmarked, so make sure you request your Post Office postmark your payment envelope.
- The expiration of the maximum period for COBRA coverage.
- The Fund is notified by the bank that a COBRA/Self-Contribution payment has been returned due to insufficient funds.
    - A $25 returned check fee will be billed to you.
    - You will have the opportunity to reinstate your coverage by paying with a cashier's check, money order, or credit card. The payment must be postmarked on or before the due date. ***Please request your Post Office to postmark your payment envelope.***
    - Any payments made to the Fund in the next 12 months must be made by cashier's check, money order, or credit card.
- Convert to Class 2, 3, or 4.

You have the right to appeal the termination of your eligibility for coverage to the OLDC-OCA Insurance Fund Appeals Review Committee *(see page 97)*.

Once you are terminated under Class 1, you must re-establish your eligibility by hours submitted through Contractor contributions or, if eligible, you may convert to another Class within the prescribed period.

Newly Organized Employer Prepayment

Notwithstanding the foregoing, you may be eligible for benefits immediately, provided:

- You are an employee of an employer, which (1) is newly organized by the Laborers; (2) has been and currently is providing insurance coverage and paying an insurance premium for you and other employees to be organized for a period of at least three months; and (3) employs at least ten Laborers, which are to be organized ("Newly Organized Employer"); and
- The Newly Organized Employer prepays contributions to the Fund at the time a collective bargaining agreement or other written agreement is executed at the current or projected contribution rate, if known, (i.e., prior to hours worked) for 450 hours on behalf of all Laborers for which it is currently providing insurance coverage and paying insurance premiums for the purposes of eligibility; and
- The Newly Organized Employer executes a written agreement which provides that a Newly Organized Employer shall not be entitled to any refund if an employee works less than 450 hours in the first three months, and shall be obligated to pay the difference in the amount of hours actually worked less the amount of hours paid in advance for each employee if any employee to be organized works more than 450 hours in the first three months following the date the Fund receives advance contributions.

A Newly Organized Employer may elect to prepay contributions on behalf of newly organized employees for each hour worked if it notifies the Fund in advance and clearly identifies the employees for which advance contributions and contemporaneous hourly contributions will be made. Immediate eligibility only occurs when contributions are made in advance, as provided above.

The Trustees shall have the discretion to accept or reject agreements between the Union and newly organized employers regarding this provision.

Class 2 Eligibility – Disability Due to End Stage Renal Disease (ESRD)

Initial Eligibility

You must meet all the following eligibility rules for participation in Class 2:

- You must be disabled as determined by the Social Security Administration due to End Stage Renal Disease (ESRD).
- You must be receiving either Occupational Disability or Total and Permanent Disability pension benefit from the Laborers' District Council and Contractors' Pension Fund of Ohio, the Laborers' International Union of North America National (Industrial) Pension Fund, the Laborers' Local #265 Pension Fund, or other Laborers' affiliated pension funds acceptable to the Trustees.
- You must be eligible for Class 1 Insurance under the Fund on the date of your disability. The Class 1 eligibility may be based on Contractor contributions or COBRA/Self-Contributions.
- You must be under Early Retirement age with the Laborers' District Council and Contractors' Pension Fund of Ohio and in the waiting period required by Medicare.
- You must apply for coverage under Class 2 within 60 days after loss of eligibility under Class 1 and after the date of the commencement of your Occupational Disability or Total and Permanent Disability pension benefit.
- You must make contributions in the amount set by the Trustees. The monthly payment must be postmarked by the last day of the month before the month for which coverage is applicable. ***Please request your Post Office to postmark your payment envelope.*** Payments may also be made for a quarterly, semi-annual, or annual period (contact Ohio Laborers Benefits for further information). To avoid termination for late payments, the Trustees strongly encourage that these contributions be made through a deduction from your pension check from the Laborers' District Council and Contractors' Pension Fund of Ohio or the Laborers' Local #265 Pension Fund.

Return to Work Eligibility

If you return to work and your pension benefits are suspended, you will re-establish eligibility under Class 1 once you work at least 1,000 hours in a 12-consecutive-month period. Your hours must be reported and paid by a Contractor. Class 1 coverage begins on the first day of the month following the month in which you meet the 1,000-hour requirement. Until Class 1 coverage begins, you will continue to be covered under Class 2 as long as you continue to make timely payments to Ohio Laborers Benefits.

Please note: pension benefits will be suspended according to the Pension Plan rules regarding disqualifying employment. If your pension benefits are suspended, you will be responsible for submitting your monthly insurance payments to Ohio Laborers Benefits.

Termination

Reasons for termination under Class 2 are as follows:

- You become eligible for Medicare Part A and Medicare Part B benefits. You will lose benefits whether or not you elect to be covered under Medicare. You and your Dependents may be eligible for coverage under Class 3 or Class 4 *(see pages 28 and 31).*
- You fail to make a monthly payment on time *(see Late Payment Policy below)*.
- You recover from the disability.

- The Fund is notified by the bank that a payment has been returned due to insufficient funds.
    - A $25 returned check fee will be billed to you.
    - If the insufficient funds notification is received prior to the 10th of the month of coverage, you will have the opportunity to reinstate your coverage by paying with a cashier's check, money order, or credit card. The payment must be postmarked on or before the 10th of the month of coverage. ***Please request your Post Office to postmark your payment envelope.***
    - Any payments made to the Fund in the next 12 months must be made by cashier's check, money order, or credit card.
- You re-establish eligibility under Class 1 with 1,000 working hours in a 12-consecutive-month period.
- Your pension benefits are terminated.

Once your coverage under Class 2 ends due to your failure to make a payment or your recovery from disability, you cannot participate in Class 2 again unless you have reinstated your eligibility under Class 1 *(see Return to Work Eligibility on the previous page)*.

Voluntary Termination of Class 2 Insurance

To terminate coverage under Class 2, you must submit your request in writing to Ohio Laborers Benefits. Termination will be the first of the month following receipt of the written notification. Terminations cannot be retroactive.

Late Payment Policy

Payment is late if the postmark is after the last day of the month preceding the month for which coverage is applicable. You are allowed one late payment in a six-month period provided the payment is postmarked no later than the 10th of the month of coverage. ***Please request your Post Office to postmark your payment envelope.***

Class 3 Eligibility – Retired Members between the Ages of 53 and 65

Initial Eligibility

You must meet all the following eligibility rules for participation in Class 3:

- You must be eligible for benefits under Class 1 when you retire.
- You must be receiving pension benefits from the Laborers' District Council and Contractors' Pension Fund of Ohio, the Laborers' International Union of North America National (Industrial) Pension Fund, the Laborers' Local #265 Pension Fund, or other Laborers' affiliated pension funds acceptable to the Trustees.
- You must be age 53 or older and no longer actively working in Covered Employment.
- You must make an application for Class 3 within 60 days after termination of benefits under Class 2; or complete and submit your Retiree Insurance Application to Ohio Laborers Benefits by the deadline date noted in your Retiree Insurance Application. Your Retiree Insurance Application must be received by the later of the day before your pension effective date or the end of the month in which 60 days have passed since the Retiree Insurance Application was mailed.
- You must make contributions in the amount set by the Trustees. The monthly payment must be postmarked by the last day of the month before the month for which coverage is applicable. ***Please request your Post Office to postmark your payment envelope.*** Payments may also be made for a quarterly, semi-annual, or annual period (contact Ohio Laborers Benefits for further information). To avoid termination for late payments, the Trustees strongly encourage that these contributions be made through a deduction from your pension check from the Laborers' District Council and Contractors' Pension Fund of Ohio or the Laborers' Local #265 Pension Fund.
- You are not eligible for Medicare benefits.

Declining Retiree Insurance

If you are not interested in enrolling in the Retiree Insurance Program with the OLDC-OCA Insurance Fund, you can decline coverage on the Retiree Insurance Application. However, if you decline the Retiree Insurance, you forfeit your right to enroll in the Retiree Insurance Program at any time in the future. Additionally, failure to return a completed Retiree Insurance Application will be construed as a forfeiture of Retiree Insurance.

Working After Retirement

If you work after you retire, it may negatively impact your Retiree Insurance.

- **If your monthly pension benefit is suspended due to Disqualifying Employment for any month, you forfeit your right to a Retiree Insurance Subsidy.** This forfeiture applies even if you are not participating in the Retiree Insurance Program at the time of your suspension. The Retiree Insurance Subsidy is the amount the cost of your monthly Retiree Insurance is reduced from the full (unsubsidized) cost. The Retiree Insurance rates are reduced (subsidized) 2% for each pension credit you earned with the LDC&C Pension Fund of Ohio or other applicable fund.

  If you lose the subsidy, your monthly Retiree Insurance will be more expensive going forward and may be unaffordable. Please give this much consideration if you return to work after you retire. **If you have any questions about what work constitutes Disqualifying Employment, please consult the Pension Fund's Summary Plan Description or contact the Pension Department at Ohio Laborers Benefits.**

- **One-Time Exception**. If you pay back the Retiree Insurance Subsidy in full for the month(s) your pension benefit is suspended due to Disqualifying Employment, your Retiree Insurance Subsidy will be reinstated. Reinstatement of your Subsidy will commence the first of the month following full repayment. ***This is a one-time-only exception***.
    - If your monthly pension benefit is suspended for one month or multiple ***consecutive*** months, the exception will apply. The second time your monthly pension benefit is suspended due to Disqualifying Employment, you forfeit your right to a Retiree Insurance Subsidy for the rest of your life.
    - Additionally, you will not be eligible for Class 3 Retiree Insurance at the higher unsubsidized rate after your second suspension, unless you pay back the subsidy received during the second suspension. **Gaps in Retiree Insurance are not permitted.**

  One-time Only Exception Example:

  - You retire and transition to Retiree Insurance coverage. Your monthly Retiree Insurance premium is reduced according to the number of pension credits you have earned. The amount your monthly premium is reduced is the Retiree Insurance Subsidy.
  - You later return to work in Disqualifying Employment causing a suspension of your monthly pension benefit.
  - While your pension benefit is suspended, the Insurance Fund continues to subsidize your Retiree Insurance coverage *(assuming you choose to make monthly payments to continue your Retiree Insurance)*. When you cease working in Disqualifying Employment and notify Ohio Laborers Benefits to reactivate your pension benefit, you will have two options:
    1. You can re-pay the Retiree Insurance Subsidy received for the time your pension benefit was suspended due to Disqualifying Employment. Once you repay the subsidy in full, you will again be eligible for the Retiree Insurance Subsidy. *(You may also elect to pay the higher unsubsidized rate each month while your pension is suspended, instead of waiting until your suspension is over to repay the entire amount at one time.)*
    2. You can choose not to repay the Retiree Insurance Subsidy received for the time your pension benefit was suspended due to Disqualifying Employment. If you choose not to repay the subsidy, you will forfeit your right to receive the Retiree Insurance Subsidy once your pension is reactivated following your Disqualifying Employment.
  - If you return to Disqualifying Employment a second time, you forfeit your right to the Retiree Insurance Subsidy forever.

Once you become a Class 3 member (Retiree Insurance benefits) you are not eligible for insurance benefits as a Class 1 member (actives) unless you work at least 1,000 hours in a 12-consecutive month period. This 1,000-hour rule applies whether or not you elect Retiree Insurance. Your hours must be reported and paid by a contractor. Class 1 coverage begins on the first day of the month following the month in which you meet the 1,000-hour requirement. Until Class 1 coverage begins, you will continue to be covered under Class 3 Retiree Insurance as long as you continue to make timely payments to Ohio Laborers Benefits.

In the event that your pension benefits are denied or terminated, your eligibility for Retiree Insurance will terminate unless you appeal the denial or termination of your pension benefits. You can maintain eligibility for Retiree Insurance until the appeals procedure is exhausted, subject to all other requirements pertaining to eligibility and termination, and as long as the required premiums are paid timely. If at the end of the appeal procedures your application for pension benefits remains denied, your Retiree Insurance would terminate and no other benefits will be available.

Termination

Reasons for termination under Class 3 are as follows:

- You become eligible for Medicare Part A and Medicare Part B benefits. You will lose benefits whether or not you elect to be covered under Medicare. You and your Dependents may be eligible for coverage under Class 4 *(see page 31).*
- You fail to make a monthly payment on time *(see Late Payment Policy below)*.
- The Fund is notified by the bank that a payment has been returned due to insufficient funds.
    - A $25 returned check fee will be billed to you.
    - If the insufficient funds notification is received prior to the 10th of the month of coverage, you will have the opportunity to reinstate your coverage by paying with a cashier's check, money order, or credit card. The payment must be postmarked on or before the 10th of the month of coverage *(subject to Late Payment Policy below)*. ***Please request your Post Office to postmark your payment envelope.***
    - Any payments made to the Fund in the next 12 months must be made by cashier's check, money order, or credit card.
- You re-establish eligibility under Class 1 with 1,000 working hours in a 12-consecutive-month period.
- Your pension benefits are terminated (other than for returning to work).

Once your coverage under Class 3 ends due to failure to make a payment, you cannot participate in the Fund again unless you reinstate your eligibility under Class 1 *(see Return to Work Eligibility above)*.

Voluntary Termination of Class 3 Insurance

In order to terminate coverage under Class 3, you must submit your request in writing to Ohio Laborers Benefits. Termination will be the first of the month following receipt of the written notification. Terminations cannot be retroactive.

Late Payment Policy

Payment is late if the postmark is after the last day of the month preceding the month for which coverage is applicable. You are allowed one late payment in a six-month period provided the payment is postmarked no later than the 10th of the month of coverage. ***Please request your Post Office to postmark your payment envelope.***

Class 4 Eligibility – Retired Members Eligible for Medicare

Initial Eligibility

You must meet all the following eligibility rules for participation in Class 4:

- You must be eligible for benefits under Class 1 when you retire or eligible for benefits under Class 2 or Class 3.
- You must be receiving pension benefits from the Laborers' District Council and Contractors' Pension Fund of Ohio, the Laborers' International Union of North America National (Industrial) Pension Fund, the Laborers' Local #265 Pension Fund, or other Laborers' affiliated pension funds acceptable to the Trustees.
- You must reach the Medicare eligibility age or be disabled and receiving Medicare coverage and no longer actively working in Covered Employment.
- **You must enroll in both Medicare Part A and Medicare Part B and submit a copy of your Medicare card to Ohio Laborers Benefits. If you enroll in Medicare Part C (Medicare Advantage) or a Medicare Part D (Prescription Drug) not offered by the Fund, federal law prohibits you from participating in the OLDC-OCA Insurance Fund.** *(See Coordination of Benefits with Medicare on page 71* for additional details.)
- If you are going directly from Class 1 to Class 4, you must complete your Retiree Insurance Application and submit it to Ohio Laborers Benefits by the deadline date noted in your Retiree Insurance Application. *(The application must be received by the later of the day before your pension effective date or the end of the month in which 60 days have passed since the Retiree Insurance Application was mailed.)*
- If you are going directly from Class 2 to Class 4, you must make an application for Class 4 within 60 days after termination of benefits under Class 2.
- You must make contributions in the amount set by the Trustees. The monthly payment must be postmarked by the last day of the month before the month for which coverage is applicable. ***Please request your Post Office to postmark your payment envelope***. Payments may also be made for a quarterly, semi-annual, or annual period (contact Ohio Laborers Benefits for further information). To avoid termination for late payments, the Trustees strongly encourage that these contributions be made through a deduction from your pension check from the Laborers' District Council and Contractors' Pension Fund of Ohio or the Laborers' Local #265 Pension Fund.

Declining Retiree Insurance

If you are not interested in enrolling in the Retiree Insurance Program with the OLDC-OCA Insurance Fund, you can decline coverage on the Retiree Insurance Application. However, if you decline the Retiree Insurance, you forfeit your right to enroll in the Retiree Insurance Program at any time in the future. Additionally, failure to return a completed Retiree Insurance Application will be construed as a forfeiture of Retiree Insurance.

Working After Retirement

If you work after you retire, it may negatively impact your Retiree Insurance.

- **If your monthly pension benefit is suspended due to Disqualifying Employment for any month, you forfeit your right to a Retiree Insurance Subsidy.** This forfeiture applies even if you are not participating in the Retiree Insurance Program at the time of your suspension. The Retiree Insurance Subsidy is the amount the cost of your monthly Retiree Insurance is reduced from the full (unsubsidized) cost. The Retiree Insurance rates are reduced (subsidized) 2% for each pension credit you earned with the LDC&C Pension Fund of Ohio or other applicable fund.

If you lose the subsidy, your monthly Retiree Insurance will be more expensive going forward and may be unaffordable. Please give this much consideration if you return to work after you retire. **If you have any questions about what work constitutes Disqualifying Employment, please consult the Pension Fund's Summary Plan Description or contact the Pension Department at Ohio Laborers Benefits.**

- **One-Time Exception**. If you pay back the Retiree Insurance Subsidy in full for the month(s) your pension benefit is suspended due to Disqualifying Employment, your Retiree Insurance Subsidy will be reinstated. Reinstatement of your Subsidy will commence the first of the month following full repayment. ***This is a one-time-only exception***.
    - If your monthly pension benefit is suspended for one month or multiple ***consecutive*** months, the exception will apply. The second time your monthly pension benefit is suspended due to Disqualifying Employment, you forfeit your right to a Retiree Insurance Subsidy for the rest of your life.
    - Additionally, you will not be eligible for Class 4 Retiree Insurance at the higher unsubsidized rate after your second suspension, unless you pay back the subsidy received during the second suspension. **Gaps in Retiree Insurance are not permitted.**

<u>One-time Only Exception Example</u>:

- You retire and transition to Retiree Insurance coverage. Your monthly Retiree Insurance premium is reduced according to the number of pension credits you have earned. The amount your monthly premium is reduced is the Retiree Insurance Subsidy.
- You later return to work in Disqualifying Employment causing a suspension of your monthly pension benefit.
- While your pension benefit is suspended, the Insurance Fund continues to subsidize your Retiree Insurance coverage *(assuming you choose to make monthly payments to continue your Retiree Insurance)*. When you cease working in Disqualifying Employment and notify Ohio Laborers Benefits to reactivate your pension benefit, you will have two options:
    1. You can re-pay the Retiree Insurance Subsidy received for the time your pension benefit was suspended due to Disqualifying Employment. Once you repay the subsidy in full, you will again be eligible for the Retiree Insurance Subsidy. *(You may also elect to pay the higher unsubsidized rate each month while your pension is suspended, instead of waiting until your suspension is over to repay the entire amount at one time.)*
    2. You can choose <u>not</u> to repay the Retiree Insurance Subsidy received for the time your pension benefit was suspended due to Disqualifying Employment. If you choose <u>not</u> to repay the subsidy, you will forfeit your right to receive the Retiree Insurance Subsidy once your pension is reactivated following your Disqualifying Employment.
- If you return to Disqualifying Employment a second time, you forfeit your right to the Retiree Insurance Subsidy forever.

Once you become a Class 4 member (Retiree Insurance benefits) you are not eligible for insurance benefits as a Class 1 member (actives) unless you work at least 1,000 hours in a 12-consecutive month period. This 1,000-hour rule applies whether or not you elect Retiree Insurance. Your hours must be reported and paid by a contractor. Class 1 coverage begins on the first day of the month following the month in which you meet the 1,000-hour requirement. Until Class 1 coverage begins, you will continue to be covered under Class 4 Retiree Insurance as long as you continue to make timely payments to Ohio Laborers Benefits.

In the event that your pension benefits are denied or terminated, your eligibility for Retiree Insurance will terminate unless you appeal the denial or termination of your pension benefits. You can maintain eligibility for Retiree Insurance until the appeals procedure is exhausted, subject to all other requirements pertaining to eligibility and termination, and as long as the required premiums are paid timely. If at the end of the appeal procedures your application for pension benefits remains denied, your Retiree Insurance would terminate and no other benefits will be available.

Termination

Reasons for termination under Class 4 are as follows:

- You fail to make a monthly payment on time *(see Late Payment Policy below)*.
- You enroll in Medicare Part C (Medicare Advantage) or a Medicare Part D (Prescription Drug) plan not offered by the Fund. The Fund is notified by the bank that a payment has been returned due to insufficient funds.
    - A $25 returned check fee will be billed to you.
    - If the insufficient funds notification is received prior to the 10th of the month of coverage, you will have the opportunity to reinstate your coverage by paying with a cashier's check, money order, or credit card. The payment must be postmarked on or before the 10th of the month of coverage *(subject to Late Payment Policy below)*. ***Please request your Post Office to postmark your payment envelope.***
    - Any payments made to the Fund in the next 12 months must be made by cashier's check, money order, or credit card.
- You re-establish eligibility under Class 1 with 1,000 working hours in a 12-consecutive-month period.
- Your pension benefits are terminated (other than for returning to work).

Once your coverage under Class 4 ends due to failure to make a payment, you cannot participate in the Fund again unless you reinstate your eligibility under Class 1 *(see Return to Work Eligibility above)*.

Voluntary Termination of Class 4 Insurance

In order to terminate coverage under Class 4, you must submit your request in writing to Ohio Laborers Benefits. Termination will be the first of the month following receipt of the written notification. Terminations cannot be retroactive.

Late Payment Policy

Payment is late if the postmark is after the last day of the month preceding the month for which coverage is applicable. You are allowed one late payment in a six-month period provided the payment is postmarked no later than the 10th of the month of coverage. ***Please request your Post Office to postmark your payment envelope.***

Dependent Eligibility

Basics

Once properly enrolled *(see Enrollment section below)*, your Dependents will be eligible for Medical, Vision, Hearing, and Prescription Drug Benefits while you are eligible for Class 1 Insurance. All claims for Dependent benefits must be filed within 15 months of the date of the service, regardless of when a Spouse or any other Dependent is added to the Fund. **You can enroll the following Dependents to the Insurance Plan:**

- Your current legal Spouse
- Your Child who is under age 26. Eligibility will extend until the end of the month in which the Child turns age 26. Child includes the following:
    - Biological Child
    - Stepchild
    - Adopted Child or Child placed with you in anticipation of adoption provided**:**
        - You intend to adopt the child (whether or not the adoption has become final);
        - The child has not attained age 18 as of the date of placement for adoption;
        - You are legally obligated for the total or partial support of the child in anticipation of adoption of the child; and
        - The child is available for adoption and the legal process has begun.
    - Child who is an alternate recipient under a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN) *(see page 36)*
    - Child for whom you have legal custody, whether permanent or temporary, including Legal Guardianship and Foster Care
- An unmarried Child age 26 and over who is permanently and totally disabled, which means that the child is unable to engage in any gainful activity because of a medically determinable physical or mental impairment that is expected to last for a continuous period of 12 months or more, or results in death who:
    - Is incapable of self-sustaining employment because of a physical handicap or mental retardation;
    - Is primarily dependent upon you for his or her support and maintenance during the calendar year; and
    - Has his or her principal place of residence with you for more than one-half of the calendar year.

  Coverage will be continued, provided the permanent and total disability began before reaching age 26. Proof of the Dependent child's disability must be submitted to the Fund no later than 60 days after attaining the age at which the coverage would otherwise end. Proof of the continued existence of such disability may be requested by Ohio Laborers Benefits from time to time. In addition, Ohio Laborers Benefits reserves the right to have your child examined by a Physician, of the Fund's choice, at the Fund's expense, to determine the existence of incapacity.

Enrollment

You must complete an Enrollment/Beneficiary Card and submit it to Ohio Laborers Benefits with the required documents noted on the next page to enroll your Dependents. You should enroll your Dependents as soon as possible to ensure timely claims processing. You do not have to wait until you become eligible for benefits to enroll your Dependents. The Enrollment/Beneficiary Card must be completed properly to be accepted, including signing and dating the card. Enrollment/Beneficiary Cards will not be accepted if completed with a pencil. Signatures will not be accepted if typed on electronic versions of the Enrollment/Beneficiary Card.

The following documentation must be submitted to Ohio Laborers Benefits and accepted to complete enrollment. **You must also provide the Social Security Number for all Dependents**:

Dependent Type	**Required Enrollment Documentation**
Spouse	Copy of your Marriage Certificate
Biological Child (under age 26)	Copy of the child's State issued Birth Certificate*
Stepchild (under age 26)	Copy of the child's State issued Birth Certificate* AND Copy of your Marriage Certificate to the biological parent of child
Adopted Child (under age 26)	Copy of the child's State issued Birth Certificate* AND Proof of Adoption or Intent to Adopt
Child named recipient under QMCSO or NMSN (under age 26)	Copy of QMCSO or NMSN
Child through Legal Custody, including Guardianship and Foster Care	Copy of the child's State issued Birth Certificate* AND Copy of court documents granting Legal Custody, Guardianship, Foster Care
Disabled Child (26 or older)	Copy of the Child's State issued Birth Certificate AND Proof of Disability
** A newborn child can be enrolled for up to one year from his or her date of birth with only a Hospital certificate of birth. The state issued birth certificate must be submitted for coverage after the child turns one year of age. For an adopted child, you have one year from the date of adoption to submit a birth certificate showing you as the parent.*	
Note: The Fund reserves the right to request additional supporting documentation, as it may deem necessary.	

In addition to enrolling your Dependents, the Enrollment/Beneficiary Card is used for you to name your beneficiaries for any death benefits available *(see pages 92-96)* under the OLDC-OCA Insurance Fund and the Laborers' District Council and Contractors Pension Fund of Ohio. Therefore, it is important to immediately file an updated card any time there is a change in the status of a Dependent (i.e., marriage, divorce, remarriage, or the birth/adoption of a child).

Eligibility

Your Dependents will become eligible on the later of two dates:

1. The date on which you become eligible, or
2. The date of your Dependent's qualifying event (marriage, birth, adoption, etc.)

Your Dependents will be eligible for Medical, Vision, Hearing, and Prescription Drug Benefits while you are eligible for Class 1 Insurance. Even though your dependent's eligibility may be retroactively dated based on the above rules, enrollment and claims submission should be done as soon as possible to avoid claims being denied due to untimely filing. *(See Filing Deadline on page 14.)*

Additional Eligibility Rules

- A Dependent working in covered employment and becoming eligible under the Plan based on his or her own employment will be considered a separate Member. These individuals will be subject to the same provisions and/or limitations as any other Member.
- A Dependent will not be eligible for coverage during any period that he or she is in the military, naval, or air force of any country, except as required by the Uniformed Services Employment and Reemployment Rights Act (USERRA), as amended *(see page 44)*.

National Medical Support Notice

The Fund provides benefits according to the requirements of a National Medical Support Notice (NMSN) or a Qualified Medical Child Support Notice (QMCSO) as defined by ERISA section 609(a). The Fund will promptly notify affected Covered Individuals and alternate recipients if an NMSN or QMCSO is received. The Fund will notify these individuals of its procedures for determining whether Medical Child Support Orders are qualified.

Within a reasonable time after receipt of such order, the Fund will determine whether the order is qualified and notify each affected Covered Individual and alternate recipient of its determination. In general, an NMSN or a QMCSO is an administrative court order issued by the child support enforcement agency that require you to provide medical coverage for your children (called alternate recipients) in situations involving divorce, legal separation, or a paternity dispute. An NMSN and/or QMCSO may not require the Fund to provide any type or form of benefit, or any option not otherwise provided under the Fund, except as otherwise required by law.

Once the Dependent child is enrolled as an alternate recipient under an NMSN or QMCSO, the child's appointed guardian/representative or parent will receive a copy of all pertinent information provided to you, the Member.

Classes 2, 3, and 4

If you elect Class 2, Class 3, or Class 4 Insurance coverage, your eligible Dependents can be covered at an additional cost set by the Trustees. You will be provided a Class Application prior to moving to Class 2, 3, or 4. At the time, you will have the opportunity to elect to maintain coverage for your eligible Dependents.

Widow/Widower Benefits

If you die while receiving pension benefits, your Spouse will be eligible for widow/widower benefits if he or she meets the following requirements:

- Any widow/widower (and any Dependent child) of a deceased Member who was eligible for benefit coverage under Class 2, 3, or 4 at the time of the Member's death, and whose Spouse was receiving pension benefits from the Laborers' District Council and Contractors' Pension Fund of Ohio, the Laborers' International Union of North America National (Industrial) Pension Fund or the Laborers' Local #265 Pension Fund will be eligible for benefits under Class 3 or Class 4 coverage (class depends on age and/or Medicare eligibility). The widow/widower can also choose to maintain coverage for a Dependent child.
- The widow/widower must make application within 60 days after the death of his/her Spouse.
- To be eligible for benefits, the widow/widower must make contributions in an amount set by the Trustees. The monthly payment must be postmarked by the last day of the month before the month for which coverage is applicable. ***Please request your Post Office postmark your payment envelope***. Payments also may be made quarterly, semi-annually, or annually. To avoid termination for late payments, the Trustees strongly recommend that contributions be made through a deduction from your pension check from the Laborers' District Council and Contractors' Pension Fund of Ohio or the Laborers' Local #265 Pension Fund.

Termination

Reasons for termination include:

- Your widow/widower fails to make a monthly payment on time. Once a widow/widower is terminated because of failure to make a payment, he or she cannot participate in the Plan again. *(See Late Payment Policy below.)*
- Remarriage (coverage ends the first day of the month following the month the widow/widower remarries);
- The Fund is notified by the bank that a payment has been returned due to insufficient funds.
    - A $25 returned check fee will be billed.
    - If the insufficient funds notification is received prior to the 10th of the month of coverage, your widow/widower will have the opportunity to reinstate coverage by paying with a cashier's check, money order, or credit card. The payment must be postmarked on or before the 10th of the month of coverage. *(See Late Payment Policy below.)* ***Please request your Post Office to postmark your payment envelope.***
    - Any payments made to the Fund in the next 12 months must be made by cashier's check, money order, or credit card.
- For any reason stated in the When Coverage Ends section *(see page 38)*.

Late Payment Policy

Payment is late if the postmark is after the last day of the month preceding the month for which coverage is applicable. You are allowed one late payment in a six-month period provided the payment is postmarked no later than the 10th of the month of coverage. ***Please request your Post Office to postmark your payment envelope.***

Dependents on Medicare

If your Dependent is eligible for Medicare, you must notify Ohio Laborers Benefits by submitting a copy of your Dependent's Medicare card. *(See Coordination of Benefits with Medicare on page 72 for additional details.)*

Additional Eligibility Information

Special Enrollment Rights

This Fund is subject to certain federal laws that affect the ability of the Fund to restrict your eligibility and enrollment. Under these federal laws, the Fund is required to give you notice of your rights.

This Fund does require you to complete an Enrollment/Beneficiary Card and have it on file with Ohio Laborers Benefits once you become eligible for coverage. You must also enroll your eligible Dependents with the Fund to start their coverage. Once the completed information for you and your eligible Dependents is received by Ohio Laborers Benefits, you and your eligible Dependents will receive coverage as described in this booklet. Eligibility will NOT be determined for any claims that are filed more than 15 months after the date the expense was Incurred.

If you are declining enrollment for your Dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll your Dependents with the Fund if your Dependents lose eligibility for that other coverage (or if the employer stops contributing to your Dependents' other coverage).

To request special enrollment or obtain more information, contact Ohio Laborers Benefits at (614) 898-9006 or (800) 236-6437.

When Coverage Ends

When your Class 1 coverage ends (other than converting to Class 2, 3, or 4) or within two years after your coverage under the Fund ends, you may request a certification of your length of coverage under the Fund (Certificate of Creditable Coverage). This may help reduce or eliminate any preexisting condition limitation under a new group medical Plan.

For You

Your coverage under the Fund will end on:

- The last day of the month in which you have sufficient hours based upon hours contributions by a Contractor on your behalf;
- The last day of the month for which you made or were eligible to make regular COBRA/Self-Contribution payments for coverage;
- The date the Fund is discontinued;
- The date of your death; or
- The date you enter the armed forces on full-time active duty (subject to the conditions of the Uniformed Services Employment and Reemployment Rights Act (USERRA)).

For Your Covered Dependent

Your Covered Dependent's coverage will end on:

- The last day of the month in which there were sufficient hours based upon contributions by a Contractor;
- The date your coverage ends (for reasons other than your death);
- In the event of your death, the last day of the month in which you die (unless you have banked hours under Class 1 or were retired and you were eligible under Class 2, 3, or 4);
- The date your Covered Dependent no longer meets the Fund's definition of a Dependent (such as a Dependent child reaching a certain age or your divorce or legal separation);
- The date your Covered Dependent enters the armed forces on full-time active duty (subject to the conditions of USERRA);

- The last day of the month for which any required regular COBRA/Self-Contributions were made;
- The date the Fund no longer offers Dependent benefits; or
- The date the Fund is discontinued.

COBRA

Continuing Coverage through COBRA Continuation Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985, also called COBRA, you and/or your Covered Dependents may continue insurance eligibility past the date eligibility would normally end. Under certain circumstances, you and/or your Covered Dependents may make payments to continue the insurance benefits available from the Fund. To maintain coverage through COBRA, you and/or your Dependent(s) must be eligible for insurance at the time of the qualifying event.

Type of Coverage to be Continued

Members – COBRA Continuation Coverage includes all benefits you were eligible for prior to your COBRA qualifying event.

Dependents – Children born, adopted, or placed for adoption, as described above, have the same COBRA rights as Dependents who were covered by the Fund before the event that triggered COBRA Continuation Coverage. These children's continued coverage depends on timely and uninterrupted COBRA/Self-Contribution payments on their behalf. For Dependents, COBRA Continuation Coverage includes Medical, Prescription, Hearing, and Vision benefits. A newly acquired Dependent is not a qualified beneficiary under COBRA.

Qualifying Events

To be eligible for COBRA, you or your Dependents must lose insurance eligibility as a result of a qualifying event. Qualifying events include your:

- Termination of employment
- Reduction in hours (your "hours bank" runs out)
- Death
- Divorce or legal separation
- Child losing Dependent status under the Fund

Notifying Ohio Laborers Benefits

You or your Dependent must inform Ohio Laborers Benefits of any qualifying events. The notice must be in writing and received by Ohio Laborers Benefits or postmarked within 60 days of the qualifying event. ***Please request your Post Office to postmark your payment envelope.*** **Ohio Laborers Benefits will rely on its records for determining when coverage is lost due to a reduction in hours being reported. If you do not notify Ohio Laborers Benefits in a timely manner, you will lose your right to elect COBRA Continuation Coverage.**

Periods of Coverage

Coverage Continues for 18 Months – You may elect to purchase continued coverage for yourself and/or your Dependent(s) for up to 18 months if coverage ends due to your termination of employment or your reduction in hours.

Coverage Continues for 29 Months – If your eligibility ends due to your termination of employment or reduction in hours and at that time or within 60 days of termination of employment or reduction in hours, you or one of your Dependents is totally disabled (as determined by the Social Security Administration), coverage may continue for you and/or your Dependent for an additional 11 months, for a total of 29 months. To continue coverage for an additional 11 months, you must notify Ohio Laborers Benefits of your or your Dependent's determination of disability by the Social

Security Administration before the 18 month COBRA Continuation Coverage period ends. In addition, you must notify Ohio Laborers Benefits if you are subsequently not considered disabled by the Social Security Administration.

Coverage Continues for 36 Months – Your Dependents may elect to continue coverage for up to 36 months if coverage ends because of your:

- Death;
- Legal separation or divorce; or
- Dependent child no longer qualifies for Dependent coverage under the Fund.

Election of COBRA Continuation Coverage

Members

If your eligibility ends due to a reduction in hours (or termination of employment), you and your Dependent(s) will be sent a COBRA Election Notice. Once you receive the COBRA Election Notice, you have 60 days from the date of this notice to respond if you wish to elect COBRA Continuation Coverage ("election period"). If you elect COBRA Continuation Coverage following a reduction in hours and you make the appropriate payments, your Dependent(s) will remain eligible with you. Dependents do not have to make separate COBRA payments in this situation. However, if you waive your COBRA Continuation Coverage, your Dependent(s) will be given the opportunity to elect coverage independently from you. A parent or guardian may make an election for a Dependent child.

Dependents

When Ohio Laborers Benefits is notified that a qualifying event (your death, divorce/legal separation, or child losing Dependent status under the Fund) has occurred, your Dependent will be notified of his or her right to elect COBRA Continuation Coverage. Once your Dependent receives the COBRA Election Notice, he or she has 60 days from the date of this notice to elect COBRA Continuation Coverage ("election period). A parent or guardian may make an election for a Dependent child.

If the COBRA election is not received by Ohio Laborers Benefits or postmarked within the 60-day election period, you or your Dependent(s) will not be entitled to COBRA Continuation Coverage. *Please request your Post Office to postmark your payment envelope.*

Waiver of COBRA Continuation Coverage

You or your Dependent(s) may waive COBRA Continuation Coverage. If you or your Dependent(s) waive COBRA Continuation Coverage, you may revoke the waiver within the 60-day election period. A revocation of the waiver is considered an election of COBRA Continuation Coverage. No response from you or your Dependent(s) will be treated as a waiver of COBRA Continuation Coverage.

Payment Deadlines for COBRA Continuation Coverage

First COBRA Payment

Once you or your Dependent(s) have elected COBRA Continuation Coverage, you or your Dependent(s) have 45 days from the date of election to submit payment in full. No benefits will be provided until your monthly payment is received. The Notice will be sent to your last known address and will include the amount needed to continue coverage. While Ohio Laborers Benefits will attempt to notify you when a payment is due, it is your responsibility to make any required payments on time. It is very important you keep your address updated with Ohio Laborers Benefits.

Subsequent COBRA Payments

Subsequent payments are due the last day of month preceding the month of coverage. (For example, your October COBRA payment is due by the end of September.) If payment is not received within 30 days of the due date, all benefits will end immediately. No benefits will be provided until your monthly payment is received. Once your COBRA Continuation Coverage ends, it cannot be reinstated. *(Please note: if your COBRA bill for a particular month is delayed*

due to the allowed COBRA notification and election time periods, you will have a minimum of 30 days from the date of the COBRA bill to submit payment.)

Determining the Cost of COBRA Continuation Coverage

Members

Ohio Laborers Benefits will notify you of the cost of your COBRA Continuation Coverage when it notifies you of your right to coverage. Your cost for COBRA Continuation Coverage will vary from month to month for your first 12-month period of coverage. The amount is determined using the three Continuing Eligibility calculations *(on page 18)*. For each month, Ohio Laborers Benefits determines the least number of hours needed under any of the three calculations for you to maintain your eligibility. Once the least number of hours is calculated, it is multiplied by the standard hourly contribution rate (based on the Ohio Highway-Municipal-Utility State Construction Agreement) to determine the amount you owe for that month. *(This is often referred to as **Self-Contributions** or **Self-Pays** since you are basically buying the hours needed to maintain your eligibility.)*

If you continue to make COBRA payments after 12 months, the monthly amount due will change to a fixed rate starting with your 13th month of COBRA Continuation Coverage and will continue through month 18. This fixed rate for COBRA Continuation Coverage will be determined by the Trustees on an annual basis and will not exceed 102% of the cost to provide this coverage. The cost for extended disability coverage (from the 19th month through the 29th month) is an amount determined by the Trustees, not to exceed 150% of the cost to provide coverage.

Dependents

Ohio Laborers Benefits will notify your Dependent(s) of the cost of COBRA Continuation Coverage. Dependents will be eligible to pay a fixed rate for up to 36 months. This fixed rate for COBRA Continuation Coverage will be determined by the Trustees on an annual basis and will not exceed 102% of the cost to provide this coverage.

Making COBRA Payments

COBRA bills are generally mailed on the 15th of the month preceding the month of coverage. You can take your monthly COBRA payment to Ohio Laborers Benefits, mail it, or pay by credit card. However, if mailing it, be sure to allow sufficient time for delivery.

If a check is returned to Ohio Laborers Benefits due to insufficient funds, that check will NOT be re-deposited, but will be returned to you. Further, your coverage will be terminated on the date indicated on the COBRA Election Notice.

Any payments made to the Fund in the next 12 months must be made by cashier's check, money order, or credit card, provided the payment is postmarked on or before the due date of the COBRA billing. ***Please request your Post Office to postmark your payment envelope.*** Late COBRA payments cannot be accepted.

In the event the full amount of the COBRA payment as indicated on the bill is not remitted and received by the due date, your coverage will end on the date indicated on the notice.

Loss of COBRA Continuation Coverage

The period of COBRA Continuation Coverage for you or your Dependents may end or be reduced if:

- You or your Dependents do not make the required COBRA payments within the time limits set forth above (You or your Dependent(s) will be notified if your COBRA Continuation Coverage ends due to non-payment);
- The Fund no longer provides any group health benefits;
- You or your Dependents first become covered under any other Group Health Care Plan after the date on which COBRA Continuation Coverage is elected (provided such plan does not contain any preexisting condition exclusions or limitations); or

- You or your eligible Spouse first becomes entitled to Medicare after the date COBRA Continuation Coverage is elected.

Once you lose COBRA Continuation Coverage, you must meet the Funds eligibility requirements *(see page 18)* to again be eligible for coverage under the Fund.

COBRA Notices Sent in Error

If you or your Dependent receives a COBRA notice from the Fund in error (i.e., you receive a notice, but you are not entitled to COBRA Continuation Coverage), the Fund shall not be required to provide you with COBRA Continuation Coverage. Further, if the Fund receives contributions for COBRA Continuation Coverage and later discovers that you were not entitled to COBRA continuation coverage under the terms of the Plan, the Fund reserves the right to terminate coverage retroactively and refund all contributions paid to the Fund to the extent permitted by law.

Required Representations

The Fund may require you make certain representations while you are receiving COBRA Continuation Coverage, including, but not limited to, your marital status and loss or reduction in hours.

USERRA Continuation Coverage

Under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), an eligible Member who is absent from his or her employment due to service in the United States military has the opportunity for a temporary extension of health benefit coverage ("USERRA Continuation Coverage") identical to the health benefits the Plan provides to similarly situated Covered Persons at the time he or she enters military service (or as those benefits may be amended during the period of continuation coverage).

Notice of Departure from Employment due to Uniformed Services

Unless prohibited by federal law, you will not be eligible for USERRA Continuation Coverage unless you notify Ohio Laborers Benefits thirty-days (30) in advance of your departure from employment due to uniformed services. If your failure to give notice is excused under USERRA because it was impossible, unreasonable, or precluded by military necessity, the Fund will reinstate your coverage retroactively upon your election to continue coverage and payment of all unpaid amounts due. You will not incur any administrative reinstatement costs under these conditions. If you are not excused from giving timely notice under USERRA, you will not be eligible for USERRA continuation coverage.

Election of USERRA Continuation Coverage

USERRA continuation coverage is available to anyone who had coverage under the Plan before coverage terminated because you left your employment due to service in the U.S. military, but it is not automatic. You must elect USERRA Continuation Coverage. After notification of departure from employment due to Uniformed Services, the Fund will provide you with the forms and information necessary to elect USERRA continuation coverage if you qualify for it (including the charge he or she must pay for USERRA continuation coverage). You must comply with the COBRA Election Procedure *(starting on page 40)* to ensure USERRA continuation coverage. Generally, this means you are required to elect coverage within 60 days of receiving notice from the Fund of the availability of USERRA continuation coverage.

Periods of Coverage

The maximum period for USERRA continuation coverage is the lesser of 24 months after the first day your absence from work began due to military service or the day after the date on which you fail to apply for or return to your position of employment after your military service has concluded.

Paying for USERRA Continuation Coverage

If the period of USERRA Continuation Coverage is 31 days or less, the Fund will only bill you for that portion, you, as an employee, are responsible to pay. If you are not required to pay an employee contribution, you will not be billed for USERAA continuation coverage. If the period of USERRA continuation coverage is more than 31 days, the Covered Person pays for USERRA Continuation Coverage. The rate to be charged for USERRA Continuation Coverage may not exceed 102% of the applicable premium. After the Covered Person elects USERRA continuation coverage, the Fund may change the charge the Covered Person must pay for USERRA continuation coverage and, if it increases it, the Covered Person will be required to pay a higher charge than the charge the Covered Person was originally quoted.

If you fail to make a timely payment, USERRA Continuation Coverage shall terminate retroactive to the last day of the period of coverage for which a payment has been received. Your first payment for USERRA Continuation Coverage must include payments for any months retroactive to the day your coverage under the Fund ended. This payment is due no later than 45 days after the date you signed the election form and returned it to Ohio Laborers Benefits.

Reinstatement Rights

If you do not elect USERRA continuation coverage, you are entitled, if you are reemployed by your former Employer, to have your coverage under the Plan reinstated without any preexisting condition limitation or waiting period, except for coverage of any Illness or injury determined by the Secretary of Veterans Affairs to have been Incurred in or aggravated during the performance of service in the U.S. military.

When USERRA Continuation Coverage Ends

USERRA continuation coverage may end before the maximum extension period is reached for various reasons, including:

- The Plan no longer provides health benefits.
- You fail to pay the charge to the Fund when it is due and any applicable grace period expires.
- The maximum extension period for coverage expires.

USERRA and COBRA continuation coverage runs concurrently, so you cannot add your USERRA coverage onto your COBRA coverage or vice versa.

Medical Benefits

Schedule of Benefits

Claims Administrator: **Anthem Blue Cross Blue Shield** (855) 878-0128		
Medicare Eligible Retirees and Medicare Eligible Dependents of Retirees (Medical and Rx) Plan details not in this booklet, will be mailed separately by Anthem Medicare (833) 848-8730.		
	Network Coverage	**Out-of-Network Coverage**
Benefit Period	January 1st through December 31st	
Pre-Existing Condition Waiting Period	No Pre-Existing Rules	
Annual Deductible All claims will be subject to the annual Deductible, unless otherwise noted. Before the Fund pays for most Covered Expenses, you pay:	$400 per person $800 family maximum	$800 per person $1,600 family maximum
Maximum Out-Of-Pocket (MOOP) Limit The Fund pays 100% for the remainder of the year once you reach your MOOP Limit. MOOP Limit includes Deductibles, Copayments, and Coinsurance, but does not include penalties or balance billings or claims denied as not medically necessary. Any future increases in the limits established in accordance with the ACA shall be split evenly between the medical and prescription limits.	$4,250 per person $8,500 family maximum *Rates subject to change annually.*	$8,500 per person $17,000 family maximum *Rates subject to change annually.*
Coinsurance All claims will be subject to the Coinsurance, unless otherwise noted. Once you meet your annual Deductible, the Fund pays:	80%, then 100% after the annual Out-of-Pocket Maximum is reached	60%, then 100% after the annual Out-of-Pocket Maximum is reached
Office Visit – LiveHealth Online Visit a doctor for free on your smartphone, tablet, or computer with webcam.	100% Not Subject to Copayment or Deductible	Not Covered
Office Visit – Primary Care Providers Applies to the cost of Office Visit only (including consultation and telemedicine services). All other covered charges are subject to Deductible and Coinsurance.	$20 Copayment, then Fund pays 100%	$20 Copayment, then Fund pays 60%
Office Visit - Specialists Applies to the cost of Office Visit only (including consultation and telemedicine services). All other covered charges are subject to Deductible and Coinsurance.	$30 Copayment, then Fund pays 100%	$30 Copayment, then Fund pays 60%
Urgent Care Applies to the cost of Office Visit only.	$50 Copayment, then Fund pays 100%	$50 Copayment, then Fund pays 60%

Emergency Room Applies to room charges only. All other covered charges are subject to Coinsurance, but not subject to Deductible.	$150 Copayment, Copayment Waived if Admitted Fund pays 100% for room charges, 80% for all other covered charges	
Routine Physical Exam – Office Visit Once per Calendar Year.	100% Not Subject to Copayment or Deductible	$20 Copayment, then Fund Pays 60%
Routine Tests EKG, Chest X-ray, Complete Blood Count, Digital Rectal Exam, Cholesterol Screening, Prostate Specific Antigen (PSA), Comprehensive Metabolic Panels, and Urinalysis. Tests covered once per Calendar Year.		60%
Preventive Services Services include evidence-based services that have a rating of "A" or "B" in the United States Preventive Services Task Force, routine immunizations, and other screenings as provided for in the Patient Protection and Affordable Care Act. **Age and other restrictions apply to certain services. Examples: Colonoscopies only covered for ages 45 to 75, Bone Density Testing only covered for women age 60 and older, Herpes Zoster (shingles) Vaccine covered age 50 and older, HPV Vaccine covered under age 27.**		
Well Child Care Plan pays for Preventive Services covered under the Affordable Care Act for children through age 20. Age and other restrictions apply to certain services.		
Birth Control for Women All contraceptive methods for women approved by the FDA. Certain restrictions may apply.		
Routine PAP Smear Test		
Routine Mammogram – Age 40 and Older Once per Calendar Year.		
Routine Mammogram – Under Age 40 Once per Calendar Year.	80%	60%
Influenza Virus Vaccine (Flu Shots) and COVID-19 Vaccine	100%	
Behavioral Health Care & Substance Abuse – Inpatient You must obtain approval before Hospital admission, except for Emergency Admission.	80%	60%
Behavioral Health Care & Substance Abuse – Outpatient	$20 Copayment 100%	$20 Copayment 60%
Speech Therapy Up to 32 visits per year, Facility and Professional.	80%	60%

Physical Therapy, Outpatient Occupational Therapy, and Chiropractic Services Combined 50 visit maximum per calendar year. (Example: 20 visits of PT and 30 visits to Chiropractor or 50 visits all PT) Not subject to Copayments.	80% Not subject to Copayment	60% Not subject to Copayment
Dental Accident Care Impacted wisdom teeth, tooth extractions, TMJ, and expenses related to all facility services for dental procedures (even when deemed a medically appropriate setting) are not covered.	80%	60%
Home Health Care Services Up to 120 days per Calendar Year. Private Duty Nursing counts toward the visit maximum.	80%	60%
Skilled Nursing Facility Care You must obtain approval before admission. Up to 120 days per Calendar Year.	80%	60%
Hospice Care Services Limited to the last six months of life expectancy.	80%	60%
Additional Covered Items Allergy Testing and Treatments Ambulance Services (out-of-network covered at in-network level) Breast Cancer Care Breast Reconstructive Surgery Care Management Durable Medical Equipment (including Jobst/Compression Stockings) General Anesthesia Services Hospital Services (including Semi-Private Room and Board) Human Organ and Tissue Transplant Services Inpatient Physical Medical Rehabilitation (limited to 30 days per calendar year) Maternity Care, Infertility, and Abortion Services (including Initial Newborn Care Exams) Prosthetic Appliances Reconstructive Surgery Sterilization (services not covered under federal mandate) Surgical Care	80%	60%
Note: This is only a partial listing of benefits. Unless otherwise specified, Coinsurance is after Deductible.		
Please note General Plan Exclusions and Limitations beginning on page 109.		

Patient Protection Disclosure

You do not need prior authorization from Anthem Blue Cross Blue Shield 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 in the Fund's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Anthem at (855) 878-0128.

Deductible

Each calendar year, you and your Covered Dependents must pay the Deductible amount before the Fund pays most benefits. The network Deductible is $400 per person with a family maximum of $800. The Deductibles are doubled for non-network claims, $800 per person with a family maximum of $1,600.

If the Deductible is met in the fourth quarter of a calendar year *(October 1 through December 31)*, those charges applied to the Deductible from October through December will carry over to the following year.

Maximum Out-Of-Pocket (MOOP) Limit

There is an annual limitation on a participant's Maximum Out-Of-Pocket (MOOP) expenses as required by the Affordable Care Act. The Fund pays 100% for the remainder of the year once you reach your MOOP Limit. MOOP Limit includes Deductibles, Copayments, and Coinsurance, but does not include penalties, balance billings, or non-covered benefits. Any future increases/decreases in the limits established in accordance with the Affordable Care Act shall be split evenly between the medical and prescription limits.

Coinsurance

Benefits are generally paid at 80% if a Network Provider is used. If an Out-of-Network Provider is used, the level of coverage will be 60%. Refer to the Schedule of Benefits for exceptions. The Coinsurance amount is the percentage you are responsible to pay (20% for network claims, 40% for out-of-network claims).

Copayment

A Copayment is the dollar amount you are required to pay at the time a Covered Service is rendered. The Copayment varies depending on where you seek treatment as shown in the Schedule of Benefits. The following providers are **considered primary care providers and will NOT be subject to the Specialist Copayment:**

- General Practice
- Family Practice
- Internal Medicine
- Obstetrics and Gynecology (OB/GYN)
- Pediatrics – Neonatology
- Certified Nurse Midwife – Nurse Practitioner – Physician Assistant
- Mental Health and Substance Abuse Providers
- Clinical/Multi Specialty Group

LiveHealth Online

LiveHealth Online lets you talk face-to-face with a doctor through your mobile device or a computer with a webcam. Appointments are not necessary. Use LiveHealth Online for common health concerns like colds, the flu, fevers, rashes, infections, and allergies. Mental health care visits with psychologist and psychiatrists are also available through LiveHealth Online; however, you will need to schedule mental health care appointments. You can get prescriptions written (except for narcotics) through LiveHealth Online. Doctors are available on LiveHealth Online seven days a week, 24 hours a day, 365 days a year.

LiveHealth Online should not be used for emergency care. If you experience a medical emergency, call 911 immediately.

When you need to see a doctor, simply go to livehealthonline.com or access the LiveHealth Online mobile app. (You can download the LiveHealth Online mobile app for free on your mobile device by visiting the App Store or Google Play.) Select the state that you are in and answer a few questions. If you are using LiveHealth Online for the first time, you will be asked to answer a brief questionnaire about your health before you speak with a doctor. Then the information from your first online visit will be available for future LiveHealth Online visits. Once connected, you can talk and interact with the doctor as if you were in a private exam room. **There is NO copay with LiveHealth Online**.

For assistance, please call the Customer Support Call Center 24/7 at (888) 548-3432.

Allergy Testing and Treatments

Allergy testing performed and related to a specific diagnosis is covered. Desensitization treatments are also covered.

Exclusion: Expenses for unproven allergy treatments, including, but not limited to, sublingual immunotherapy (i.e., oral antigen drops administered under the tongue), rhinophototherapy (use of ultraviolet lights as a treatment for allergic rhinitis), repository emulsion therapy (a form of immunotherapy where allergens are administered in a solution with vegetable or mineral oil into the body to provide a slow release of the allergen(s) from the administration site).

Ambulance Services

Local service to the closest appropriate Hospital in connection with care for a Medical Emergency or if otherwise Medically Necessary. Such service also covers your transfer from one Hospital to another if Medically Necessary. Air ambulance is covered subject to Medical Necessity.

Transportation services provided by an ambulette or a wheelchair van are not Covered Services.

Behavioral Health Care and Substance Abuse Treatment

The following are Covered Services for the treatment of Behavioral Health Care and Substance Abuse Treatment. Both Inpatient and Outpatient care are covered. These services will also be covered when you have a medical condition that requires Medically Necessary treatment.

- Individual and group psychotherapy
- Electroshock therapy and related anesthesia only if given in a Hospital or psychiatric Hospital
- Psychological testing
- Family counseling: counseling with family members to assist with diagnosis and treatment. This coverage will provide payment for Covered Services only for those family members who are considered eligible Dependents under this Plan. Charges will be applied to the Covered Person who is receiving family counseling services, not necessarily the patient.
- Detoxification and rehabilitation services are provided for the treatment of Drug Abuse or Alcoholism.

Services for Developmental Delay, mental deficiency or intellectual disability, other than those necessary to evaluate or diagnose these conditions, are not covered. Services for the treatment of attention deficit disorder are covered. Residential care rendered by a Residential Treatment Facility is not covered, except as required under the Mental Health Parity and Addition Equity Act, and the regulations promulgated thereunder.

Breast Cancer Care

Covered Services are provided for Inpatient care following a mastectomy or lymph node dissection until the completion of an appropriate period of stay as determined by the attending Physician in consultation with the Member. Follow-up visits are also included and may be conducted at home or at the Physician's office as determined by the attending Physician in consultation with the Member.

Breast Reconstructive Surgery

Covered Services are provided following a mastectomy for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications, including lymphedemas.

Care Management

Care Management is a Health Care Management service designed to help promote the timely coordination of services for Members with health care related needs due to serious, complex, and/or chronic medical conditions. Anthem's Care Management programs coordinate health care benefits and available services to help meet health-related needs of Members who are invited and agree to participate in the Care Management Program.

Care Management programs are confidential and voluntary. These programs are provided at no additional cost to you and do not affect Covered Services in any way. Licensed health care professionals trained in care management and familiar with the benefit plan provide these services.

For Members who meet program requirements/criteria and who agree to participate in a Care Management program, a licensed health care professional completes an assessment and develops an individualized plan designed to help meet their identified health care related needs. This is achieved through communication, and collaboration with the Member and/or Member's designated representative, treating Physician(s), and other providers. The licensed health care professional remains in contact with the Member by telephone on a periodic basis to help accomplish the goals of the plan.

In addition to coordinating benefits, the licensed health care professional may assist with coordination of care with existing community-based programs and services to meet the Member's needs. Care coordination may include referrals to external agencies and available community-based programs and services.

Consultation Services

Covered when the special skill and knowledge of a consulting Physician is required for the diagnosis or treatment of an illness or injury. Second surgical opinion consultations are covered. Inpatient second surgical opinions are not covered. Staff consultations required by Hospital rules are excluded. Referrals, the transfer of a patient from one Physician to another for treatment, are not consultations under this Plan.

Dental Services and Oral Surgery

Dental services will only be covered for initial Injuries sustained in an accident. The Accidental Injury must have caused damage to the jaws, sound natural teeth, mouth or face. Injury as a result of chewing or biting shall not be considered an Accidental Injury.

Additional Covered Services include: oral and/or craniofacial surgery including, but not limited to, the treatment of jaw dislocations, facial/oral wounds, lacerations or infections (cellulitis), or the removal of cysts or tumors of the jaws/facial bones.

Durable Medical Equipment

This Plan will pay the rental charge up to the purchase price of the equipment. In addition to meeting criteria for Medical Necessity, and applicable Precertification requirements, the equipment must also be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the Member's medical condition. The equipment must be ordered and/or prescribed by a Physician and be appropriate for in-home use.

The equipment must meet the following criteria:

- It can stand repeated use;
- It is manufactured solely to serve a medical purpose;
- It is not merely for comfort or convenience;
- It is normally not useful to a person not ill or Injured;
- It is ordered by a Physician;
- The Physician certifies in writing the Medical Necessity for the equipment. The Physician also states the length of time the equipment will be required. The Plan may require proof at any time of the continuing Medical Necessity of any item;
- It is related to the Member's physical disorder.

This section describes supplies and equipment that are covered when prescribed by your Physician. These supplies and equipment must serve a specific therapeutic purpose in the treatment of a condition. Disposable supplies which serve a specific therapeutic purpose are covered. Certain diabetic items may be covered at no charge through your Prescription benefit *(see page 79 for details.)* Rigid or semi rigid supportive orthotic devices which limit or stop the motion of a weak or diseased body part are covered. Covered DME includes:

- Blood glucose monitors
- Breastfeeding equipment (as required by federal government mandate)
- Crutches
- Home dialysis equipment
- Hospital beds
- Mastectomy bra
- Respirators
- Wheelchairs
- Needles
- Oxygen
- Surgical dressings and other similar items
- Syringes
- Braces for the leg, arm, neck, or back
- Trusses
- Back and special surgical corsets

Items usually stocked in the home for general use are not covered. Non-covered equipment includes, but is not limited to:

- Elastic bandages
- Thermometers
- Replacement of lost, missing, or stolen, duplicate or personalized corrective appliances, orthotic devices, prosthetic appliances, or DME.
- Rental costs if you are in a facility which provides such equipment
- Repair costs which are more than the rental price of another unit for the estimated period of use, or more than the purchase price of a new unit
- Physician's equipment, such as a blood pressure cuff or stethoscope
- Corrective appliances and DME to the extent they exceed the cost of standard models of such appliances or equipment.
- Deluxe equipment such as specially designed wheelchairs for use in sporting events
- Items not primarily medical in nature such as:
    - Exercycle, treadmill, bidet toilet seat, elevator and chair lifts, lifts for vans for motorized wheelchairs and scooters
    - Items for comfort and convenience
    - Disposable supplies and hygienic equipment
    - Occupational therapy adaptive supplies and devices used to assist a person in performing activities of daily living, including self-help devices such as feeding utensils, reaching tools, devices to assist in dressing and undressing, shower bench, raised toilet seat, etc.
    - Self-help devices such as: bed boards, bathtubs, sauna baths, overbed tables, adjustable beds, special mattresses, telephone arms, air conditioners and electric cooling units
- Garter belts, arch supports, corsets, and corn and bunion pads;
- Corrective shoes, except with accompanying orthopedic braces;
- Arch supports and other foot care or foot support devices only to improve comfort or appearance. These include but are not limited to care for flat feet and subluxations, corns, bunions, calluses, and toenails.

Emergency Services

Emergency Services" shall be covered at network copays and coinsurance levels, without prior authorization, even if provided at an out-of-network facility, including a freestanding emergency department. Emergency Services provided at an out-of-network facility shall be subject to, and accumulate to, the network deductible and out-of-pocket maximum.

A service is an "Emergency Service" if a prudent layperson would deem the service an emergency in the specific situation. "Emergency Services" also include post-stabilization services at an out-of-network facility until all of the following are met:

- The attending emergency physician or treating provider determines that the patient is able to travel using non-medical transportation or nonemergency medical transportation to an available participating network provider or facility within a reasonable travel distance (taking into account the individual's medical condition);
- The provider or facility furnishing post-stabilization services satisfies certain notice and consent requirements;
- The individual (or the individual's authorized representative) is in a condition to receive the notice and to provided informed consent; and

- The provider or facility satisfies any additional requirements or prohibitions as may be imposed under applicable state law.

Ancillary Services, Prohibition of Balance Billing & External Review

You will not be balanced billed by an out-of-network provider for Ancillary Services at a network facility, for Emergency Services, or for air ambulance services. Determinations regarding Emergency Services, Ancillary Services and air ambulances shall be subject to the Plan's provisions on external review.

"Ancillary Services" are any of the following:

- Emergency Services
- Anesthesiology
- Pathology
- Radiology
- Neonatology
- Items and services provided by other specialists as specified in regulations
- Diagnostic services (unless regulations list the services as advanced diagnostic laboratory tests)
- Items and services provided by an out-of-network provider if there is no in-network provider who can furnish the services at the facility.

For all other services, an out-of-network provider providing services in a network facility may only balance bill you if they provide you with 72 hours in advance of the appointment (or the day the appointment is made if made less than 72 hours in advance, but at least 3 hours before the appointment) the following:

- A good faith estimate for the charge for the services in writing, paper or electronic form (as selected by the participant; this good faith estimate requirement is currently postponed pending further guidance from the United States government);
- A list of network providers at the facility who can perform the service and notification that you can be referred, at their option, to one of those providers and that the additional amount over the allowed amount would not apply to a network provider;
- Information about any prior authorization or care management requirements.

Consent must be signed by the participant and a copy provided to the participant through mail or e-mail (as selected by the participant).

Certain Payments to Out-of-Network Providers

Out-of-network providers shall be paid in accordance with the provisions of the Consolidated Appropriations Act, 2021, including the provisions regarding independent dispute resolution.

Continuity of Care

A "Continuing Care Patient" who receives care from a network provider or facility who has terminated its contract with the Plan may elect to continue to receive care under the same terms and conditions as would have applied had the provider or facility remained in network for a period of up to 90 days (but not later than the date at which the participant is no longer a Continuing Care Patient).

A Continuing Care Patient is a patient that falls into one of the following categories:

a) is undergoing a course of treatment for a serious and complex condition defined as:
   i) if an acute illness, a condition serious enough to require specialized medical treatment to avoid the possibility of death or permanent harm
   ii) if a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care of a prolonged period of time
b) is undergoing a course of institutional or inpatient care
c) is scheduled to undergo nonelective surgery, including postoperative care
d) is pregnant and undergoing a course of treatment for the pregnancy
e) is terminally ill and receiving treatment for such illness (as determined under Section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

Certain Errors Regarding Network Providers

If you are inaccurately informed that a provider or facility was in the network by the Plan's website, printed provider directory, or customer service phone, text or instant messenger line, services provided to you by the out-of-network provider shall be treated for claims payment purposes as though the services were received by a network provider.

COVID-19 Tests and Vaccines

Any applicable cost sharing will be waived for items or services furnished during office (in person and virtual) visits, urgent care, and emergency room visits that result in an order for, or the administration of, an FDA approved or authorized COVID-19 test (but only to the extent such items or services relate to the furnishing or administration of the test or the evaluation of whether the Member or Dependent needs the test).

Any applicable cost sharing shall also be waived for any "qualifying coronavirus preventative service". A "qualifying coronavirus preventative service" means an item, service, or immunization that is intended to prevent or mitigate coronavirus disease that is "A" or "B" rated by the United States Preventative Services Task Force; or, an immunization recommended by the Centers for Disease Control with respect to the individual involved.

The Plan will cover the cost of any FDA approved test, FDA emergency use authorized test, State authorized tests that are reported to the Department of Health and Human Services (HHS), and other HHS approved tests when the test is ordered by an attending health care provider who has determined that the test is medically appropriate for the individual based on current standards of medical practice and the test otherwise meets the applicable criteria established under federal law.

Also, after January 15, 2022, the Plan will cover the cost of FDA approved COVID-19 self-tests/at-home tests obtained without a prescription (i.e., obtained over-the-counter). The Plan will reimburse eligible Members and Dependents for the actual cost of the test if they are obtained through a network provider. The Plan will cover a maximum of 8 tests per Member or Dependent per calendar month. Reimbursements for tests obtained from an out-of-network provider may be limited to $12 per test. No reimbursements will be issued for tests purchased for employment purposes.

These benefits will terminate when the COVID-19 public health emergency declared by the Secretary of the U.S. Department of Health & Human Services expires or is terminated.

General Anesthesia Services

Covered when ordered by the attending Physician and administered by another Physician who customarily bills for such services, in connection with a covered procedure. Such anesthesia service includes the following procedures which are given to cause muscle relaxation, loss of feeling, or loss of consciousness:

- Spinal or regional anesthesia;
- Injection or inhalation of a drug or other agent (local infiltration is excluded).

Anesthesia services administered by a Certified Registered Nurse Anesthetist (CRNA) are only covered when billed by the supervising anesthesiologist.

Home Health Care Services

Home Health Care provides a program for the Member's care and treatment in the home. Your coverage is outlined in the Schedule of Benefits. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the Member's attending Physician. Services may be performed by either Network or Out-of-Network Providers.

Some special conditions apply:

- The Physician's statement and recommended program must be Precertified.
- Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis. Note: Covered Services available under Home Health Care do NOT reduce Outpatient benefits available under the Physical Therapy section shown in this Plan.
- A Member must be essentially confined at home.
- Private duty nursing is only covered in the home and visits count toward the Home Health Care visit maximum.

Covered Services:

- Visits by an RN or LPN. Benefits cannot be provided for services if the nurse is related to the Member.
- Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.
- Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable the Member to understand the emotional, social, and environmental factors resulting from or affecting the Member's illness.
- Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN.
- Nutritional guidance when Medically Necessary
- Administration or infusion of prescribed drugs.
- Oxygen and its administration

Home Health Care exclusions:

- Food, housing, homemaker services, sitters, home-delivered meals
- Home Health Care services which are not Medically Necessary or of a non-skilled level of care
- Services and/or supplies which are not included in the Home Health Care plan as described
- Services of a person who ordinarily resides in the Member's home or is a member of the family of either the Member or Member's Spouse
- Any services for any period during which the Member is not under the continuing care of a Physician

- Convalescent or Custodial Care where the Member has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the Member
- Any services or supplies not specifically listed as Covered Services
- Routine care and/or examination of a newborn child.
- Dietician services
- Maintenance therapy
- Dialysis treatment
- Purchase or rental of dialysis equipment

Hospice Care Services

Hospice benefits cover Inpatient and Outpatient services for patients certified by a Physician as terminally ill with a life expectancy of six months or less.

Your Plan provides Covered Services for Inpatient and Outpatient Hospice care as stated in the Schedule of Benefits. The Hospice treatment program must:

- Be recognized as an approved Hospice program by Anthem;
- Include support services to help covered family members deal with the Member's death; and
- Be directed by a Physician and coordinated by an RN with a treatment plan that:
  - Provides an organized system of home care;
  - Uses a Hospice team; and
  - Has around-the-clock care available.

To qualify for Hospice care, the attending Physician must certify that the Member is not expected to live more than six months. Also, the Physician must design and recommend a Hospice Care Program.

Hospital Services

You may receive treatment at a Network or an Out-of-Network Hospital. However, payment is significantly reduced if services are received at an Out-of-Network Hospital. Your Plan provides Covered Services when the following services are Medically Necessary.

Inpatient Services

Inpatient room charges. Covered Services include Semiprivate Room and board, general nursing care and intensive or cardiac care. If you stay in a private room, the Maximum Allowed Amount is based on the Hospital's prevalent Semiprivate rate. If you are admitted to a Hospital that has only private rooms, the Maximum Allowed Amount is based on the Hospital's prevalent room rate.

Services and supplies provided and billed by the Hospital while you're an Inpatient, including the use of operating, recovery and delivery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, x-ray examinations, and radiation and speech therapy are also covered.

Convenience items (such as radios, TV's, record, tape or CD players, telephones, visitors' meals, etc.) will not be covered.

Length of Stay will be determined by Medical Necessity.

Outpatient Hospital Services

The Plan provides Covered Services when the following Outpatient services are Medically Necessary: pre-admission tests, surgery, diagnostic X-rays, and laboratory services. Certain procedures require Precertification.

Hospital Visits

The Physician's visits to his or her patient in the Hospital. Covered Services are limited to one daily visit for each attending Physician specialty during the covered period of confinement.

Human Organ and Tissue Transplant Services

Notification

The Plan strongly encourages the Member to call Anthem's transplant department to discuss benefit coverage when it is determined a transplant may be needed. Contact the customer service telephone number on your Identification Card and ask for the transplant coordinator. Anthem will then assist the Member in maximizing their benefits by providing coverage information including details regarding what is covered and whether any medical policies, network requirements or benefit booklet exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for the Member.

Covered Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Contact Anthem for specific Network Transplant Provider information for services received at or coordinated by a Network Transplant Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Out-of-Network Transplant Provider Facility.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Anthem when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Covered Transplant Procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility and lodging for the transplant recipient Member and one companion for an adult Member, or two companions for a child patient. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Anthem when claims are filed. Contact the Claims Administrator for detailed information. Anthem will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

Maternity Care, Infertility, and Abortion Services

Covered Services are provided for Network Maternity Care subject to the benefit stated in the Schedule of Benefits. If you choose an Out-of-Network Provider, benefits are subject to the Deductible and percentage payable provisions as stated in the Schedule of Benefits.

Routine newborn nursery care is part of the mother's maternity benefits. Benefits are provided for well-baby pediatrician visits performed in the Hospital. Should the newborn require other than routine nursery care, the baby will be admitted to the Hospital in his or her own name.

Under federal law, the Plan may not restrict the length of stay to less than the 48/96-hour periods or require Precertification for either length of stay. The length of hospitalization which is Medically Necessary will be determined by the Member's attending Physician in consultation with the mother. Should the mother or infant be discharged before 48 hours following a normal delivery or 96 hours following a cesarean section delivery, the Member will have access to two post-discharge follow-up visits within the 48 or 96-hour period. These visits may be provided either in the Physician's office or in the Member's home by a Home Health Care Agency. The determination of the medically appropriate place of service and the type of provider rendering the service will be made by the Member's attending Physician.

Coverage also includes:

- Breastfeeding support, counseling, and equipment for the duration of breastfeeding as required by federal government mandate.
- Therapeutic and elective abortions.
- Benefits for the diagnosis of Infertility. *(Treatment of Infertility is not covered.)*

Prosthetic Appliances

Prosthetic devices to improve or correct conditions resulting from Accidental Injury or illness are covered if Medically Necessary and ordered by a Physician. Prosthetic devices include: artificial limbs and accessories; artificial eyes, one pair of glasses or contact lenses for eyes used after surgical removal of the lens(es) of the eye(s); arm braces, leg braces (and attached shoes); and external breast prostheses used after breast removal.

The following items are excluded: corrective shoes; dentures; replacing teeth or structures directly supporting teeth, except to correct traumatic Injuries; electrical or magnetic continence aids (either anal or urethral); and implants for cosmetic purposes except for reconstruction following a mastectomy.

Preventive Care

These services are services not considered to be Medically Necessary and are generally not covered by the Fund. However, certain preventive/routine/wellness services are covered by the Fund as outlined in the Schedule of Benefits and below. (Please refer to the schedule of benefits for applicable Copayments, Coinsurance, and Deductibles.) All other Routine Services are not covered by the Fund, unless specifically noted.

Preventive Care services include Outpatient services and Office Services. Screenings and other services are covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit.

Preventive Care Services in this section shall meet requirements as determined by federal law. Many preventive care services are covered by this Plan with no Deductible, Copayments, or Coinsurance from the Member when provided by a Network Provider. That means the Plan pays 100% of the Maximum Allowed Amount.

Reconstructive Surgery

Precertification is required. Reconstructive surgery does not include any service otherwise excluded in this Benefit Booklet. *(See General Plan Exclusions on starting on page 109.)*

Reconstructive surgery is covered only to the extent Medically Necessary:

- To correct significant anatomic deformities which are not within normal anatomic variation and which are caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving the significant anatomic deformity toward a normal appearance; or
- To correct medical complications or post-surgical deformity, unless the previous surgery was not a Covered Service.

Skilled Nursing Facility Care

Benefits are provided as outlined in the Schedule of Benefits. This care must be ordered by the attending Physician. All Skilled Nursing Facility admissions must be Precertified. Claims will be reviewed to verify that services consist of Skilled Convalescent Care that is medically consistent with the diagnosis.

Skilled Convalescent Care during a period of recovery is characterized by:

- A favorable prognosis;
- A reasonably predictable recovery time; and
- Services and/or facilities less intense than those of the acute general Hospital, but greater than those normally available at the Member's residence.

Covered Services include:

- Semiprivate or wardroom charges including general nursing service, meals, and special diets. If a Member stays in a private room, this Plan pays the Semiprivate Room rate toward the charge for the private room;
- Use of special care rooms;
- Pathology and radiology;
- Physical or speech therapy;
- Oxygen and other gas therapy;
- Drugs and solutions used while a patient; or
- Gauze, cotton, fabrics, solutions, plaster and other materials used in dressings, bandages, and casts.

This benefit is available only if the patient requires a Physician's continuous care and 24-hour-a-day nursing care.

Benefits will not be provided when:

- A Member reaches the maximum level of recovery possible and no longer requires other than routine care;
- Care is primarily Custodial Care, not requiring definitive medical or 24-hour-a-day nursing service;
- Care is for mental illness including drug addiction, chronic brain syndromes and Alcoholism, and no specific medical conditions exist that require care in a Skilled Nursing Facility;
- A Member is undergoing senile deterioration, mental deficiency or retardation, and has no medical condition requiring care;
- The care rendered is for other than Skilled Convalescent Care.

Speech Therapy

Therapy must be for rehabilitation of speech and language impairments and will only cover organic and physiologic impairments (those resulting from an identifiable medical condition, injury, or defect that either affects the ability to use the mouth/voice box to produce speech or affect the mechanics of speech). Examples include stroke patients or cleft lip/palate. Speech therapy benefits will not cover treatment for problems that result from:

- Non-curable developmental disorders – includes Developmental Delay, intellectual disability, and Down syndrome
- Non-organic/functional disorders – lisping, stuttering, stammering
- Delayed speech development of unknown origin in children younger than 18 months
- Maintenance therapy
- Treatments that can be provided by family members/caregivers (which can include routine, repetitious and reinforced procedures that are diagnostic or therapeutic in nature)
- Services available or provided in a school setting

Speech therapy treatment must be ordered by a Physician, be provided by a speech-language pathologist, and be expected to show improvement through short-term therapy within a certain period of time.

Surgical Care

Surgical procedures including the usual pre- and post-operative care are covered when Medically Necessary. Some procedures require Precertification. Services rendered by an assistant surgeon are covered based on Medical Necessity.

24/7 NurseLine

Call the 24/7 NurseLine at **(888) 249-3820** to talk with a registered nurse about your health concern no matter the time or day, just by calling the Customer Service number on the back of your ID card and asking for the 24/7 NurseLine. Whether it's a question about allergies, fever, types of preventive care or any other topic, nurses are always there to provide support and peace of mind. And, if you want, a nurse will call you later to see how you're doing.

Anthem's nurses can help you choose the right place for care if your doctor isn't available and you aren't sure what to do. Do you need to head straight to the emergency room? Is Urgent Care best? Or do you need to see your doctor? Making the right call can save you time and money – and give you access to the best possible care.

Do you speak Spanish or another language other than English? We have Spanish-speaking nurses and translators on call. TTY/TDD services are available, too.

If you'd prefer not to talk about your health concern over the phone, the AudioHealth Library might be for you. These helpful prerecorded messages cover more than 300 health topics in English and Spanish. Just call the 24/7 NurseLine number and choose the AudioHealth Library option.

Precertification - Health Care Management

Please contact Anthem to confirm the most current requirements for Precertification for the Plan.

The Plan includes the processes of Pre-Service, Concurrent, and Retrospective Reviews to determine when services should be covered. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service that they are performed. The Plan requires that Covered Services be Medically Necessary for benefits to be provided. When setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting.

Prior Authorization – **Network Providers are required to obtain Prior Authorization in order for you to receive benefits for certain services.** Prior Authorization criteria will be based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may determine that a service that was initially prescribed or requested is not Medically Necessary if you have not previously tried alternative treatments which are more cost effective.

If you have any questions regarding the information contained in this section, you may call the Customer Service telephone number on your Anthem identification card or visit www.anthem.com.

Types of Requests:

Precertification – A required review of a service, treatment or admission for a benefit coverage determination which must be obtained prior to the service, treatment or admission start date. For emergency admissions, you, your authorized representative or Physician must notify Anthem within 2 business days after the admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.

Predetermination – An optional, voluntary Prospective or Concurrent request for a benefit coverage determination for a service or treatment. Anthem will review your Plan to determine if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether

the service meets the definition of Medical Necessity under this Plan or is Experimental/Investigative as that term is defined in this Plan.

Post Service Clinical Claims Review – A Retrospective review for a benefit coverage determination to determine the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not require Precertification and did not have a Predetermination review performed. Medical Reviews occur for a service, treatment or admission in which Anthem has a related clinical coverage guideline and are typically initiated by Anthem.

Referrals:

Requests for Out of Network Referrals for care that Anthem determines are Medically Necessary may be pre-authorized, based on network adequacy.

Utilizing a provider outside of the Network may result in significant additional financial responsibility for you, because your health benefit Plan cannot prohibit Out-of-Network Providers from billing you for the difference between the provider's charge and the benefit the Plan provides.

The ordering provider, facility or attending Physician should contact Anthem to request a Precertification or Predetermination review ("requesting provider"). Anthem will work directly with the requesting provider for the Precertification request. However, you may designate an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification?	
Services provided by a Network Provider, including BlueCard Providers in the service areas of Anthem Blue Cross and Blue Shield (CO, CT, IN, KY, ME, MO, NH, NV, OH, VA, WI); Anthem Blue Cross (CA); Empire Blue Cross Blue Shield; Blue Cross Blue Shield of Georgia; and any future affiliated Blue Cross and/or Blue Shield Plans resulting from a merger or acquisition by Anthem's parent company.	Services provided by BlueCard providers outside the service areas of the states listed in the column to the left, BlueCard providers in other states not listed, and any Out-of-Network/Non-Participating Provider.
Provider is responsible for Precertification.	Member is responsible for Precertification. Member is financially responsible for service and/or setting that are not covered under this Plan based on an Adverse Determination of Medical Necessity or Experimental/ Investigative.

Anthem will utilize its clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, and preventive care clinical coverage guidelines, to assist in making Medical Necessity decisions. Anthem reserves the right to review and update these clinical coverage guidelines periodically. Your Employer's Group Health Plan Document takes precedence over these guidelines.

You are entitled to receive, upon request and free of charge, reasonable access to any documents relevant to your request. To request this information, contact the Customer Service telephone number on your Identification Card.

Anthem may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Anthem's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, Anthem may select certain qualifying providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. Anthem may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, provider or claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future or will do so in the future for any other provider, claim, or Member. Anthem may stop or modify any such exemption with or without advance notice.

You may determine whether a provider is participating in certain programs by contacting the customer service number on the back of your ID card.

Request Categories:

- Urgent – A request for Precertification or Predetermination that in the opinion of the treating provider or any Physician with knowledge of the Member's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function or subject the Member to severe pain that cannot be adequately managed without such care or treatment.
- Prospective – A request for Precertification or Predetermination that is conducted prior to the service, treatment or admission.
- Concurrent – A request for Precertification or Predetermination that is conducted during the course of treatment or admission.
- Retrospective – A request for Precertification that is conducted after the service, treatment or admission has occurred. Post Service Clinical Claims Review is also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notification Requirements

Timeframes and requirements listed are based in general on federal regulations. You may call the telephone number on your membership card for additional information.

Request Category	**Timeframe Requirement for Decision and Notification**
Prospective Urgent	72 hours from the receipt of request
Prospective Non-Urgent	15 calendar days from the receipt of the request
Concurrent when hospitalized at time of request	72 hours from request and prior to expiration of current certification
Other Concurrent Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Concurrent Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Concurrent Non-Urgent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If additional information is needed to make a decision, Anthem will notify the requesting provider and send written notification to you or your authorized representative of the specific information necessary to complete the review. If Anthem does not receive the specific information requested or if the information is not complete by the timeframe identified in the written notification, a decision will be made based upon the information in Anthem's possession.

Anthem will provide notification of its decision in accordance with federal regulations.

Notification may be given by the following methods:

- Verbal: oral notification given to the requesting provider via telephone or via electronic means if agreed to by the provider.

- Written: mailed letter or electronic means including email and fax given to, at a minimum, the requesting provider and the Member or authorized Member representative.

Precertification does not guarantee coverage for or payment of the service or procedure reviewed. For benefits to be paid, on the date you receive service:

1. You must be eligible for benefits;
2. The service or surgery must be a covered benefit under your Plan;
3. The service cannot be subject to an exclusion under your Plan; and
4. You must not have exceeded any applicable limits under your Plan.

Claims Payment

Providers who participate in the BlueCard® PPO Network have agreed to submit claims directly to the local Blue Cross and/or Blue Shield Plan in their area. Therefore, if the BlueCard® PPO Network Hospitals, Physicians, and Ancillary providers are used, claims for their services will generally not have to be filed by the Member. In addition, many Out-of-Network Hospitals and Physicians will also file claims if the information on the Blue Cross and Blue Shield Identification Card is provided to them. If the provider requests a claim form to file a claim, a claim form can be obtained by visiting www.anthem.com.

How to File Claims

Under normal conditions, Anthem should receive the proper claim form within 15 months after the service was provided. This section of the Benefit Booklet describes when to file a benefits claim and when a Hospital or Physician will file the claim for you.

Each person enrolled through the Plan receives an Identification Card. Remember, in order to receive full benefits, you must receive treatment from a Network Provider. When admitted to a Network Hospital, present your Identification Card. Upon discharge, you will be billed only for those charges not covered by the Plan

When you receive Covered Services from a Network Physician or other Network licensed health care provider, ask him or her to complete a claim form. Payment for Covered Services will be made directly to the provider.

For health care expenses other than those billed by a Network Provider, use a claim form to report your expenses. You may obtain these from Anthem. Claims should include your name, Plan and Group numbers exactly as they appear on your Identification Card. Attach all bills to the claim form and file directly with Anthem. Be sure to keep a photocopy of all forms and bills for your records. The address is on the claim form.

Save all bills and statements related to your illness or injury. Make certain they are itemized to include dates, places and nature of services or supplies.

Maximum Allowed Amount

This section describes how Anthem determines the amount of reimbursement for Covered Services. Reimbursement for services rendered by Network and Out-of-Network Providers is based on this/your Plan's Maximum Allowed Amount for the Covered Service that you receive. Please see the BlueCard section for additional information.

The Maximum Allowed Amount for this Plan is the maximum amount of reimbursement Anthem will allow for services and supplies:

- That meet Our definition of Covered Services, to the extent such services and supplies are covered under your Plan and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your Plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from an Out-of-Network

Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the provider's actual charges. This amount can be significant.

When you receive Covered Services from a provider, Anthem will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Anthem's determination of the Maximum Allowed Amount. Anthem's application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means Anthem has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Physician or other healthcare professional, the Plan may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the provider is a Network Provider or an Out-of-Network Provider.

A Network Provider is a provider who is in the managed network for this specific product or in a special Center of Excellence or other closely managed specialty network, or who has a participation contract with Anthem. For Covered Services performed by a Network Provider, the Maximum Allowed Amount for this/your Plan is the rate the provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Network Provider or visit www.anthem.com.

Providers who have not signed any contract with Anthem and are not in any of Anthem's networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from an Out-of-Network Provider, the Maximum Allowed Amount for this Plan will be one of the following as determined by Anthem:

a) An amount based on Anthem's Out-of-Network Provider fee schedule/rate, which Anthem has established in its' discretion, and which Anthem reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with the Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or

b) An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or

c) An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or

d) An amount negotiated by Anthem or a third-party vendor which has been agreed to by the provider. This may include rates for services coordinated through case management; or

e) An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this product, but contracted for other products with Anthem are also considered Out-of-Network. For this/your Plan, the Maximum Allowed Amount for services from these providers will be one of the five methods shown above unless the contract between Anthem and that provider specifies a different amount.

Unlike Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the provider's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the provider charges. This amount can be significant. Choosing a Network Provider will likely result in lower Out of Pocket costs to you. Please call Customer Service for help in finding a Network Provider or visit Anthem's website at www.anthem.com.

Customer Service is also available to assist you in determining this/your Plan's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for Anthem to assist you, you will need to obtain from your provider the specific procedure code(s) and diagnosis code(s) for the services the provider will render. You will also need to know the provider's charges to calculate your Out-of-Pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the provider.

Member Cost Share

For certain Covered Services and depending on your Plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

Your cost share amount and Out-of-Pocket Limits may vary depending on whether you received services from a Network or Out-of-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the Schedule of Benefits in this Benefit Booklet for your cost share responsibilities and limitations, or call Customer Service to learn how this Plan's benefits or cost share amounts may vary by the type of provider you use.

The Plan will not provide any reimbursement for Non-Covered Services. You may be responsible for the total amount billed by your provider for Non-Covered Services, regardless of whether such services are performed by a Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of this Benefit Booklet and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances, you may only be asked to pay the lower Network cost sharing amount when you use an Out-of-Network Provider. For example, if you go to a Network Hospital or Provider facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Network Hospital or facility, you will pay the Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

Authorized Services

In some circumstances, such as where there is no Network Provider available for the Covered Service, the Plan may authorize the Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you must contact Anthem in advance of obtaining the Covered Service. The Plan also may authorize the Network cost share amounts to apply to a claim for Covered Services if you receive Emergency Services from an Out-of-Network Provider and are not able to contact Anthem until after the Covered Service is rendered. If the Plan authorizes a Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Customer Service for Authorized Services information or to request authorization.

Services Performed During Same Session

The Plan may combine the reimbursement of Covered Services when more than one service is performed during the same session. Reimbursement is limited to the Plan's Maximum Allowed Amount. If services are performed by Out-of-Network Providers, then you are responsible for any amounts charged in excess of the Plan's Maximum Allowed Amount with or without a referral or regardless if allowed as an Authorized Service. Contact Anthem for more information.

Processing Your Claim

You are responsible for submitting your claims for expenses not normally billed by and payable to a Hospital or Physician. Always make certain you have your Identification Card with you. Be sure Hospital or Physician's office personnel copy your name, and identification numbers (including the 3-letter prefix, if applicable) accurately when completing forms relating to your coverage.

Timeliness of Filing for Member Submitted Claims

To receive benefits, a properly completed claim form with any necessary reports and records must be filed by you within 15 months of the date of service. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, you will be notified of the reason for the delay and will receive a list of all information needed to continue processing your claim. After this data is received, Anthem will complete claims processing. No request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Necessary Information

In order to process your claim, Anthem may need information from the provider of the service. As a Member, you agree to authorize the Physician, Hospital, or other provider to release necessary information.

Anthem will consider such information confidential. However, the Plan and Anthem have the right to use this information to defend or explain a denied claim.

Explanation of Benefits

After you receive medical care, you will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement sent by Anthem, to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received;
- The amount of the charges satisfied by your coverage;
- The amount for which you are responsible (if any); and
- General information about your Appeals rights and for ERISA plans, information regarding the right to bring an action after the Appeals process.

Out-of-Area Services

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area Anthem serves (the "Anthem Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Anthem Service Area, you will receive it from one of two kinds of Providers. Most Providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("nonparticipating providers") don't contract with the Host Blue. Below is an explanation of how Anthem pays both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are prescription drugs that you obtain from a pharmacy and most dental or vision benefits.

A. BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, Anthem will still fulfill its contractual obligations. But, the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When you receive Covered Services outside the Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price Anthem used for your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem may process your claims for Covered Services through negotiated arrangements for national accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) made available to Anthem by the Host Blue.

C. Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a value-based program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem through average pricing or fee schedule adjustments.

If Anthem has entered into a negotiated arrangement with a Host Blue to provide value-based programs to the Plan on your behalf, Anthem will follow the same procedures for value-based programs administration and care coordinator fees as noted above for the BlueCard Program.

D. Nonparticipating Providers Outside Anthem Service Area

1. Allowed Amounts and Member Liability Calculation

When Covered Services are provided outside of Anthem's Service Area by non-participating providers, the Plan may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as deductible, copayment or coinsurance will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-participating provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. Exceptions

In certain situations, the Plan may use other pricing methods, such as billed charges the pricing it would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price to determine the amount the Plan will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment the Plan makes for the Covered Services as set forth in this paragraph.

E. BlueCard Worldwide® Program

If you plan to travel outside the United States, call customer service to find out your BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. The plan only covers Emergency, including ambulance, {and Urgent Care} outside of the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care, you can call the BlueCard Worldwide Service Center any time. They are available 24 hours a day, seven days a week. The toll-free number is 800-810-2583. Or you can call them collect at 804-673-1177.

Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

How claims are paid with BlueCard Worldwide

In most cases, when you arrange inpatient hospital care with BlueCard Worldwide, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance or deductible amounts that may apply.

You will typically need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need BlueCard Worldwide claim forms you can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bluecardworldwide.com.

You will find the address for mailing the claim on the form.

Coordination of Benefits

The Fund has been designed to help you meet the cost of medical benefits. It is not intended that you receive greater benefits than your actual health care expenses. **If you and/or your Dependent(s) are covered under another plan, you must report all other coverage when you file a claim.** The amount of benefits payable under this Fund will be coordinated with any coverage Covered Individuals have under any:

- Group, blanket, or franchise insurance coverage
- Group coverage or group-type coverage through HMOs and other prepayment, group practice, and individual practice plans
- Coverage under employee benefit welfare plans as defined by ERISA
- Coverage under any plan largely tax-supported or otherwise provided for by or through action of any government and any coverage required or provided by any statute (except Medicaid)
- Plan that is paid for entirely by a Covered Individual only if the plan contains a provision for coordinating benefits
- Part A and Part B of Medicare, regardless of whether or not the Covered Individual is enrolled

This Fund will always pay either its regular benefits in full or a reduced amount that, when added to the benefits payable by the other plan(s), will equal the total allowable expenses. (*Allowable expenses are any necessary, usual, customary, and reasonable charge at least part of which is covered under one of the plans covering the Covered Individual.)* If a plan provides benefits in the form of services or supplies instead of cash, the reasonable cash value of the service rendered and supplies furnished (if otherwise an allowable expense) will be considered both an allowable expense and a benefit paid. However, no more than the maximum benefits payable under this Fund will be paid.

Please note that you must file a claim for any benefits you are entitled to from any other source. Whether or not you file a claim with any other source, your payments from this Fund will be calculated as though you have received any benefits you are entitled to from other sources. In addition, you must comply with all rules of any other plan. If you do not and benefits are reduced from the other plan for failure to follow the appropriate procedures, benefits paid under this Fund will be limited to the amount that would have been paid had you followed the appropriate procedures.

Order of Payment

If you and/or your Dependent(s) are covered under more than one plan, the primary plan pays first, regardless of the amount payable under any other plan. The other plan, the secondary plan, will adjust its benefit payment so that the total benefits payable do not exceed 100% of the allowable expense Incurred.

In general, a plan that covers an individual as an employee is primary. If an individual is an employee under more than one plan or no other rule determines the order of payment, the plan that has covered the Covered Individual longer is primary.

If a Dependent child is covered under more than one plan and the parents are *not* divorced or legally separated, the following rules determine which plan's benefits are primary:

- The plan that covers the parent whose date of birth occurs earlier in the calendar year, excluding the year of birth, is primary (this is known as the birthday rule).
- If the birthday of both parents occurs on the same date, the plan that has covered the parent for the longer period of time is primary.
- If a plan does not use the birthday rule to determine which plan pays first, the rules of that plan determine the order of benefit payments, provided the rules are not based on the parents' gender, in which case, the rules of the other plan will not be followed and the Fund will follow the birthday rule.

If a Dependent child is covered under more than one plan and the parents are divorced or legally separated, the following rules determine which plan's benefits are primary:

- Where there is a court decree that establishes financial responsibility for medical expenses, the plan covering the Dependent child of the parent who has financial responsibility will pay first.
- Where there is no court decree or a court order does not specify which plan is primary, the plan of the parent with custody is primary. If the parent with custody has remarried, then the:
    - Stepparent with custody of the child pays second; and
    - Parent not having custody of the child pays third.

If the Fund makes payments it is not required to pay, it may recover and collect those payments from you, your Dependents, or any organization or insurance company that should have made the payment. The Fund's right to reimbursement under the Subrogation and Reimbursement provision of this SPD shall also apply in those instances where the Fund has made payments it is not required to pay.

Coordination of Benefits with Managed Care Plans

If you or your Dependents are covered by a managed care plan, such as a Health Maintenance Organization (HMO) plan, the Fund will assume that you and your Dependents have complied with that plan's rules necessary for your expenses to be covered by the managed care plan.

This Fund is not responsible for medical expenses that could have been paid or would otherwise be paid under the managed care plan had you followed that plan's rules. If the managed care plan is considered the primary plan and is not used, this Fund payment will be limited to the amount that would have been payable had the Covered Individual followed the Fund requirements.

Coordination of Benefits with Medicare

Medicare consists of four parts.

1. The first part, officially called Hospital Insurance Benefits for the Aged and Disabled, is commonly referred to as Part A of Medicare. Part A of Medicare primarily covers Hospital benefits, although it also provides other benefits.
2. The second part, officially called Supplementary Medical Insurance Benefits for the Aged and Disabled, is commonly referred to as Part B of Medicare. Part B of Medicare primarily covers Physician's services, although it, too, covers a number of other items and services.
3. The third part, Medicare Advantage, is commonly referred to as Part C. Part C is the managed care program under Medicare.
4. The fourth part is referred to as Part D. Part D is the Prescription Drug coverage under Medicare.

Typically, you become eligible for Medicare when you reach age 65. Under certain circumstances, you may become eligible for Medicare before age 65, if you are a disabled worker, Dependent widow, or have chronic end-stage renal disease (ESRD). If you are eligible for Medicare based solely on permanent kidney failure (ESRD), there is a period of time when the Fund is primary and will pay health care bills first. Generally, this Fund is primary and pays benefits first, without regard to a Covered Individual's entitlement to Medicare if such Covered Individual is entitled to Medicare as an ESRD beneficiary, and not more than 33 months have elapsed since the earliest of:

- The month in which the Covered Individual began a regular course of renal dialysis;
- The month in which the Covered Individual was admitted to the Hospital in anticipation of a kidney transplant that was performed within the next two months; or
- The second month before the month the kidney transplant was performed, if performed more than two months after admission.

If you have COBRA continuation coverage, the Fund generally pays first and Medicare pays second if you and your Spouse are under age 65. If you and your Spouse are over age 65, then Medicare pays first and the Fund pays second.

Any benefits payable to you or your Dependents under any portion of this Fund will be reduced by the amount of any benefits or other compensation to which you are entitled under any federal law, rules, or regulations constituting a governmental health plan, such as Medicare. Benefits will similarly be reduced if you or your Dependents are above age 65, regardless of whether or not you have received or made application for such benefits or compensation.

For all purposes of this provision, if you or your Dependents are eligible for benefits or other compensation under Medicare, the Fund will reduce your benefits by the amount Medicare would have paid, even if you are not enrolled or participating.

If you or your Dependents enroll for Medicare Prescription coverage (Part D): If Medicare is primary for you and you enroll in a Part D (Medicare Prescription Drug coverage) not offered by the Fund, you will no longer be covered by the Fund for health care, including Medical, Vision and Prescription Drug coverage. In addition, your Covered Dependents will also lose coverage.

If you are retired and eligible for Medicare, you must enroll for Parts A & B. Even if you do not enroll, the Fund will pay benefits as if you are enrolled in Medicare Parts A and B.

Please see the chart on the following page for a summary of when the Fund and Medicare pay primary.

Information Gathering

To implement the provisions in this Coordination of Benefits section, the Trustees may release or obtain any information necessary to or from any insurance company, organization, or person without your consent or release, in accordance with the Fund's Privacy Policy. Any person claiming benefits under this Fund must provide any information necessary to implement the Coordination of Benefits provisions or to determine their applicability.

Summary of Primary Coverage between Fund and Medicare

Member's Status	Member's Primary Coverage	Spouse's Status	Spouse's Primary Coverage
Active	Fund	Under Age 65	Fund
		Disabled	Fund
		Over Age 65	Fund
Over Age 65 & Retired	Medicare	Under Age 65	Fund
		Disabled	Medicare
		Over Age 65	Medicare
Under Age 65 Retired (not Disabled)	Fund	Under Age 65	Fund
		Disabled	Medicare
		Over Age 65	Medicare
Under Age 65 Disabled & Retired	Medicare	Under Age 65	Fund
		Disabled	Medicare
		Over Age 65	Medicare

Prescription Drug Benefits

Schedule of Benefits

Claims Administrator: **Anthem – CarelonRx** Pharmacy Member Service is available 24/7 by calling (844) 993-4314		
CarelonRx Home Delivery: (833) 236-6196		
Specialty Medications: **CarelonRx Specialty Pharmacy (833) 255-0645**		
Medicare Eligible Retirees and Medicare Eligible Dependents of Retirees (Medical and Rx) Plan details not in this booklet, will be mailed separately by Anthem Medicare (833) 848-8730.		
Copayments	Retail Pharmacy *(30 days)*	Home Delivery *(90 days)*
Tier 1	$10	$25
Tier 2	$30	$75
Tier 3	$50	$125
Maximum Out-Of-Pocket (MOOP) Limit The Fund pays 100% for the remainder of the calendar year once you reach your MOOP Limit. MOOP Limit does not include penalties or ingredient charges. Any future increases in the limits established in accordance with the ACA shall be split evenly between the medical and prescription limits.	$4,825 per person $9,650 family maximum *Rates subject to change annually.*	
Quantity Limits Taking too much medicine or using it too often isn't safe. And it may even drive up your health care costs. That's why this program limits the amount of medicine that's covered by your plan for a certain length of time. For example, a drug may have a limit of 30 pills per 30 days. You can always find the most current information about covered quantity limits when you log in at anthem.com or call Pharmacy Member Services.		
Mandatory Home Delivery You must use the Home Delivery pharmacy or a CVS retail pharmacy to fill prescriptions for maintenance medications (with limited exceptions). You are permitted to use a retail pharmacy three times (the original prescription, plus two refills) for a maintenance medication. Home Delivery refills require a 90-day prescription.		
Mandatory Generic Drugs The Fund will only pay the cost of the generic drug, if a generic is available. If you or your Physician request a brand name drug instead of a generic drug, you will be responsible for paying the cost difference between the generic and brand name drug in addition to the brand name drug Copayment.		
Specialty Medications You are required to use the Specialty Pharmacy to fill all your prescriptions for specialty medications.		

Step Therapy Certain medications may qualify for Step Therapy, which encourages doctors to first attempt to prescribe lower cost drugs to treat an ongoing condition.	
Smoking Cessation Prescription and over-the-counter FDA approved smoking cessation medications. To get the over-the-counter drugs at no cost, you must have a prescription.	Plan Pays 100%
Influenza Virus Vaccine (Flu Shots) and COVID-19 Vaccine Administration fees may not be covered.	Plan Pays 100%
Diabetic Supplies Insulin needles and syringes; lancets and devices (spring or powered); blood glucose testing strips for home glucose monitors; normal, low, and high calibrator solution/chips; and Alcohol wipes	Plan Pays 100% (coverage limited to listed items only)
Birth Control for Women All contraceptive methods for women approved by the FDA. (* Tier 2 and Tier 3 prescriptions are subject to Copayments when Tier 1 prescriptions are available.)	Plan Pays 100% (certain restrictions apply*)
Prior Authorization Certain medications that may have a risk of side effects, a risk of harmful effects when taken with other drugs, potential for incorrect use or abuse, better options that may cost you less and work better, and rules for use with certain health conditions require authorization from Anthem-CarelonRx before your prescription can be filled.	
Please note General Plan Exclusions and Limitations beginning on page 109.	

Retail Pharmacy

You may purchase drugs and medication with a written prescription by a Physician through the Prescription Drug Benefit administered by Anthem – CarelonRx. Anthem – CarelonRx utilizes a formulary drug list. A formulary is a list of preferred medications organized into groups or "tiers".

- Tier 1 drugs have the lowest cost share for you. These are usually generic drugs that offer the best value compared to other drugs that treat the same conditions. Generic equivalents are in Tier 1 and are mandatory if available.
- Tier 2 drugs have a higher cost share for you than Tier 1 drugs. They may include:
  - Preferred brand-name drugs. They are preferred because of how well they work and their cost compared to other drugs used for the same type of treatment.
  - Generic drugs that may cost more because they're newer to the market.
- Tier 3 drugs have the highest cost share. They often include non-preferred brand and generic drugs. They may cost more than drugs on lower tiers that are used to treat the same condition. Tier 3 may also include drugs that were recently approved by the FDA.

The higher you go on the tier structure, the higher your Copayments.

You will be responsible for the following Copayments:

- Tier 1 – Generic $10
- Tier 2 – Brand Preferred $30
- Tier 3 – Brand Non-Preferred $50

Anthem – CarelonRx reviews the formulary list regularly and makes changes when deemed appropriate.

If you pay for a prescription at a retail pharmacy and mail in a claim for reimbursement, you will only be reimbursed the network price, less the appropriate Copayment.

Mandatory Home Delivery

If you take a prescription medication for a chronic condition (referred to as maintenance medication), you will be required to use the Home Delivery pharmacy or a CVS retail pharmacy. You will be allowed to obtain a prescription for maintenance medications from a retail pharmacy three times (the original prescription plus two refills). After that, you will not be allowed to use a retail pharmacy (with limited exceptions) for the maintenance medication. All future refills for the maintenance medication will require a 90-day prescription and must be filled through the Home Delivery pharmacy or a CVS retail pharmacy.

Prior to using Home Delivery, you should contact CarelonRx to set up your mailing and payment preferences. To fill a prescription through the Home Delivery pharmacy, you must:

1. Obtain a 90-day prescription from your Physician. With e-prescribing, your Physician can send a 90-day prescription electronically to the Home Delivery pharmacy (or a CVS retail pharmacy), or
2. If you have a written prescription from your Physician, request an order form from CarelonRx or visit ohiolaborers.com.
3. Follow the order form directions.

Once your prescription is received by CarelonRx Home Delivery pharmacy, your prescription will be delivered to your home address in approximately 14 days. Refills can be ordered by phone or online at anthem.com or through the Sydney app.

You will be responsible for the following Copayments for a 90-day supply of medication filled by the Home Delivery pharmacy or a CVS retail pharmacy:

- Tier 1 $25
- Tier 2 $75
- Tier 3 $125

Please note that certain Prescription Drugs may be subject to regulation by federal laws, which may require that only a 30-day maximum prescription is dispensed. You will be notified if you are unable to obtain a 90-day supply.

Mandatory Generic Drugs

The Fund only covers the cost of the generic drug (if a generic is available). If you or your Physician request the brand name drug, you would be responsible for the price difference between the generic and the brand name drug. In addition to the cost difference, you are still responsible for the brand name Copayment.

A generic equivalent is a copy of a brand-name medication that is no longer protected by a patent. When a new drug comes to market for the first time, the drug company that manufactures it has a patent to be the sole manufacturer. Once the patent has expired, other manufacturers can produce the drug as a generic. A generic drug is identical to a brand name drug in that it is required to have the same active ingredient(s), strength, dosage, way it works, way it is taken, and the way it should be used. When a generic drug product is approved, it has met rigorous standards established by the Food and Drug Administration (FDA). There is little difference between a brand-name drug and its generic equivalent. The generic may differ from the brand-name drug in color, shape, size, or taste, but these things don't affect the way the drug works, and they are looked at by FDA. The big difference is that **generics usually cost less than the brand**; therefore, using generic medications can be a significant source of savings for you and the Fund.

You are encouraged to work with your doctor to use generics, when right for you. Your doctor or pharmacist can assist you in substituting generic medications when appropriate. If you or your doctor feel the generic equivalent drug is not clinically appropriate (e.g., it will be or has been ineffective or would have adverse effects), you are entitled to submit an Appeal of the price difference between the generic and the brand name drug.

Prescription Drug List

The Plan uses an Anthem Prescription Drug List, (a formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness. Benefits may not be covered for certain Drugs if they are not on the Prescription Drug List.

The Drug List is developed based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by our Members, and where proper, certain clinical economic reasons.

You may request a copy of the Prescription Drug list by calling the Member Services telephone number on the back of your Identification Card or visiting our website at www.anthem.com. The Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Specialty Medications

You are required to use CarelonRx Specialty Pharmacy for all your specialty medication needs. Specialty medications are typically high cost medications that may be self-injected or taken by mouth. The medications require special handling and close monitoring by your health care providers. Examples of medical conditions for which there are specialty drugs include, but are not limited to various forms of cancer, growth hormone deficiencies, hepatitis c, multiple sclerosis, psoriasis, and rheumatoid arthritis. These medications are mailed directly to your house, prescriber's office, or location of your choice.

Because specialty medications can be more difficult to manage, CarelonRx Specialty Pharmacy offers the following patient support services at no charge:

- Personalized support to help you achieve the best results from your prescribed therapy
- Convenient delivery to your home or prescriber's office
- Easy access to a Care Team who can answer medication questions, provide educational materials about your condition, help you manage any potential medication side effects, and provide confidential support - all with one toll-free phone call
- Assistance with your specialty medication refills

You will be required to use CarelonRx Specialty Pharmacy for all your specialty medication needs. If you have any questions, or to begin taking advantage of the complimentary patient support services, please call CarelonRx Specialty Pharmacy toll free at (833) 255-0645.

Drug Cost Share Assistance Programs

If you qualify for certain non-needs based drug cost share assistance programs offered by drug manufacturers (either directly or indirectly through third parties) to reduce the amount you pay for certain Specialty Drugs, CarelonRx may enroll you in a program, the CarelonRx Cost Relief Program, that allows you to further reduce your costs, and may eliminate your out-of-pocket costs altogether. CarelonRx will work with manufacturers to get the maximum cost share assistance you are eligible for and will manage enrollment and renewals on your behalf.

Participation in this program is voluntary. If you currently take one or more Prescription Drugs included in this program, CarelonRx will automatically enroll you in the program and send you a welcome letter, followed up with a phone call that provides specific information about the program as it pertains to your medication.

If you or a covered family member are not currently taking but will start a new Prescription Drug covered under this program, you can either contact CarelonRx or they will proactively contact you so that you can take full advantage of the program.

Some drug manufacturers will require you to sign up to take advantage of the assistance that they provide. In those cases, CarelonRx will contact you to let you know what you need to do.

The list of Prescription Drugs covered by the CarelonRx Cost Relief Program may be updated periodically by the Plan. Please refer to www.anthem.com, for the latest list.

If you do not wish to participate in this program, you can opt out, and you will be responsible for the full amount of the cost share for the Specialty Drug.

Because certain Specialty Drugs are not classified as "essential health benefits" under the Plan in accordance with the Affordable Care Act, Member cost share payments for these Specialty Drugs, whether made by you or a manufacturer copayment assistance program, do not count towards the Plan's Out-of-Pocket Limit. A list of Specialty Drugs that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a Specialty Drug that is not an essential health benefit is medically necessary for a particular individual.

Step Therapy

Certain medications may qualify for a step therapy program. Step therapy requires one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated. Step therapy helps you and the Fund control the rising cost of drugs.

Your doctor can ask for an exemption from the step therapy protocol for you by contacting Anthem online or by calling the phone number on your ID card. If the request is approved, you will only pay the appropriate Copayment for the drug. If it is not approved, you may need to pay up to the full price of the drug. You can always find the most current information about drugs that have a step therapy requirement when you log in at anthem.com or call Pharmacy Member Services.

Drugs will be added to or removed from the step therapy program when deemed appropriate by Anthem–CarelonRx.

Quantity Limits

Prescriptions written for certain drugs that have a high potential for inappropriate use will only be filled up to a predetermined quantity limit. If your prescription exceeds the quantity limit, you will have the option to purchase the medication above the limit at your own expense. Individuals with certain severe medical conditions may be permitted to receive higher limits. You can always find the most current information about covered quantity limits when you log in at anthem.com or call Pharmacy Member Services. Quantity limits will be added, removed, or adjusted when deemed appropriate by the Anthem – CarelonRx.

Prior Authorization

Prior Authorization is required for certain drugs that may have a risk of side effects, a risk of harmful effects when taken with other drugs, potential for incorrect use or abuse, better options that may cost you less and work better, and rules for use with certain health conditions. Prescribing Physicians must obtain prior authorization in order for you to get benefits for certain Drugs. At times, your Physician will initiate a prior authorization on your behalf before your Pharmacy fills your Prescription. At other times, the Pharmacy may make you or your Physician aware that a prior authorization or other information is needed. In order to determine if the Prescription drug is eligible for coverage, we have established criteria which can be viewed online at anthem.com or by calling Pharmacy Member Services. Drugs will be added to or removed from the Prior Authorization list when deemed appropriate by Anthem – CarelonRx.

Diabetic Supplies

You can get the following diabetic supplies at no cost through your Prescription Drug Benefit:

- Insulin needles and syringes
- Lancets and devices (spring or powered)

- Blood glucose testing strips for home glucose monitors
- Normal, low, and high calibrator solution/chips
- Alcohol wipes

To receive the above noted supplies at no cost, you must get a prescription from your Physician. The supplies will be subject to mandatory home delivery; therefore, we recommend you ask your doctor for a 90-day prescription. If necessary, you will be able to get your first 3 fills at a retail pharmacy prior to using the Home Delivery program which includes the option to fill a 90 day supply of diabetic supplies at a CVS retail pharmacy.

Discount Program for Non-Covered Drugs

This program allows you to save money on certain types of drugs which are not currently covered by the Fund. With this program, the Fund pays $0 for these non-covered drugs, however, you can still receive a discount from the normal cost of the drugs. Prescription drug categories that are included in the discount program are: Acne, Cosmetic, Impotency, Nutritional and Dietary Supplements and Weight Loss. The list is subject to change without notice.

You must have a prescription for these drugs and present your ID card to the pharmacy to get the available discounts.

Online Pharmacy Resources

Find your closest network pharmacy, get the most up-to-date coverage information on your drug list including details about pricing your medication, brands and generics, dosage/strength options, prior authorization and step therapy requirements and much more — when you log in at anthem.com.

Covered Items

The following is a list of commonly covered prescription drugs. If you are unsure whether a certain drug is covered, please contact Anthem – CarelonRx or Ohio Laborers Benefits.

- Federal Legend Drugs
- State restricted drugs
- FDA approved over-the-counter and prescription smoking cessation medications for an eligible member or dependent age 18 or older (To get the over-the-counter drugs at no cost, you must have a prescription.) These products will be covered under the “Preventive Care” benefit.
- Compound medications when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound drug are FDA approved, as designated in the FDA’s Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, require a prescription to dispense, and are not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.
- Self-administered contraceptives for women, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; Certain contraceptives are covered under the “Preventive Care” benefit. Orally administered cancer Drugs. As required by Ohio law, your cost-share (e.g., Copayment, Deductible, or Coinsurance) will not be more than $100 at retail for 30 day supply and $300 for 90 day supply at retail and mail order per Prescription Order
- Immunosuppressive drugs
- Insulin with a prescription

- Injectable drugs
- Diabetes related needles and syringes
- Diabetic test strips and lancets
- Cholesterol reducing agents
- Mental health drugs
- NSAIDS medication
- Bee Sting kits
- Prenatal vitamins
- ADHD drugs (only covered up to age 24, thereafter prior authorization is required)
- Acne products (covered up to age 26, thereafter prior authorization is required)
- Growth Hormones (subject to Prior Authorization)
- Low dose, daily use generic Cialis (2.5 mg) prescribed specifically for the treatment of BPH (enlarged prostate) (subject to Prior Authorization)

Non-Covered Items

The following is a list of non-covered Prescription Drugs (unless otherwise required through federal government mandate). If you are unsure whether a certain drug is covered, please contact Anthem – CarelonRx.

- Most over-the-counter medications
- Diabetic machines (certain glucometers may be available at no cost from the manufacturers)
- Medical Marijuana as defined in the Ohio Revised Code or any other state or federal law.
- Fertility drugs
- Diet medications
- Vitamins (including children's vitamins with fluoride)
- Medical devices and appliances
- Ostomy products
- Sexual dysfunction drugs (except as otherwise noted in the Plan)
- Yohimbine products
- Investigational and Experimental drugs (except where costs for these items and services are provided in connection with participation in a clinical trial and federal law requires these items and services be covered)
- Diagnostic agents
- Biological sera, blood, or plasma
- Any medication that is administered by a Physician (including IV medications)
- Any medication lawfully obtained without a prescription
- Topical analgesic drugs
- Hair-growth medications
- Cosmetic skin products

- Allergy serums
- Non-FDA approved drugs or items, including prescription drug “kits” that combine FDA approved drugs with other items that are not FDA approved
- Any drug that is approved by the FDA for only a specific diagnosis is not covered for any other use

Vision Benefits

Schedule of Benefits

Claims Administrator: **National Vision Administrators (NVA)** (800) 672-7723		
	Participating Provider	**Non-Participating Provider**
Examination Once every two calendar years * Higher copayment may apply for Contact Lenses Eye Examination.	100% After $5 Copayment*	Up to $30
Lenses Once every two calendar years *Lens options will be priced by NVA Providers at their wholesale price plus 25%.*	100% Standard Glass or Plastic	Single Vision – Up to $25 Bifocal – Up to $35 Trifocal – Up to $45 Lenticular – Up to $75
Frame Once every two calendar years *Provider will charge the difference between the wholesale cost and the plan allowance plus 20%.*	Wholesale Allowance Up to $40	Up to $25
Maximum Out-Of-Pocket (MOOP) Limit The Fund pays 100% for the remainder of the year once you reach your MOOP Limit. MOOP Limit includes Examination Copayment and purchase of standard frames and lenses, but does not include additional costs for upgraded frames, lenses, and contacts.	$25 per person $50 family maximum	
Contact Lenses Once every two calendar years *In lieu of Lenses & Frame* *Pre-approval required from NVA for Medically Necessary*	Elective – Up to $105, plus routine eye exam Medically Necessary – Up to $150 including routine eye exam	

Fixed Prices on Lens Options Lens options purchased from a participating NVA Provider will be provided to the Member at the amounts listed: *Options not listed will be priced by participating NVA Providers at their wholesale cost plus 25%.*	$10 Solid Tint $12 Fashion / Gradient Tint $10 Standard Scratch-Resistant Coating $12 Ultraviolet Coating $40 Standard Anti-Reflective $20 Glass Photogrey (Single Vision) $30 Glass Photogrey (Multi-Focal) $75 Polarized $50 Progressive Lenses Standard * $65 Transitions Single Vision Standard $70 Transitions Multi-Focal Standard $25 Polycarbonate (Single Vision) $30 Polycarbonate (Multi-Focal) $30 Blended Bifocal (Segment) $55 High Index $100 Progressive Lenses Premium * *Fixed Pricing not available on certain brands.
Discounts In addition to your funded benefit, you are eligible to access the EyeEssential® Plan discount (in network only) on additional purchases during the plan period. Please contact NVA for details.	
Please note General Plan Exclusions and Limitations beginning on page 109.	

Basics

Vision Benefits are provided through National Vision Administrators (NVA). You may use any provider; however, if you use an NVA Participating Provider, you will be charged a discounted price and the provider will submit the claim for you. If you do not use an NVA Participating Provider, you must pay the provider the full amount and then submit the paid invoice to NVA for reimbursement, subject to the applicable limits. Be sure to tell NVA Participating Providers that you are covered through NVA at the time you make your appointment and take your card with you to the appointment.

Service by a Participating Provider

When making an appointment with a National Vision Administrators (NVA) Participating Provider, tell the vision care office that coverage is administered by NVA and sponsored by OLDC-OCA Insurance Fund. The identification number for the Fund's vision contract is printed on your identification card. The provider will telephone NVA to verify eligibility and available vision benefits. To find a Participating Provider, please call NVA at (800) 672-7723 or visit the NVA website at http://www.e-nva.com.

The NVA Participating Provider must provide the wholesale price on frames. When selecting frames, you should request a confirmation that prices are based on wholesale pricing. Frames within the approved Fund allowance are covered in full. If a higher cost frame is selected, there is an additional charge. The NVA Provider may only charge the difference between the wholesale cost and the allowance, plus 20% of the difference.

The Vision Benefit covers standard single vision, bifocal, trifocal or aphakic/lenticular lenses.

You have the option of selecting contact lenses instead of glasses and frames. You are responsible for the difference in the regular eye examination and the contact lenses eye examination.

- Elective contact lenses are covered in lieu of all other materials (lenses and frames). The contact lens benefit includes all types of contact lenses such as hard, soft, gas permeable, and disposable lenses.
- Medically Necessary contact lenses may be covered with Prior Authorization when prescribed for post cataract surgery, correction of extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, Anisometropia, or Keratoconus.

Service by a Non-Participating Provider

If a Non-Participating Provider is used, you are responsible for paying 100% of the cost at the time of service. You must then request reimbursement from NVA. You will be eligible for the reimbursement amounts listed in the above schedule. To receive reimbursement:

- Complete a "Claim for Vision Care Expense" form. Forms can be downloaded at www.e-nva.com or www.ohiolaborers.com.
- Mail completed claim form and itemized receipt (copy or original) to:

  National Vision Administrators
  P.O. Box 2187
  Clifton, NJ 07015

- If you cannot print the claim form, you may submit receipts along with a letter containing Member's full name, patient's full name, address, ID number, and OLDC-OCA Insurance Fund.

Remember, obtaining vision care services from a Non-Participating Provider will result in greater out-of-pocket expenses for you.

Additional Vision Benefits

NVA has partnered with The National LASIK Network to offer certain discounts. You are entitled to significant discounts and a free initial consultation with all Network Providers. Please contact NVA for additional details: (877) 295-8599.

You are also eligible for a mail order contact lens replacement service, Contact Fill. You can access Contact Fill's services online at www.contactfill.com or by calling (866) 234-1393.

Benefit Exclusions

Some services and materials are not covered under the Vision Benefit. The following is a partial list of what is not covered:

- Medical or surgical treatments
- Prescription Drugs or over-the-counter medications
- Non-prescription lenses
- Two pair of glasses in lieu of bifocals
- Subnormal visual aids
- Vision examination or materials required for employment
- Replacement of lost, stolen, broken, or damaged lenses
- Contact lenses or frames except at normal intervals when service would otherwise be available

- Services or materials provided by Federal, State, or local government or worker's compensation
- Examination, procedures training, or materials not listed as a Covered Service
- Industrial safety lenses and safety frames with or without side shields
- Parts or repair of frame
- Sunglasses

Hearing Benefits

Schedule of Benefits

Claims Administrator: **HearUSA*** (800) 442-8231	
	Network Coverage
Hearing Screening One per calendar year	100%
Hearing Aids	$1,200 per ear every 36 months
Additional Hearing Aid Supplies/Services	Unlimited visits during the first year of purchase for adjustments, cleaning, and programming 3-year warranty including loss and damage on all hearing aids 2-year supply of hearing aid batteries with purchase
** Additional hearing benefits noted below covered through Anthem Blue Cross Blue Shield, not HearUSA.*	

Hearing Benefits with HearUSA

HearUSA providers offer a basic annual audiologic assessment, including air conduction testing, bone conduction testing, and word recognition measures. Additionally, your HearUSA provider will assist you in recognizing factors which may damage your hearing and will provide helpful solutions. *(You will not receive an identification card from HearUSA and do not need one for any appointment.)*

- Call (800) 442-8231 to schedule an appointment and identify yourself as a member of the Ohio Laborers' Insurance Fund.
- HearUSA will confirm your eligibility.
- HearUSA sends you an appointment confirmation.
- For in-network claims, the Fund pays benefit amounts directly to your network provider. You pay the provider the balance of the discounted allowable charges above benefit amounts. HearUSA reviews all in-network claims to ensure that costs do not exceed allowable charges. Allowable charges vary according to the hearing aid technology recommended.

Hearing Benefits with Anthem Blue Cross Blue Shield

Hearing Benefits are covered when provided and billed by covered providers acting within the scope of their license. Covered providers include a Physician, Audiologist, or a Hearing Aid Specialist.

Hearing Benefits covered through Anthem:

- Outpatient Services for bone-anchored hearing aids
- Outpatient Services for implantable middle ear hearing aids
- Pediatric hearing aids
- Newborn hearing screenings
- Non-routine hearing exams in an Office/Outpatient/Home Visit setting

- Audiometric exam is payable at 100% after Office Visit copay - 1 per benefit period
- Hearing aid evaluation and conformity evaluation each - 1 per rolling 36 months

Hearing Benefits not covered through Anthem:

- Hearing aids (except as noted above)
- Routine hearing exam

Benefit Exclusions

- A medical exam of the ear by a Physician to determine the absence of or the loss of hearing acuity as these services would be covered under the Medical Benefits of the Plan
- Hearing exams or materials ordered as a result of a hearing exam conducted prior to the claimant's eligibility
- Services and supplies not prescribed by or performed by/upon the direction of a covered provider
- Any other services not specified as being covered under the Hearing Benefit

Short Term Disability *(Class 1 Members Only)*

Schedule of Benefits

Weekly Benefit *Net after standard FICA and Medicare withholdings*	$400
Maximum Benefit Period	26 weeks
Day Benefit Begins	
Accident	Day 1
Sickness (one week waiting period)	Day 8
Please note General Plan Exclusions and Limitations beginning on page 109.	

Basics

If you are eligible for Class 1 Insurance benefits and become totally disabled (unable to work in employment that qualifies for Fund eligibility), you may be eligible for a monetary benefit from the Fund. This benefit pays $400 per week *(net after standard FICA and Medicare withholdings)* for a maximum of 26 weeks for non-work related disabilities. There are generally no monetary benefits available from the Fund for work related disabilities. *(See Work Related Disabilities below.)* A period of less than a full week will be calculated on a daily basis. Short Term Disability benefits are not payable for the "Disability" of a Dependent.

Submitting a Claim

In order to apply for a Short Term Disability benefit, you must complete a Short Term Disability form. You can get the form by calling Ohio Laborers Benefits, visiting your Local Union Office, or downloading one from www.ohiolaborers.com. You need to complete the top section of the form and have your doctor complete the bottom section. Once you and your doctor complete your respective sections, simply send the form to Ohio Laborers Benefits for review. Ohio Laborers Benefits or the Trustees may deny your benefit if each section of the form is not completed, or you fail or refuse to provide evidence of your disability.

Payments and Maintenance

Once Ohio Laborers Benefits is in receipt of the disability form and it determines you have met the eligibility requirements for a Short Term Disability benefit, your payments may begin.

- For disabilities related to Sickness, there is a one week waiting period from the date of disability before the benefit will start. No benefit is payable during the waiting period. There is not a waiting period for accidents.
- If your disability lasts 13 weeks or longer, you will be required to complete a Disability Continuance form. The continuance form is used to make sure your return-to-work date has not changed. The form is mailed with a weekly check prior to your thirteenth week of disability. Like the initial form, both you and your doctor must complete a portion of the form. If the continuance form is not returned to Ohio Laborers Benefits by week 13, your benefits will be suspended until receipt or terminated.
- If you are not eligible for Class I Insurance benefits on the date you became totally disabled, but become eligible during your disability, your date of disability will be considered the first day you become eligible for Class I Insurance benefits. Payments will only be made while totally disabled and eligible for Insurance. You will still be subject to the one week waiting period for Sickness and the maximum Benefit Period.

- If your eligibility transitions from Class 1 Insurance to Self-Payments, COBRA, Class 2, 3, or 4 Insurance while receiving Short Term Disability payments, such benefits will continue to be payable for that period of disability, subject to the maximum Benefit Period.
- If your Insurance eligibility (under all classes) terminates during a period of disability, your Short Term Disability payments will cease upon your last day of eligibility.
- If you become totally disabled subsequent to your initial disability from the same or related condition while eligible under the Fund, the Fund will consider the subsequent Total Disability to be related and only pay you a maximum Short Term Disability benefit of 26 weeks. If you return to active employment for four consecutive weeks (160 hours) between disabilities, then the Fund will not consider the subsequent total disability to be related to the prior disability.
- Short Term Disability checks are mailed weekly, generally on Friday.
- Short Term Disability claims must be filed within 15 months of the date of disability.

Taxability

Short Term Disability benefits are taxable. If you do not complete and submit a W-4 and/or state withholding form with the blue disability form, federal and state taxes will be withheld from your Short Term Disability benefit at a standard rate. You should contact Ohio Laborers Benefits to get federal (W-4) and state tax forms if you want to change the standard withholding. The forms are also available to download at www.ohiolaborers.com.

Disability Credit Hours

In addition to the monetary benefit available, you may also be entitled to disability credit hours (DCH). If you receive Short Term Disability benefits from the Fund, you will receive four (4) hours of credit for each day you are receiving such benefits up to a maximum of 500 DCH per period of disability. This may help extend your insurance eligibility even though you are unable to work. DCH are not granted if your employer is required to submit insurance contributions on your behalf for your period of disability. (You may also be eligible for DCH through the LDC&C Pension Fund Ohio. Please consult the pension summary plan description for details.)

Work Related Disabilities

If your disability is work related, there are no monetary benefits available to you from the Fund. However, you are entitled to Disability Credit Hours (as stated above) if you are eligible and entitled to benefits under any Workers' Compensation or Occupational Disease Law. In order to get the DCH from the Insurance Fund, simply complete and submit the blue Short Term Disability form for review. Additionally, if you have a work related disability and are denied benefits from a workers' compensation program, you may still be eligible for a Short Term Disability benefit, subject to the exclusions listed below. For example, if you are denied Workers Compensation benefits because you engaged in or provoked an assault, you would not be eligible for a Short Term Disability benefit.

Benefit Exclusions

No benefit is provided for loss caused by or resulting from:

- Declared war or undeclared war or any act of war;
- The use of any amphetamine, barbiturate, hallucinogen, narcotic, or other drug, except when prescribed by a Physician and used in accordance with his or her directions;
- Injury or Sickness arising out of or in the course of occupation or employment for compensation, profit or gain, and which is compensable under any Workers' Compensation or Occupational Disease Act or Law *(except as described in Work Related Disabilities above)*;

- Disability while receiving pension benefits. However, if the disability occurs prior to the pension effective date, such benefits will continue to be payable for that period of disability, subject to the maximum Benefit Period;
- Self-inflicted injury while sane or insane;
- Participation in a felony attempted or committed assault (intentional or unintentional); or
- Injuries or Sickness caused in a motor vehicle accident if the Covered Individual was operating the vehicle while intoxicated (had a blood alcohol level that exceeded the legal limit of the jurisdiction in which the accident occurred or no breathalyzer exam was performed or the person refused to submit to a requested breathalyzer or blood test) or was under the influence of illegal drugs; unless the Injuries arise as a result of a physical or mental health condition.

Permanent Disability

If your disability is permanent, please see the Waiver of Premium – Continuation of Death Benefit During Disability section *(on page 93)* for additional benefit information.

Death Benefits *(Members Only)*

Schedule of Benefits

Class 1	$14,000
Class 2, Class 3, Class 4	$2,500
The amount of Death Benefits continued under Waiver of Premium is $5,000 and will be reduced to $2,500 at Early Retirement age with the Laborers' District Council and Contractors' Pension Fund of Ohio or entry into Class 2, 3, or 4, whichever occurs first.	
Please note General Plan Exclusions and Limitations beginning on page 109.	

Basics

If you are a Member and eligible for Insurance benefits on the date of your death, your named beneficiary will be entitled to a monetary benefit based on the above schedule. Death benefits are payable to a beneficiary or Member's estate for the death of an Active or Retired Member only, not for the death of a Dependent.

Naming or Changing a Beneficiary

A beneficiary is the person or persons (including a trust or estate) you have named on your Enrollment/Beneficiary Card on record with Ohio Laborers Benefits. You may name a new beneficiary at any time by completing a new Enrollment/Beneficiary Card. The change will become effective upon receipt of the properly executed Enrollment/Beneficiary Card at Ohio Laborers Benefits. When the request is received, the change will relate back to and take effect as of the date it was signed, regardless of whether you are alive or not when Ohio Laborers Benefits receives the request. Even though the change of beneficiary will relate back to the date it was signed, it will be without prejudice to the Trustees with regard to any payment already made.

You may list more than one person to be your beneficiary. For example, if you have two children, you can name both as primary beneficiaries, and they will evenly split any Death Benefit payable. You can also name a secondary beneficiary in case your primary beneficiary dies before the payment of the Death Benefit. You also have the option to name your estate as beneficiary.

Please make sure you keep your beneficiaries up to date. The Fund will pay your named beneficiary regardless of your relationship to the individual at the time of your death.

Submitting a Claim

Upon your death, Ohio Laborers Benefits should be notified as soon as possible in order to facilitate payment. Upon notification, Ohio Laborers Benefits will request the following information directly from your named beneficiary:

- Death Certificate
- Signature Card (supplied by Ohio Laborers Benefits)
- Social Security Card of Beneficiary
- Photo ID of Beneficiary
- Federal and State Tax forms (supplied by Ohio Laborers Benefits)

Payments and Maintenance

Upon receipt of the above documents, payment will be made in one sum to the designated beneficiary.

- If there is no surviving named beneficiary, payment will be made to your estate.
- If you name yourself as beneficiary, payments will be made to your estate.
- If there is no estate, payment will be made in the following succession order: Spouse, child(ren), parents, brother(s) and/or sister(s), next of kin. If the Fund pays someone other than your named beneficiary, additional documentation may be required for proof of familial relationship. In the event a minor child is named beneficiary, payments will be made to the Legal Guardian of the minor.
- If any beneficiary entitled to receive death benefits is a minor, or in the opinion of the Trustees is physically or mentally incapable of receiving or administering the benefits or acknowledging receipt and the Trustees are not aware of any legal representative having been appointed for that individual, the Trustees may cause any benefit otherwise payable to the individual to be paid to one or more of the following as may be chosen by the Trustees:
    - Any institution maintaining the individual;
    - The individual's Spouse, parents, children, and/or other relatives by blood or marriage; and/or
    - Any person whom the Trustees reasonably determined is caring for the individual or otherwise providing support and maintenance.

  The Trustees have no obligation or duty to see that the funds are used or applied for the purpose(s) for which paid, and any payment so made will be a complete discharge of any and all liability with respect to such payment.

Taxability

Death Benefits are taxable. Your beneficiary will be provided federal and state tax forms for completion once the Fund is notified of your death. If your beneficiary does not complete and submit a W-4 with proof of death, federal taxes will be withheld from your Death Benefit at a standard withholding of Single with Zero Allowances. Tax forms are also available to download at www.ohiolaborers.com.

Widow/Widower Benefits

Please refer to page 36 in the Dependent Eligibility section.

Waiver of Premium - Continuation of Death Benefit During Disability

If you become permanently Totally Disabled, you may be eligible to continue a Death Benefit, even if you lose eligibility under the Fund. The Fund will continue a Death Benefit during a permanent Total Disability if:

- Your permanent Total Disability begins while you are eligible under the Fund,
- Your permanent Total Disability begins before your 60th birthday, and
- The Fund receives acceptable proof of your permanent Total Disability.

The amount of the Death Benefit continued under Waiver of Premium is $5,000 and will be reduced to $2,500 at either Early Retirement age with the Laborers' District Council and Contractors' Pension Fund of Ohio or entry into Class 2, 3, or 4, whichever occurs first. If you are eligible to receive the Death Benefit available under Class 1, 2, 3, or 4, you are not eligible to receive the Continuation of Death Benefit during Disability.

If you are awarded either an Occupational Disability Pension or a Permanent and Total Disability Pension from the Laborers' District Council and Contractors' Pension Fund of Ohio, you will automatically be eligible for the Continuation of Death Benefit during Disability.

If you receive disability benefits from Social Security and submit proof of the award, you may be eligible for the Continuation of Death Benefit during Disability.

If you become permanently Totally Disabled, but do not receive disability benefits from Social Security or the Laborers' District Council and Contractors' Pension Fund of Ohio, you must submit either a completed green Statement of Continuance of Disability form or blue Short Term Disability form. Upon receipt of one of these forms and approval by Ohio Laborers Benefits, you will be eligible for the Continuation of Death Benefit during Disability for twelve (12) months from the date of disability. Once the Death Benefit has been continued for twelve (12) months under this provision, the coverage will only continue for each succeeding twelve (12) month period if a new Statement of Continuance of Disability form is submitted to Ohio Laborers Benefits. The form must be submitted during the last three (3) months of the preceding twelve (12) month period.

You may be required to be examined by a Physician designated by the Fund to continue this benefit. The required proof of permanent Total Disability must be furnished to Ohio Laborers Benefits by the Member on his behalf or by his authorized representative. Failure to do so may result in loss of coverage. If your disabling condition improves and you are no longer considered permanently Totally Disabled, you will lose eligibility for the Continuation of Death Benefit during Disability.

Accidental Death & Dismemberment *(Class 1 Members Only)*

Schedule of Benefits

Accidental Death	$10,000
Dismemberment Quadriplegia or loss of one of the following: • Both Hands • Both Feet • Sight in Both Eyes • One Hand and One Foot • One Hand or Foot and Sight in One Eye • Speech and Hearing	$10,000
Paraplegia or Hemiplegia	$7,500
Loss of one of the following: • Hand • Foot • Sight in One Eye • Speech • Hearing	$5,000
Loss of Thumb and Index Finger of the Same Hand	$2,500
No more than $10,000 will be paid for all losses suffered due to the same accident.	
Please note General Plan Exclusions and Limitations beginning on page 109.	

Basics – Accidental Death

If you are eligible for Class 1 Insurance benefits on the date of your death, your named beneficiary will be entitled to a $10,000 lump sum payment if your death is ruled "Accidental" on your Death Certificate. Accidental Death benefits are payable to a beneficiary or Member's estate for the death of a Member only, not for the death of a Dependent.

Naming or Changing a Beneficiary, Submitting a Claim, Payments and Maintenance, and Taxability for Accidental Deaths are consistent with those for the Death Benefit *(see pages 92-93 for details)*.

Basics – Dismemberment

If you are eligible for Class 1 Insurance benefits on the date you become "Dismembered," you will be entitled to a monetary benefit from the Fund based on the above schedule. Dismemberment benefits are not payable for the dismemberment of a Dependent.

- Quadriplegia is the total and irreversible paralysis of all four limbs.
- Paraplegia is the total and irreversible paralysis of both lower limbs.
- Hemiplegia is the total and irreversible paralysis of one side of the body.

- Loss, as used with reference to hand or foot, means complete severance through or above the wrist or ankle joint. As used with reference to eyes, loss means the irrecoverable loss of entire sight.

Submitting a Claim – Dismemberment

Proof of Dismemberment should be submitted to Ohio Laborers Benefits as soon as possible in order to facilitate payment. A blue Short Term Disability form should be submitted as proof; additional medical records may also be required. Ohio Laborers Benefits or the Trustees may deny your benefit if you fail or refuse to provide evidence of your disability.

Payments and Maintenance – Dismemberment

Once Ohio Laborers Benefits is in receipt of proof of Dismemberment and it determines you have met the eligibility requirements, you will receive a lump sum payment.

If you are, in the opinion of the Trustees, physically or mentally incapable of receiving or administering the benefits or acknowledging receipt and the Trustees are not aware of any legal representative having been appointed for you, the Trustees may cause any benefit otherwise payable to you to be paid to one or more of the following as may be chosen by the Trustees:

- Any institution maintaining you;
- Your Spouse, parents, children, and/or other relatives by blood or marriage; and/or
- Any person whom the Trustees reasonably determined is caring for you or otherwise providing support and maintenance.

The Trustees have no obligation or duty to see that the funds are used or applied for the purpose(s) for which paid and any payment so made will be a complete discharge of any and all liability with respect to such payment.

Taxability – Dismemberment

Dismemberment benefits are not taxable.

Appeals

In most cases, disagreements about benefit eligibility or amounts can be handled informally by calling the Claims Administrator or Ohio Laborers Benefits. If a disagreement is not resolved, there are formal procedures you can follow to have your claim reconsidered. Depending on the type of claim, the procedures can be very different. Please read this section carefully to make certain you are following the correct procedures. You must follow the appeals procedure before you file a lawsuit against the Trustees under ERISA, the federal law governing employee benefits.

How to Appeal a Denied Claim

If your claim is denied (in whole or in part) or you disagree with the Fund's determination regarding your eligibility for benefits or the amount of the benefit, you have the right to have the initial determination reviewed.

When you submit an appeal for a claim your appeal will be given a full and fair review. Specifically, you will be provided:

- Specific time frames, as described below, in which to appeal your claim;
- The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- Reasonable access to, and copies of, all documents, records, and other information relevant to your claim, upon request and free of charge; and
- A review that takes into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim determination.

In addition, for health care and disability appeals, you will be provided:

- A review that does not defer to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Fund who is neither the individual who made the initial determination nor a subordinate of that individual;
- That in determinations based in whole or in part on medical judgment (including determinations regarding whether a treatment, drug or item is Experimental, Investigational, or Medically Necessary), that the 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; and
    - Was not consulted (or is not subordinate to the person who was consulted) in connection with the denial of your claim. You have the right to be advised of the identity of any medical experts consulted in making a determination of your appeal.

In health care appeals involving Urgent Care, an expedited review process where the request for review may be submitted in writing or orally and communications between you and the Fund may be made in an expedited manner, such as, telephone or facsimile.

In addition, for disability claims, you will be provided a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- The views presented by you to the Fund of health care professionals treating you and vocational professionals who evaluated the claimant;
- The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

- A disability determination made by the Social Security Administration presented by you to the Fund.

Claim Review Process for Anthem Claims

If you are not satisfied with a benefit determination decision you receive from Anthem, you may file an appeal with Anthem as explained below. No more than one appeal on one claim will be considered by Anthem. You must follow the appeals procedure before you file a lawsuit under ERISA.

To file an appeal, please write a letter with the following information: Your full name; patient's full name; identification number; claim number if a claim has been denied; the reason for the appeal; date of services; the provider/facility name; and any supporting information or records, X-rays or photographs you would like considered in the appeal.

Send or fax the letter to:

Anthem Blue Cross Blue Shield
Attn: Anthem Appeals
P O Box 105568
Atlanta, GA 30348-5568

Fax for expedited appeals: (800) 368-3238

Fax for non-expedited appeals: (888) 859-3046

To submit an appeal electronically, go to Anthem's Web site, www.anthem.com, under Members' section. If you have any questions about what information to submit, please call Anthem's Customer Inquiry at (855) 878-0128.

You may appeal if your claim is denied because Anthem determined (1) the Services received or requested were not Covered Services or (2) the services received or requested to be received were not Medically Necessary.

First Level Mandatory Appeal

When you write, fax or electronically submit an appeal with Anthem as described above, you have submitted a First Level Mandatory Appeal. The Fund requires you to submit a First Level Mandatory Appeal with Anthem before you request external review or file a lawsuit against the Fund. If you fail to file a First Level Mandatory Appeal with Anthem, you forever waive your right to take any legal action against the Fund, request external review of or further dispute your claim.

First Level Mandatory Appeals related to a claim decision must be filed within 180 days from your receipt of the notice of denial of benefits. All requests for appeal may be made by calling Customer Service or in writing as described above.

Under the appeal process there will be a full and fair review of the claim. The internal appeal process is a review of your appeal by an Appeals Coordinator, a Physician consultant, and/or other licensed health care professional. The appeal will take into account all comments, documents, records, and other information submitted by you and the provider relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. All determinations of Medical Necessity that are based in whole or in part on a medical judgment, are made by health care professionals who have the appropriate training and experience in the field of medicine involved in the medical judgment. The health care professionals who review the appeal will not have made any prior decisions about your care and will not be a subordinate of the professional who made the initial determination on your claim.

You may submit written comments, documents, records, and other information relating to the claim being appealed. Upon written request, you may have reasonable access to and copies of documents, records, and other information used to make the decision on your claim for benefits that you are appealing.

Answer to First Level Mandatory Appeal

Depending on the type of claim, i.e., Urgent Care, Pre-Service or Post-Service, Anthem will provide an answer to you regarding your First Level Mandatory Appeal as follows:

- **Urgent Care Appeal** – Urgent Care Claim appeals are typically those claims for medical care or treatment where withholding immediate treatment could seriously jeopardize the life or health of a patient or a patient's unborn child, or could affect the ability of the patient to regain maximum functions. The appeal must be decided as soon as possible, taking into account the medical exigencies, but not later than 72 hours of the request.
- **Pre-Service Claim Appeal** – Pre-Service Claim appeals are those requested in advance of obtaining medical care for approval of a benefit, as it relates to the terms of this SPD booklet. The Pre-Service Claim appeal must be decided within 30 days of the request and must be requested within 180 days of the date your received notice of denial.
- **Post Service Claim Appeal** – Post-Service Claim appeals are those requested for payment or reimbursement of the cost for medical care that has already been provided. As with Pre-Service Claims, the Post-Service Claim appeal must be decided within 60 days of the request and must be requested within 180 days of the date your received notice of the denial.

If your claim involves medical judgment, including, but not limited to, those based on Fund's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of covered benefit, or its determination that a treatment is Experimental or Investigational, or a rescission of coverage and was denied in the First Level Mandatory Appeal, you may request an external review with Anthem, provided you submit such request in writing within four months after the date of receipt of notice of the determination on the First Level Mandatory Appeal. *(See External Review section below.)*

If your claim does not involve medical judgment or rescission of coverage, then you may elect to file a Voluntary Second Level of Appeal with the Board of Trustees. *(See Board of Trustees Appeals on page 102.)*

You are not required to request an external review or file a Second Level Voluntary Internal Appeal before filing a legal action under ERISA. However, if you elect not to request external review or file a Second Level Voluntary Internal Appeal, you must file any legal action within 180 days of the date of First Level Mandatory Appeal determination. If you fail to file a lawsuit within 180 days of the date of the First Level Mandatory Appeal determination, you forever forfeit your right to file a lawsuit.

External Review

The answer to your First Level Mandatory Appeal will provide you with important information regarding when and how you may seek external review of your appeal. As noted above, if the denial of your appeal involves medical judgment or a rescission of coverage, you have the right to seek external review of your appeal. You must file your request for external review with Anthem as instructed in the answer to your First Level Mandatory Appeal within 120 days of the date of Anthem's First Level Appeal response. For prescription claims, you must file your request for external review with Anthem – CarelonRx as instructed in the answer to your First Level Mandatory Appeal within four (4) months of the date of receipt of the answer.

Within five (5) business days following the date of receipt of the external review request, the Fund or its designated agent must complete a preliminary review of the request to determine the following:

- The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
- The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Group Health Plan (e.g., worker classification or similar determination);
- The claimant has exhausted the Plan's internal appeal process, i.e., filed a First Level Mandatory Appeal;

- The claimant has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Fund or its designated agent must issue a notification in writing to the claimant. If an adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, and the claimant has filed a request for an expedited internal appeal; or the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function ("a claim involving an external expedited review"), the Fund or its designee must complete its preliminary review immediately and provide notice of its determination immediately.

If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (866) 444-EBSA. If the request is not complete, the Fund or its designated agent will describe the information or materials needed to make the request complete and to allow a claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Independent Review Organization

The Fund is required under Federal law to assign an independent review organization ("IRO") that is accredited by Utilization Review Accreditation Commission (URAC) or by similar nationally-recognized accrediting organization to conduct the external review.

The Fund is also required to take action against bias and to ensure independence. To meet this requirement, the Fund or its designated agent will contract with at least three (3) IROs for assignments under the Plan and rotates claims assignments among them.

The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO within ten (10) business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may accept and consider additional information submitted after ten business days.

Within five business days after the date of assignment of the IRO, the Fund or its designated agent will provide to the assigned IRO the documents and any information considered in making the final internal adverse benefit determination. If the claim involves an expedited external review, the Fund or its designated agent must provide or transmit all necessary documents and information considered in making the final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

Upon receipt of any information submitted by the claimant, the assigned IRO must within one (1) business day forward the information to the Fund or its designated agent. Upon receipt of any such information, the Fund or its designated agent may reconsider its final adverse determination that is the subject of the external review. Reconsideration by the Fund or its designated agent must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Fund or its designated agent decides, upon completion of its reconsideration, to reverse its final internal adverse benefit determination and provide coverage or payment. Within one (1) business day after making such a decision, the Fund or its designated agent must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Fund or its designated agent.

The IRO will review all the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- The claimant's medical records;

- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by Fund, claimant or the claimant's treating provider;
- The applicable provisions of the SPD to ensure that the IRO's decision is not contrary to the terms of the SPD, unless the terms are inconsistent with applicable law;
- 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;
- Any applicable clinical review criteria developed and used by the Fund or its designated agent, unless the criteria are inconsistent with the terms of the SPD or with applicable law; and
- The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for external review to the claimant and the Fund. If the claim involves an expedited external review, the IRO must provide written notice of the final external review decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the Fund.

The assigned IRO's decision notice will contain the following:

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

After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the claimant, the Fund, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a final external review decision reversing the final internal adverse benefit determination, the Fund immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Upon receipt of a notice of final external review decision sustaining the final internal adverse benefit determination, you must file any legal action within 180 days of the date of the final external review decision. If you fail to file a lawsuit within 180 days of the date of the final external review decision, you forever forfeit your right to file a lawsuit.

Summary for Anthem Claims

	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
Am I Required to File a First Level Mandatory Appeal?	Yes	Yes	Yes
Days to File First Level Mandatory Appeal	180	180	180
Answer from Anthem	72 Hours	30 Days	60 Days
Right to Second Voluntary Appeal	Yes	Yes	Yes
Right to External Review	Yes, if denial involves medical judgment or a rescission of coverage	Yes, if denial involves medical judgment or a rescission of coverage	Yes, if denial involves medical judgment or a rescission of coverage
Days to Request External Review	120	120	120
Answer from IRO	As soon as practicable, but not more than 72 hours	45 Days	45 Days

Claims Review for Anthem Medicare Claims

Please contact Anthem Medicare at (833) 848-8730 for appeal information.

Board of Trustees Appeals

You have the right to appeal certain claim decisions for claims which are not administered by Anthem, Anthem – CarelonRx, or Anthem Medicare. This includes any denial of a claim for Short Term Disability, Vision, Death, Accidental Death and Dismemberment benefits.

You also have a right to file a Second Level Voluntary Appeals for all claims, including claims administered by Anthem, Anthem – CarelonRx, or Anthem Medicare, which do not involve medical judgment or a rescission of coverage. (For claims involving medical judgment and rescission of coverage, you have a right to an external review. Please refer to page 99.)

You, your Covered Dependent, beneficiary (when an appropriate claimant), or a duly authorized representative may file a written appeal with the Board of Trustees.

The written request must be sent to:

OLDC-OCA Insurance Fund Appeals Review Committee
c/o The Administrative Manager
800 Hillsdowne Road
Westerville, OH 43081-3302

In connection with a request, documents pertinent to the administration of the Fund may be reviewed by you, and comments and issues outlining the basis of the appeal may be submitted in writing.

The First Level Mandatory Appeal for Short Term Disability, Vision, Death, and Accidental Death and Dismemberment claims is mandatory and must be filed within one hundred eighty (180) days of the initial adverse benefit determination. If you fail to file your initial appeal within one hundred eighty (180) days, your appeal will be denied and your right to file a lawsuit forever waived.

For claims which do not involve medical judgment or rescission of coverage, you may file a Second Level Voluntary Appeal under this provision with the Board of Trustees within thirty (30) days of the date of the determination on the First Level Mandatory Appeal.

The Fund gives the Board of Trustees full discretion and authority to make the final decision regarding all areas of Fund interpretation and administration, including: eligibility for benefits, the level of benefits provided, or interpretation of the Fund language included in this Plan document/SPD or administrative procedures.

The Appeals Review Committee will review the appeal. The Appeals Review Committee is designated by the Board of Trustees. The determination of your appeal will generally be made at the next scheduled meeting or the following meeting (you will be notified if there is a delay).

The decisions of the Appeals Review Committee or the Board of Trustees are final and binding on all individuals dealing with or claiming benefits under the Fund, and if challenged in court, the Fund intends for the Board of Trustees' decision to be upheld, unless found by a court of competent jurisdiction to be arbitrary and capricious.

Prior to issuance of a decision on First Level Mandatory Appeal and sufficiently in advance of the date on which the notice of the decision is required to be provided to give the claimant a reasonable opportunity to respond prior to that date, the Fund will provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund in connection with the claim or any new or additional rationale.

Disability, Death, and Accidental Death and Dismemberment Claim Appeals

If additional information is needed to process your claim, the initial period will be suspended, and you will be notified of what information is needed. In the event an extension of time is necessary due to the failure to submit necessary information, the time frame for making a benefit determination is tolled (i.e., stopped) until the date you provide the required information.

A determination will be made by the Appeals Review Committee no later than the date of the next regularly scheduled meeting that immediately follows the Fund's receipt of the appeal, unless the request for the appeal is filed within 30 days preceding the date of such meeting. In such a case, a benefit determination may be made by no later than the date of the second meeting following the Fund's receipt of the appeal. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the Appeals Review Committee following the receipt of the appeal. If such an extension of time for review is required because of special circumstances, the Plan Administrator shall provide you with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Plan Administrator shall notify you of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made. In the event an extension of time is necessary due to the failure to submit necessary information, the time frame for making a benefit determination is tolled (i.e., stopped) until the date you provide the required information.

Adverse Benefit Determination and Appeal Determination Notice

When you are notified of a determination on your claim or appeal, the notice will include:

- Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- The specific reason(s) for the determination;

- Reference to the specific Plan provision on which the denial is based; if an internal rule, guideline, protocol or similar criteria was relied upon in making the benefit determination, then that information will be provided free of charge upon written request;
- If the claim was denied based on a Medical Necessity or Experimental treatment, or similar exclusion or limit, then an explanation of the scientific or clinical judgment used for the determination applying the terms of the Plan to your circumstances will be provided free of charge upon request;
- Upon specific written request from you, the identification of the medical or vocational expert whose advice was obtained on behalf of Anthem in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim of benefits;
- A statement that the Fund may have other voluntary appeal procedures offered by the Fund, as applicable, and your right to obtain information about such procedures; and
- A statement that you have a right to bring a civil action under ERISA Section 502(a) following the denial of your claim;
- For health care or disability claims, if your claim is denied based on:
    - Any rule, guideline, protocol, or similar criteria, either the rule, guideline, protocol or similar criteria that was relied upon or a statement that such rule, guideline, protocol, or similar criteria was relied upon and a copy is available to you, at no cost, upon request; or
    - Medical Necessity, Experimental treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the Fund terms to your circumstances or a statement that a copy of the scientific or clinical judgment or exclusion or limit is available to you, at no cost, upon request.
- For disability claims, a discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    - The views presented by you to the Fund of health care professionals treating you and vocational professionals who evaluated the claimant;
    - The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
    - A disability determination made by the Social Security Administration presented by you to Fund.
- For disability claims, the notification shall be provided in a culturally and linguistically appropriate manner.

Right to Full and Fair Review During the Appeals Process

When you submit an appeal of a claim, your appeal will be given a full and fair review. Specifically, you will be provided:

- Specific time frames, as described below, in which to appeal your claim;
- The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- Reasonable access to, and copies of, all documents, records, and other information relevant to your claim, upon request and free of charge; and
- A review that takes into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim determination.

In addition, for health care and disability appeals, you will be provided:

- A review that does not defer to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Fund who is neither the individual who made the initial determination nor a subordinate of that individual;
- That in determinations based in whole or in part on medical judgment (including determinations regarding whether a treatment, drug or item is Experimental, Investigational or Medically Necessary), that the 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; and
    - Was not consulted (or is not subordinate to the person who was consulted) in connection with the denial of your claim. You have the right to be advised of the identity of any medical experts consulted in making a determination of your appeal.

In health care appeals involving Urgent Care, an expedited review process where the request for review may be submitted in writing or orally and communications between you and the Fund may be made in an expedited manner, such as, telephone or facsimile.

For disability benefits,

- the adverse benefit determination shall be provided in a culturally and linguistically appropriate manner;
- the Fund shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund, in connection with the claim as soon as possible and sufficiently in advance of the date on which the notice of any appeal determination is required to be provided by the Fund so that you have a reasonable opportunity to respond prior to that date; and
- the Fund shall provide you, free of charge, with any new or additional rationale considered or relied upon, in connection with the claim as soon as possible and sufficiently in advance of the date on which the notice of any appeal determination is required to be provided by the Fund so that you have a reasonable opportunity to respond prior to that date; and
- the statement of your right to bring an action under section 502(a) of ERISA shall also describe any applicable contractual limitations period that applies to the right to bring such an action, (180 days from the last notice you receive from the Fund) including the calendar date on which the contractual limitations period expires for the claim.

Authorized Representatives

When appealing a claim, you may authorize a representative to act on your behalf. You must provide written notification authorizing this representative. The written notification must include the individual's name, address, and phone number. However, if you are unable to provide a written statement, the Fund requires other written proof (such as power of attorney for health care purposes or court order of guardian/conservator) that the proposed authorized representative has been authorized to act on the individual's behalf.

Authorized representatives may include a:

- Health care provider that has knowledge of the condition
- Legal Spouse
- Dependent child age 18 or over
- Parent or adult sibling
- Grandparent

- Court-ordered representative, such as an individual with power of attorney for health care purposes, Legal Guardian, or conservator
- Other adult

Once a representative is authorized, all future claims and appeals related correspondence will be sent to the authorized representative. The Fund will recognize the designated authorized representative for one year, or as mandated by a court order, before requiring a new authorization. However, the individual may revoke a designated authorized representative at any time by submitting a signed statement.

Ohio Laborers Benefits has the discretion to determine whether an authorized representative has been properly designated in accordance with the Fund's terms. Ohio Laborers Benefits reserves the right to withhold information from a person who claims to be an authorized representative if there is suspicion about the qualifications of that individual.

Trustee Authority and Interpretation

The Trustees or, where Trustee responsibility has been delegated to others, (e.g., Anthem), such other persons will be the sole judges of the standard of proof required in any case and the application and interpretation of this Fund, and decisions of the Trustees or their delegates are final and binding. Benefits under this Fund will be paid only when the Board of Trustees, or persons delegated by them, decides, in their discretion, that the Member or beneficiary is entitled to benefits in accordance with the terms of the Fund. If a claim for benefits has been denied, no lawsuit or other action against the Fund or its Trustees may be filed until the matter has been submitted for review under the ERISA-mandated review procedure adopted by the Trustees, from time to time. The decision on review is binding upon all persons dealing with the Fund or claiming any benefit hereunder, except to the extent that the decision may be determined to be arbitrary or capricious by a court or arbitrator having jurisdiction over such matter.

You or any other claimant may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the procedures described in this section. You may, at your own expense, have legal representation at any stage of the review process. The Trustees will make every effort to interpret Fund provisions in a consistent and equitable manner.

Time Limitations for Legal Proceedings

After you have exhausted the appeal procedure set forth above, you have 180 days to file a legal proceeding against the Fund. Unless you file a second voluntary appeal or seek external review, **you forfeit your right to file a legal proceeding against the Fund if you fail to file a legal proceeding within 180 days from the date of the answer to the First Level Appeal issued by Anthem or, for non-medical claims, the date of the final determination of the Board of Trustees.** If you elect to file a second, voluntary appeal for medical benefits (Anthem only), this time limitation commences from the date of the final determination rendered by the Board of Trustees. If you elect to request external review after filing a First Level Mandatory Appeal, then this time limitation commences from the date of the determination rendered by the IRO. For claims of retirees or Covered Dependents age 65 or older, this time limitation commences from the date of the final Medicare determination, or if an appeal is filed with the Board of Trustees, the date of the Board of Trustees' final determination. For all other claims, this time limitation commences from the date of the Board of Trustees' final determination.

Appeals Summary

Type of Claim	First Level Mandatory Appeal With	Second Voluntary Appeal With	External Review	Right to Sue Within
Anthem	Anthem	Board of Trustees	Yes	180 days of first, second or external review
Anthem – CarelonRx	Anthem	Board of Trustees	Yes	180 days of final determination
Vision, Death, Accidental Death, Short-Term Disability	Board of Trustees	Board of Trustees	Yes	180 days of final determination
Anthem Medicare	Please contact Anthem Medicare at (833) 848-8730 for appeal information.			

General Plan Exclusions and Limitations

In addition to any specific exclusions and limitations listed in this booklet, Fund benefits are not paid for the following:

1. Services not prescribed by or performed by or under the direction of a Physician or other professional provider.
2. Services not performed within the scope of the provider's license.
3. Services received from other than a provider.
4. Experimental or Investigational drugs, devices, medical treatments, or procedures, except where costs for these items and services are provided in connection with participation in a clinical trial and federal law requires these items and services to be covered.
5. Benefits provided by governmental units or their agencies provide benefits, except Health Departments.
6. A condition that occurs as a result of any act of war, declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.
7. Services for which the Covered Individual has no legal obligation to pay in the absence of this or like coverage.
8. For a particular health service in the event that a non-PPO Network Provider waived Copayments, non-PPO network Coinsurance (and/or the Non-PPO Network Deductible per Benefit Period) no benefits are provided for the health service for which the Copayments, non-PPO network Coinsurance (and/or the Non-PPO Network Deductible per Benefit Period) are waived.
9. Services received from a dental or medical department maintained by or on behalf of a Contractor, mutual benefit association, labor union, or similar person or group.
10. Services provided by any Physician or other health care practitioner who is the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Member.
11. Services Incurred when the Covered Individual does not meet the eligibility requirements *(except as specified on pages 40-45)*.
12. Injury or Sickness occurring in the course of employment for compensation, profit, or gain or for occupational Injuries sustained by sole proprietors, if whole or partial benefits or compensation is available under the laws of any governmental unit, including Workers' Compensation coverage. This applies, whether or not the Covered Individual claims such compensation or recovers losses from a third party.
13. Cosmetic Surgery (that is, surgery or medical treatment to improve or preserve physical appearance, but not physical function) including but not limited to removal of tattoos, breast augmentation (except reconstructive services after a mastectomy), breast reduction, elimination of redundant skin of the abdomen, surgery to improve self-esteem or treat psychological symptoms or psychosocial complaints related to one's appearance, treatment of varicose veins, upper eyelid blepharoplasty, cosmetic skin products such as Restylane, Renova or other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee. However, this Cosmetic Surgery exclusion does not apply to reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part, or because of a congenital disease or anomaly.
14. Expenses for Custodial Care, regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, personal care, sitter/companion service, etc.
15. Expenses for dental services or supplies of any kind (even if they are necessary because of symptoms, Congenital Anomaly, illness or injury affecting the mouth or another part of the body), including but not limited to dental prosthetics, endodontics such as root canal, dental restorations, and dental services for the care, filling, removal or replacement of teeth, or the treatment of disease of the teeth, gums, or structures directly supporting or attached to the teeth. Expenses for certain dental care and treatment may be covered when needed for the repair or alleviation of damage because of injury. For the purposes of this coverage by the Plan, an accident does not include any injury caused by biting or chewing. This exclusion shall not apply to covered oral and/or

craniofacial surgery including, but not limited to, the treatment of jaw dislocations, facial/oral wounds, lacerations or infections (cellulitis), or the removal of cysts or tumors of the jaws/facial bones.

16. Expenses for the diagnosis, treatment, or prevention of temporomandibular joint (TMJ) dysfunction or syndrome.
17. Expenses for orthognathic services/surgery for treatment of aesthetic malposition of the bones of the jaw such as with prognathism, retrognathism, temporomandibular joint dysfunction/syndrome, or other cosmetic reasons.
18. Expenses for dental services such as removal of teeth including wisdom teeth, gingivectomy, procedures in preparation for future dental work or dental implant (such as sinus lift, soft tissue graft, bone graft/replacement), root canal (endodontic) therapy.
19. Expenses related to all facility services for dental procedures, even when deemed a medically appropriate setting.
20. Self-inflicted injury while sane or insane, unless otherwise required by federal law.
21. Participation in a felony; attempted or committed assault, whether intentional or unintentional. Expenses Incurred by any Covered Individual for Injuries resulting from or sustained as a result of commission, or attempted commission by the Covered Individual, of an illegal act that the Plan Administrator determines in his or her sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the Covered Individual. The Plan Administrator's discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the Covered Individual (including, without limitation, acquittal, or failure to prosecute) in connection with the acts involved.
22. Expenses Incurred related to male sexual dysfunction, penile prosthesis, or sex transformations.
23. Personal hygiene and convenience items, even though a Physician may prescribe them.
24. Expenses for smoking cessation, nicotine, or tobacco abuse, unless required through federal government mandate.
25. Services or supplies for the treatment of Infertility along with services to induce pregnancy and complications thereof, including, but not limited to services, Prescription Drugs, procedures or devices to achieve fertility, in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete intra fallopian transfer, zygote transfer, surrogate expenses, donor egg/semen or other fees, cryostorage of egg/sperm, ovarian transplant, Infertility donor expenses, fetal implants, fetal reduction services, surgical impregnation procedures and reversal of sterilization procedures.
26. Expenses for pre-implantation genetic diagnosis (PGD) where one or more cells are removed from an embryo and genetically analyzed to determine if it is normal.
27. Services or supplies related to reversal of sterilization procedures or services associated with surrogate parenting.
28. Services received in a military facility for a military service-related condition.
29. For Outpatient educational or vocational training purposes, including, but not limited to computers, computer devices/software, printers, books, tutoring or interpreters, visual aids, vision therapy, auditory or speech aids/synthesizers, auxiliary aids such as communication boards, listening systems, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or Developmental Delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education and associated costs in conjunction with sign language education for a patient or family members, and implantable medical identification/tracking devices.
30. For treatment of conditions related to learning disabilities, behavioral problems, or intellectual disability, except as specified in this SPD.
31. Topical anesthetics.

32. For arch supports and other foot support devices only to improve comfort or appearance which includes, but is not limited to, care for flat feet, subluxations, corns, bunions (except capsular and bone surgery), calluses, and toenails.

33. Expenses for routine foot care including but not limited to trimming of toenails, removal or reduction of corns and calluses, removal thick/cracked skin on heels, foot massage, and hygienic/preventive care (hygienic/preventive care includes cleaning and soaking of the feet, applying skin creams to help maintain skin tone, and other services that are performed when there is no evidence of a localized illness, injury, or symptoms involving the foot).

34. Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment and weight training services.

35. Except as required by federal law, expenses for dieting, weight loss, or treatment of obesity, including but not limited to: bariatric surgery, drug therapy, gastric restrictive procedures, gastric or intestinal bypass, reversal of a previously performed weight management surgery, weight loss programs, dietary supplements, vitamins, dietary instructions, skin reduction procedures/treatment, and any complications thereof, even if to treat a comorbid or underlying health condition. Notwithstanding the foregoing, gastric bypass and gastric restrictive procedures (including surgical repair/correction or reversal) deemed to be medically necessary (as determined by Anthem) will be covered.

36. Marital counseling, religious counseling, sex counseling, and sex therapy.

37. Treatment of sexual problems not caused by a biological condition.

38. Transsexual surgery or any medical, surgical or Prescription Drug treatment leading to or in connection with transsexual surgery, including any complications resulting from such procedures.

39. Birth control devices, unless required through federal government mandate.

40. Hypnosis, acupuncture, acupressure, or biofeedback.

41. Equine assisted psychotherapy or equine assisted learning (also known as horse therapy or equine therapy).

42. Missed appointments, administrative fees, completion of claim forms, or copies of medical records. Examples of administrative fees include, but are not limited to, holiday or overtime rates, fees charged for educational brochures or calling a patient to provide test results, specific medical reports including those not directly related to the treatment of the Member; e.g., employment or insurance physicals, and any reports prepared in connection with litigation.

43. Expenses for any and all telephone calls between a Physician or other health care provider and any other health care provider, utilization management company, or any representative of the Plan for any purpose whatsoever, including, without limitation: communication with any representative of the Plan or its utilization management company for any purpose related to the care or treatment of a Covered Individual, consultation with any health care provider regarding medical management or care of a patient; coordinating medical management of a new or established patient; coordinating services of several different health professionals working on different aspects of a patient's care; discussing test results; initiating therapy or a plan of care that can be handled by telephone.

44. Fraudulent or misrepresented claims.

45. Blood which is available without charge or blood storage services provided by other than a Hospital.

46. Non-Covered Services or services specifically excluded in the text of this booklet.

47. Except as required by federal law, expenses for genetic tests, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics, determined to be not medically necessary by Anthem medical policy.

48. Treatment with intraoral prosthetic devices or by any other method to alter vertical dimension.

49. Adult immunizations (except for tetanus), except as specified in this SPD or unless required through federal government mandate.

50. Equipment that exceeds medical needs.

51. Coverage for Inpatient care is not provided when the services could have been performed on an Outpatient basis, and it was not Medically Necessary for the Covered Individual to be an Inpatient to receive them.

52. Services or supplies determined by the Plan Administrator or its designee not to be Medically Necessary, except as specified in this SPD or unless required through federal government mandate.

53. Expenses for cryopreservation and/or cryostorage of egg/sperm, peripheral stem cells in teeth or other tissue, umbilical cord blood or other tissue or organs.

54. Examinations which are not covered:

    a. Physical examinations or services required by an insurance company to obtain insurance, a governmental agency such as the FAA and DOT, or a Contractor in order to begin or continue working
    b. Pre-marital examinations
    c. Screening examinations, except as classified
    d. X-ray examinations made without film

55. Expenses for physical examinations, screenings, testing and immunizations required for functional capacity/job analysis examinations and testing required for employment/career, government or regulatory purposes, camp, recreation, sports, vocation, workers' compensation, required by any third party, education, travel, marriage, judicial or administrative proceedings/orders, medical research, or to obtain or maintain a license of any type.

56. Expenses for all medical or surgical services or procedures, including Prescription Drugs and the use of prophylactic surgery, when the services, procedures, prescription of drugs, or prophylactic surgery is prescribed or performed for the purpose of: (1) avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on family history and/or genetic test results; or (2) treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder.

57. Expenses related to the medical or surgical treatment of sleep disorders or snoring including medical equipment, except that coverage is provided for diagnostic sleep studies and for treatment of documented obstructive sleep apnea.

58. Expenses that exceed any Plan benefit limitation or maximum Plan benefit.

59. Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the Maximum Allowed Amount.

60. Expenses (past, present or future) for which another party is required to pay (e.g., no-fault insurance, personal injury protection, etc.).

61. Services in a U.S. Department of Veterans Affairs Hospital or other military medical facility in connection with a military service-related illness or injury.

62. Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a Covered Individual, including, without limitation, construction or modification of ramps, elevators, handrails, chair lifts, spas/hot tubs, air conditioning, dehumidification devices, asbestos removal, air filtration/purification, swimming pools, emergency alert system, etc.

63. Expenses for and related to non-emergency travel or transportation (including lodging, meals, and related expenses) of a health care provider, Covered Individual, or family member of a Covered Individual, unless those travel expenses are related to an approved transplant.

64. Expenses for medical services or supplies rendered or provided outside the United States, except for treatment of a Medical Emergency or unexpected medical condition.

65. As determined by the Plan Administrator or its designee, expenses were Incurred by any Covered Individual for Injuries caused in a motor vehicle accident if the Covered Individual was operating the vehicle while intoxicated (had a blood alcohol level that exceeded the legal limit of the jurisdiction in which the accident occurred or no breathalyzer exam was performed or the person refused to submit to a requested breathalyzer or blood test) or was under the influence of illegal drugs; unless the Injuries arise as a result of a physical or mental health

condition. The Plan Administrator's discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the Covered Individual (including, without limitation, acquittal, or failure to prosecute) in connection with the motor vehicle accident.

66. Expenses related to complications of a Non-Covered Service.

67. Any surcharge fees resulting from state laws (e.g., New York Health Care Reform Act).

68. Expenses for residential care services, except as required under mental health parity rules and regulations promulgated thereunder, residential schools, wilderness program, halfway house, boarding school and group home.

69. Expenses for services related to reading and learning disorders, dyslexia, educational delays, or vocational disabilities.

70. Expenses for court-ordered services unless the services are both Medically Necessary and a covered benefit of the Plan, parental custody services or adoption services.

71. Services, supplies, care and/or treatment of an injury or Sickness that results from engaging in hazardous pursuit, hobby, or activity. A pursuit, hobby, or activity is hazardous if it involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the Covered Person's customary occupation or if it involves leisure time activities commonly considered as involving unusual or exceptional risks, characterized by a constant threat of danger or risk of bodily harm.

72. Expenses that result from traveling to countries with advisory warnings.

73. Services related to a provider-preventable condition including a health care-acquired condition. Provider-preventable condition means a condition that meets the definition of a "health care-acquired condition" or an "other provider-preventable condition" as defined in accordance with Medicare or Medicaid regulations. Conditions include, but are not limited to, wrong surgical/invasive procedure performed on a patient; surgical/invasive procedure performed on the wrong body part; surgical/invasive procedure performed on the wrong patient.

74. Expenses Incurred by any Covered Individual as a result of failure to comply with medically appropriate treatment, as determined by the Plan Administrator or its designee.

75. Hospital or other health care facility expenses if you leave the facility against the medical advice of the attending Physician.

76. Expenses Incurred by any Covered Individual during travel if a Physician or other health care provider has specifically advised against such travel because of the health condition of the Covered Individual.

77. Separate charges by interns, residents, house Physicians, medical students, or other health care professionals who are employed by the covered facility, which makes their services available.

78. Expenses for any Physician or other health care provider who did not directly provide or supervise medical services to the patient, even if the Physician or health care practitioner was available to do so on a stand-by basis.

79. Expenses for chelation therapy, except as may be Medically Necessary for treatment of acute arsenic, gold, mercury, or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron.

80. Expenses for prayer/faith, religious healing, or spiritual healing.

81. Expenses for naturopathic, naprapathic, and/or homeopathic services, treatments, products, or supplies.

82. Expenses for an autopsy or forensic examination and any related expenses, except as required by the Plan Administrator or its designee.

83. Services, supplies, or other expenses associated with a clinical trial program, unless the Fund is prohibited from denying coverage for such services, supplies, or other expenses under federal law.

84. Services paid under Medicare or which would have been paid if the Member had applied for Medicare and claimed Medicare benefits. With respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payor whether or not the Member has enrolled in Medicare Part B.

85. Drugs, devices, products, or supplies with over-the-counter equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over-the-counter drug, device, product, or supply.

86. Donor Search/Compatibility Fee (except as otherwise indicated on the Plan Design with Anthem).

87. Hair transplants, hair pieces or wigs, wig maintenance, or prescriptions or medications related to hair growth.

88. Christian Science practitioner.

89. Routine care is not covered, except for stated covered preventive services.

90. Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment of acne.

91. Services for Outpatient therapy or rehabilitation other than those specifically noted. Excluded forms of therapy include, but are not limited to: primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, in-home wrap around treatment, wilderness therapy, and boot camp therapy.

92. Vision surgeries related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services, or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.

93. Expenses for unproven allergy treatments, including, but not limited to immunotherapy (i.e., oral antigen drops administered under the tongue), rhinophototherapy (use of ultraviolet lights as a treatment for allergic rhinitis), repository emulsion therapy (a form of immunotherapy where allergens are administered in a solution with vegetable or mineral oil into the body to provide a slow release of allergen(s) from the administration site.

94. Services for Hospital confinement primarily for diagnostic studies.

95. Transportation services provided by an ambulette or a wheelchair van are not Covered Services.

96. Expenses related to marijuana, regardless of whether it is lawfully prescribed by a provider or you may lawfully possess it.

General Claims Information

Health Care Claim Determinations

When you submit a claim for benefits, the appropriate Claims Administrator will determine if you are eligible for benefits and calculate the amount of benefits payable, if any. All claims are processed promptly and will be paid as soon as administratively possible, when complete claim information is received.

You will be notified of an initial determination within certain time frames. If a claim for Post-Service or Concurrent care is approved, payment will be made, and the payment will be considered your notice that the claim was approved. However, for Urgent Care and Pre-Service Care Claims, you will have written notice of a determination on your claim.

If circumstances require an extension of time for making a determination on your claim, you will be notified, in writing, that an extension is necessary. The notice will state the special circumstances and the date a determination is expected.

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

- **Urgent Care Claims** – An initial determination will be made within 72 hours from receipt of your claim, unless additional information is needed. Notice of a determination on your Urgent Care Claims may be provided to you orally within 72 hours and then confirmed in writing within three days after the oral notice. If additional information is needed to process your claim, you will be notified within 24 hours of receipt of your claim. You will then have up to 48 hours to provide the additional information. The initial 72-hour deadline is suspended for up to 48 hours or, if sooner, until the information is received. Notice of the determination will be provided no later than 48 hours after the earlier of the time the Claims Administrator receives the additional information or, the end of the period given for you to provide this information. In addition, if the proper procedures for filing an Urgent Care Claim are not followed, you will be notified of the failure and the proper procedures for filing a claim within 24 hours of the failure. Notification may be oral, unless written notification is requested.
- **Pre-Service Claims** – An initial determination will be made within 15 days from receipt of your claim. If the Claims Administrator determines that additional time is necessary to make a determination, due to matters beyond the control of the Fund, you will be notified within the initial 15-day deadline that up to 15 additional days may be needed. If additional information is needed to process your claim, the initial period will be suspended, and you will be notified of what information is needed. You then have up to 45 days from receipt of the notice to provide the requested information. In the event an extension of time is necessary due to the failure to submit necessary information, the time frame for making a benefit determination is tolled (i.e., stopped) until the earlier of (a) the date you provide the required information, or (b) the expiration of the 45-day period. In addition, if the proper procedures for filing a Pre-Service Claim are not followed, you will be notified of the failure and the proper procedures for filing a claim within 5 days of the failure. Notification may be oral, unless written notification is requested.
- **Post-Service Claims** – An initial determination will be made within 30 days from receipt of your claim. If the Claims Administrator determines that additional time is necessary to make a determination due to matters beyond the control of the Claims Administrator, you will be notified within the initial 30-day deadline that up to 15 additional days may be needed. If additional information is needed to process your claim, the initial period will be suspended, and you will be notified of what information is needed. You then have up to 45 days from receipt of the notice to provide the requested information. In the event an extension of time is necessary due to the failure to submit necessary information, the time frame for making a benefit determination is tolled (i.e., stopped) until the earlier of (a) the date you provide the required information, or (b) the expiration of the 45-day period.
- **Concurrent Care Claims** – While other claims have certain deadlines throughout the claim and appeal process, there is not one specific deadline to notify you of the reconsideration of a concurrent claim. However, you will be notified as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated. If you request an extension of approved Urgent Care treatment (i.e., longer than the prescribed period of time or number of treatments), the Fund will act on your request as soon as possible and you will be notified within 24 hours after the Claims Administrator receives your request, provided your claim

is received at least 24 hours before the expiration of the approved treatment (i.e., prescribed period of time or number of treatments). For new claims to extend concurrent care treatment, the claim may be considered a pre- or Post-Service Claim depending on when it is submitted.

Payment of Health Care Benefits

Benefits are only paid for Covered Expenses Incurred by persons who are covered under the Fund at the time the expenses are Incurred, provided a claim(s) is made for the benefits within the applicable time limits.

Generally, payment is made directly to the provider. However, if you submit the claim along with a paid receipt, payment will be made directly to you. If payment is made to you, you are responsible for payment to the provider. Once the Fund makes payment on a claim, no further payment will be made. You will receive an Explanation of Benefits (EOB) form from the Claims Administrator showing what the Fund has paid. You are responsible for paying any amounts not paid by the Fund.

If an individual is, in the opinion of the Trustees, legally incapable of giving a valid receipt for any payment due and no guardian has been appointed, the Trustees may, at their option, make such payment to the person or persons who, in the opinion of the Trustees, have assumed the care and principal support of such individual.

If an individual dies before all amounts due have been paid, the Trustees may, at their option, make such payment to the executor, administrator, or personal representative of the individual's estate or to his or her surviving Spouse, parent, child(ren), or to any other person(s) entitled to such payments.

Any payment made by the Fund fully discharges the liability of the Trustees to the extent of such payment. Benefits payable under the Fund are limited to the Fund assets available for payment of benefits. See the Claims Payment section *(on pages 65-70)* for additional information regarding Anthem claims.

Submitting Death, Accidental Death and Dismemberment, and Short Term Disability Claims

Written proof of claims for payment of benefits on account of Death, Accidental Death and Dismemberment, or Short Term Disability must be furnished as soon as possible after the loss has been Incurred. Proof of loss for a death benefit claim should be shown using the death certificate. Proof of loss for an accidental death claim should be shown using the death certificate, which indicates the death was the result of an accident. Claim forms for short-term disability and dismemberment claims are available from Ohio Laborers Benefits and should be substantiated with medical records.

Claim Determinations

When you submit a claim for benefits, Ohio Laborers Benefits will determine if you are eligible for benefits and calculate the amount of benefits payable, if any. All claims are processed promptly and will be paid as soon as administratively possible by Ohio Laborers Benefits, after complete claim information is received.

You will be notified of an initial determination within certain time frames. If a claim is approved, payment will be made, and the payment will be considered your notice that the claim was approved.

If circumstances require an extension of time for making a determination on your claim, you will be notified, in writing, that an extension is necessary. The notice will state the special circumstances and the date a determination is expected.

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

- **Death and Accidental Death and Dismemberment Claims** – An initial determination will be made within 90 days from receipt of your claim. If Ohio Laborers Benefits determines that additional time is necessary to make a determination, due to matters beyond the control of the Fund, you will be notified within the initial 90-day deadline that up to 90 additional days may be needed.
- **Disability Claims** – An initial determination will be made within 45 days from receipt of your claim. However, Ohio Laborers Benefits is allowed up to two 30-day extensions in reviewing your claim. If Ohio Laborers Benefits determines that additional time is necessary to make a determination due to matters beyond the control of the Fund, you will be notified within the initial 45-day deadline that up to 30 additional days may be

needed. If an additional extension is necessary, you will be notified during the first 30-day extension. The extension notice will explain:

- The standards used in determining entitlement to the benefit;
- The unresolved issues that prevent a determination;
- The additional information necessary to resolve those issues; and
- The date by which Ohio Laborers Benefits expects to render a decision.

If additional information is needed to process your claim, the initial period will be suspended, and you will be notified of what information is needed. You then have up to 45 days from receipt of the notice to provide the requested information. In the event an extension of time is necessary due to the failure to submit necessary information, the time frame for making a benefit determination is tolled (i.e., stopped) until the earlier of (a) the date you provide the required information, or (b) the expiration of the 45-day period.

Important Information about Claims

Consent to Release Medical Information - Denial of Coverage

You consent to the release of medical information to the Fund when you complete your Enrollment/Beneficiary Card. When you present your identification card for Covered Services, you are also giving your consent to release medical information to the Fund. The Fund has the right to refuse to reimburse for Covered Services if you refuse to consent to the release of any medical information.

Right to Receive and Release Necessary Information

To determine the applicability of and implementing the terms of this provision of this Fund or any other plan, the Fund may, without the consent of or notice to any persons, release to, or obtain from any insurance company or other organization or person, any information with respect to any person which it deems to be necessary for such purposes in compliance of your privacy rights under HIPAA. Any person claiming benefits under this Fund will furnish to the Fund information as may be necessary to implement this provision.

Facility of Payment

Whenever payments, which should have been made under the Fund in accordance with this provision, have been made under any other plan, the Fund will have the right, exercisable alone and at its sole discretion, to pay any organizations making such other payments, any amounts it determines to be warranted in order to satisfy the intent of this provision. Amounts so paid will be deemed to be benefits paid under this Fund and to the extent of such payment for Covered Services the Fund will be fully discharged from liability.

Payments Directly to Providers

Benefits will generally be paid directly to the provider on whose charge the claim is based.

Other Service Plan Contracts

If a Covered Individual is covered under more than one plan, the benefits that are provided under this Fund will be coordinated with the benefits payable from other plans so that the sum of all benefits together will not exceed the total charges for the health services. *(See Coordination of Benefits starting on page 71 for additional information.)*

Physical Examination

The Fund will have the right to examine you at its own expense if your injury or Sickness is the basis of any claim as often as it may be reasonably required to process your claim.

Notice

The Fund is not in lieu of, is not in any way subject to, and does not affect any requirement for coverage by Workers' Compensation Insurance.

Notices and Services in Applicable Non-English Language

The Fund provides oral language services that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals. The Fund, upon request, will provide a notice in any applicable non-English language. The Fund will include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Fund. A non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined by the Secretary of the Department of Labor.

If A Claim Is Denied – All Claims (Health Care and Non-Health Care)

If your claim is denied (in whole or in part), you will be provided with certain information about your claim within the time frames described. When you are notified of an initial denial on your claim, the notice will include:

- The specific reason(s) for the determination;
- Reference to the specific Fund provision(s) on which the determination was based;
- A description of any additional information or material needed to properly process your claim and an explanation of the reason it is needed;
- A copy of the Fund's claims review procedures and time periods to appeal your claim;
- A statement of your right to bring a lawsuit under ERISA Section 502(a) following the denial of a claim on review; and
- For health care or disability claims, if your claim is denied based on:
    - Any internal rule, guideline, protocol, or similar criteria, either the rule, guideline, protocol or similar criteria that was relied upon or a statement that such rule, guideline, protocol, or similar criteria was relied upon and a copy is available to you, at no cost, upon request; or
    - Medical Necessity, Experimental treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the Fund terms to your circumstances or a statement that a copy of the scientific or clinical judgment or exclusion or limit is available to you, at no cost, upon request; and
- For health care claims only, if your appeal is due to the denial of an Urgent Care Claim, a description of the expedited review process.

Examples of when a Claim May Be Denied

The Trustees, or their representatives, have the authority to make determinations on claims. Following are some examples of when a claim may be denied, or that may result in reduced benefits:

<u>For All Benefits:</u>

- The individual on whose behalf the claim was filed was not covered under the Fund on the date the expenses were Incurred.
- The claim was not filed within the Fund time limits.
- Plan eligibility rules or benefits were amended.
- A Covered Individual's future benefits were reduced or temporarily suspended to recover an overpayment of benefits previously made.
- The Fund was terminated.

<u>For Health Care Benefits:</u>

- The claim was not for Covered Expenses under the Fund.

- The claim was for expenses that were not actually Incurred.
- The individual for whom the claim was filed already received the maximum allowable under the Fund for the type of expense.
- Another plan was primary for the Covered Expense.
- No payment was made, or a reduced amount was paid, because the applicable Deductible was not yet paid.
- A third party was responsible for paying the expenses and the required Subrogation and Repayment Agreement was not completed.
- Hospital benefits were reduced because of the non-Precertification.

This list is not all-inclusive, but rather representative of the types of circumstances, in addition to failure to meet the Fund's regular eligibility requirements for coverage under the Fund, that may cause benefits to be denied or reduced.

HIPAA Privacy and Security

The Fund's Disclosure of Protected Health Information to the Plan Sponsor

For purposes of this section the Board of Trustees is the Plan Sponsor. The Fund will disclose Protected Health Information (PHI), as defined in the regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan Documents have been amended to incorporate the following provisions:

With respect to PHI, the Plan Sponsor agrees to:

- Not use or further disclose the information other than as permitted or required by this Summary Plan Description and Plan Document or as required by law
- Ensure that any agents, including a Subcontractor, to whom the Plan Sponsor provides PHI received from the Fund agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information
- Not use or disclose the information for employment-related actions and decisions unless authorized by the individual
- Not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual
- Report to the Fund any use or disclosure of the information of which it becomes aware that is inconsistent with the uses or disclosures provided for in this document
- Make PHI available to the individual in accordance with the access requirements of HIPAA
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA
- Make the information available that is required to provide an accounting of disclosures
- Make internal practices, books, and records relating to the use and disclosure of PHI received from the Group Health Plan available to the Secretary of HHS for the purposes of determining compliance by the Group Health Plan with HIPAA
- If feasible, return or destroy all PHI received from the Fund that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

Adequate separation between the Fund and the Plan Sponsor will be maintained. Therefore, in accordance with HIPAA, only the following employees or classes of employees will be given access to PHI:

- Fund Administrator
- Staff designated by the Fund Administrator

The persons described above will only have access to and will only use and disclose PHI for Fund administration functions that the Plan Sponsor performs for the Fund. If these persons do not comply with this Summary Plan Description and Plan Document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

The Fund's Protection of the Security of Your PHI

The Plan Sponsor will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI, as defined under HIPAA, that it creates, receives, maintains, or transmits on behalf of the Group Health Plan
- Ensure that the adequate separation between the Fund and Plan Sponsor, specific to electronic PHI, is supported by reasonable and appropriate security measures
- Ensure that any agent, including a Subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI
- Report to the Fund any security incident of which it becomes aware concerning electronic PHI

Subrogation and Reimbursement

The benefits payable hereunder as a result of any condition which give rise to a claim by any Member, Covered Individual, beneficiary, Dependent, or any other Covered Person, hereinafter individually and collectively "Covered Person," against a third party tortfeasor or against any person or entity as the result of the actions of a third party are excluded from coverage under this Fund. This Fund also does not provide benefits to the extent that there is other coverage under non-group medical payments (including auto) or medical expense type coverage to the extent of that coverage. However, this Fund will provide benefits, otherwise payable under this Fund, to or on behalf of said Covered Person only on the following terms and conditions:

1. In the event that benefits are provided under this Fund, the Fund shall be subrogated to all of the Covered Person's rights of recovery against any person or organization to the extent of the benefits provided. The Covered Person shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The Covered Person shall do nothing after loss to prejudice such rights. The Covered Person hereby agrees to cooperate with the Fund and/or any representatives of the Fund in completing such forms and in giving such information surrounding any incident as the Fund or its representatives deem necessary to fully investigate the incident giving rise to a condition. The Fund may deny coverage to any Covered Person who refuses or fails to cooperate with the Fund. To extent a Covered Person misrepresents facts or circumstance with respect to any injury the Fund may retroactively deny coverage to the extent allowed under law.
2. The Fund is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the Fund. The Fund's share of recovery will not be reduced because the Covered Person has not received the full damages claimed, unless the Fund agrees in writing to a reduction.
3. The Fund retains the right to pursue all rights of recovery without an agreement from the Covered Person and may require Covered Persons to file claims for payments with other parties.
4. By accepting benefits hereunder, the Covered Person hereby grants a lien and assigns to the Fund the proceeds of any settlement, judgment or other payment intended for, payable to, or received by the Covered Person or his/her representatives, and the Covered Person hereby consents to said lien and agrees to take whatever steps are necessary to help the company secure said lien. The Covered Person agrees that said lien shall constitute a charge upon the proceeds of any recovery and the Fund shall be entitled to assert security interest thereon. By the acceptance of benefits under the Fund, the Covered Person and his or her representatives agree to hold the proceeds of any settlement in trust for the benefit of the Fund to the extent of 100% of all benefits paid on behalf of the Covered Person. This assignment is binding on any attorney who represents the Covered Person whether or not an agent of the Covered Person and on any insurance company or other financially responsible party against whom a Covered Person may have a claim provided said attorney, insurance carriers or others have been notified by the Fund or its agents.
5. The subrogation and reimbursement rights and liens apply to any recoveries made by the Covered Person as a result of the Injuries sustained, including but not limited to the following:
    a. Payments made directly by the third-party tortfeasor, or any insurance company on behalf of the third parry tortfeasor, or any other payments on behalf of the third party tortfeasor.
    b. Any payments or settlements or judgment or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of a Covered Person or other person.
    c. Any other payments from any source designed or intended to compensate a Covered Person for Injuries sustained as the result of negligence or alleged negligence of a third party.
    d. Any workers' compensation award or settlement.
    e. Any recovery made pursuant to no-fault insurance.

f. Any medical payments made as a result of such coverage in any automobile or homeowners insurance policy.

6. No adult Covered Person hereunder may assign any rights that he or she may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult Covered Person without the prior express written consent of the Fund. The Fund's right to recover (whether by subrogation or reimbursement) shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.

7. No Covered Person shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude the benefits provided by the Fund.

8. The Fund's right of recovery shall be a prior lien against any proceeds recovered by the Covered Person, which right shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine," "Rimes Doctrine," or any other such doctrine purporting to defeat the Fund's recovery rights by allocating the proceeds exclusively to non-medical expense damages. The Fund's first dollar right of recovery shall have priority over yours or anyone else's rights until the Fund recovers the total amount the Fund paid for Covered Services. The Fund's right of reimbursement for the total amount the Fund paid for Covered Services is absolute and applies whether or not you receive (or are entitled to receive) a full or partial recovery or whether or not you are "made whole" by reason of any recovery from any other person or entity.

9. No Covered Person hereunder shall incur any expenses on behalf of the Fund in pursuit of the Fund's rights hereunder. By way of example, no Covered Person shall deduct court costs or attorney's fees from the Fund's recovery without the prior express written consent of the Fund. This right shall not be defeated by any so-called "Fund Doctrine," or "Common Fund Doctrine," or "Attorney's Fund Doctrine."

10. The Fund shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Covered Person, whether under comparative negligence or otherwise.

11. The benefits under this Fund are secondary to any coverage under no-fault or similar insurance.

12. In the event that a Covered Person shall fail or refuse to honor his or her obligations hereunder, then the Fund shall be entitled to recover any costs Incurred in enforcing the terms hereof including but not limited to attorney's fees, litigation, court costs, and other expenses. The Fund shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Covered Person has fully complied with his or her reimbursement obligations hereunder, regardless of how those future medical benefits are Incurred.

13. By acceptance of benefits under the Fund, the Covered Person agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Fund shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Fund, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

Administrative Information

Information about the Fund

The following sections contain information provided to the Member by the Plan Administrator to meet the requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It DOES NOT constitute a part of the Fund. All inquiries relating to the following material should be referred directly to Ohio Laborers Benefits.

Name of Plan

The name of the Plan is Ohio Laborers' District Council – Ohio Contractors' Association Insurance Fund (the "Fund"), located at 800 Hillsdowne Road, Westerville, Ohio 43081-3302, (614) 898-9006 or (800) 236-6437.

Maintenance of Plan

The Fund is sponsored and maintained by the Board of Trustees, Ohio Laborers' District Council – Ohio Contractors' Association Insurance Fund, located at 800 Hillsdowne Road, Westerville, Ohio 43081-3302, (614) 898-9006 or (800) 236-6437.

Employer Identification and Plan Numbers

The Employer Identification Number (EIN) assigned by the Internal Revenue Service to the Plan Sponsor is 31-6052984. The Plan number assigned by the Plan Sponsor is 501.

Type of Welfare Plan

The Plan is a Death, Accidental Death and Dismemberment, Short-Term Disability, and Comprehensive Major Medical Plan, including Vision, Hearing, and Prescription Drugs.

Administration of Plan

The Fund is administered by the Ohio Laborers' District Council - Ohio Contractors' Association Insurance Fund Board of Trustees.

Plan Administrator and Plan Sponsor

Name of Plan Administrator and Plan Sponsor: Board of Trustees, Ohio Laborers' District Council – Ohio Contractors' Association Insurance Fund.

Address: 800 Hillsdowne Road, Westerville, Ohio 43081-3302

Telephone Number: (614) 898-9006 or (800) 236-6437

Claims Administrators

Comprehensive Major Medical	Anthem Blue Cross Blue Shield P O Box 105187 Atlanta, GA 30348-5187 Member Services: (855) 878-0128 www.anthem.com
Medical and Prescription Drug Benefits for Medicare Eligible Retirees and Medicare Eligible Dependents of Retirees	Anthem Medicare PO Box 105187 Atlanta, GA 30348-5187 Claims Dept Part D Services PO Box 52077 Phoenix, AZ 85072-2077 Member Services: (833) 848-8730 www.anthem.com
Death, Accidental Death and Dismemberment, Short-Term Disability	OLDC-OCA Insurance Fund 800 Hillsdowne Road Westerville, OH 43081-3302 (614) 898-9006 or (800) 236-6437 www.ohiolaborers.com
Vision	National Vision Administrators (NVA) P.O. Box 2187 Clifton, NJ 07015 (800) 672-7723 www.e-nva.com
Prescription Drugs	Anthem – CarelonRx PO Box 105187 Atlanta, GA 30348-5187 Member Services: (844) 993-4314 www.anthem.com
Hearing	HearUSA 11400 N. Jog Road Palm Beach Gardens, FL 33418 (800) 442-8231 http://members.hearusa.com/olfbp

Agent for Service of Legal Process

The person designated as agent for service of legal process upon the Fund is any member of the Board of Trustees. The address at which process may be served on such person is: 800 Hillsdowne Road, Westerville, Ohio 43081-3302. In addition, service of process may be made upon the Administrative Manager.

Board of Trustees

The name and address of each Trustee of the Fund is:

UNION TRUSTEES

Mr. Robert Richardson
LIUNA Ohio Valley & Southern States Region
2135 Dana Avenue, Suite 240
Cincinnati, OH 45207

Mr. Ralph Cole
Laborers' District Council
152 Dorchester Square, Suite 200
Westerville, OH 43081

Mr. Robert McCaskill
Laborers' Local 423
620 Alum Creek Drive
Columbus, OH 43205-1619

Mr. Anthony Liberatore, Jr.
Laborers' Local 860
3334 Prospect Avenue
Cleveland, OH 44115-2616

MANAGEMENT TRUSTEES

Mr. James Ruhlin
The Ruhlin Company
6931 Ridge Road
Sharon Center, OH 44274

Mr. Mitch Trucco
Trucco Construction
3531 Airport Road
Delaware, OH 43015

Mr. Eric Girard
McDaniel's Construction Corp.
1069 Woodland Avenue
Columbus, OH 43219

Mr. Scott Erick
Kokosing Construction Company
PO Box 226
Fredericktown, OH 43019

Collective Bargaining Agreements

The Fund is maintained pursuant to collective bargaining agreements between contributing Contractors and Local Unions affiliated with the Laborers' District Council of Ohio. A copy of each such agreement may be obtained upon written request to the Plan Administrator, who may make a reasonable charge for the copies, and is available for examination by Members and beneficiaries at Ohio Laborers Benefits, Ohio Laborers' District Council - Ohio Contractors' Association Insurance Fund, 800 Hillsdowne Road, Westerville, Ohio 43081-3302.

Eligibility and Benefits

The Fund's requirements respecting eligibility for participation, the conditions pertaining to eligibility to receive benefits, and a description or summary of the benefits are included in the eligibility rules set forth in this booklet. The Plan Administrator has sole discretion in determining eligibility for benefits and interpreting Plan language. The Plan Administrator's decisions should receive judicial deference to the extent that they do not constitute that they are determined to be arbitrary or capricious.

Circumstances Which May Affect Benefits

Circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture, or suspension of benefits are included in the eligibility rules listed in this booklet. The Board of Trustees or Ohio Laborers Benefits reserves the right to impose restrictions on acceptance of checks and/or credit cards.

Source of Plan Contributions

Contributions to the Fund will be made by participating Contractors working within the jurisdiction of the collective bargaining agreement on behalf of Members and by contributions made to the Fund by Members on their own behalf. The amount of contributions is negotiated through the collective bargaining agreements. A list of Contractors is available upon written request to the Fund at no cost.

Medium for Providing Benefits

Other than Medical Benefits provided to Retired Members and Dependents ages 65 or older, benefits are provided on a self-funded basis. Medical benefits provided to Retired Members and Dependents ages 65 or older are provided on an insured basis through a Health Insurance Issuer. That means the Fund pays the Health Insurance Issuer a premium each month and the Issuer provides health care benefits out of its own assets. In the event the Health Insurance Issuer becomes insolvent or refuses or fails to pay claims for medical benefits, the Fund shall not be responsible for the payment of such claims.

Fund's Fiscal Year

The Fund's fiscal year is January 1 through December 31.

Booklets

This booklet is intended to satisfy the written instrument requirement of Section 402 of ERISA and is also the Fund's Summary Plan Description ("SPD") as required by Section 102 of ERISA. This booklet is amended and restated effective January 1, 2022.

Plan Modification and Amendment

The Board of Trustees of the Ohio Laborers' District Council – Ohio Contractors' Association Insurance Fund may modify or amend the Fund from time to time at its sole discretion, and such modification or amendment will be final and binding on all individuals claiming benefits under this Fund. You cannot reasonably expect that the Plan in place will include the same provisions for eligibility or benefits or other provisions that are currently in place. To amend the Fund, the Board of Trustees must vote to accept the amendment by simple majority at a scheduled meeting. A written notice of any amendments made to the Fund will be mailed to your home address on file.

Plan amendments may include, but are not limited to, any of the following changes:

- The level at which benefits are paid
- The expenses that are covered
- Adding benefits
- Eligibility requirements
- Termination of some or all benefits
- Replacing providers

Plan Termination

The Board of Trustees of the Ohio Laborers' District Council – Ohio Contractors' Association Insurance Fund may terminate the Fund at any time. There is no guarantee that the Fund will continue and not be terminated. You cannot reasonably expect that the Fund will continue in its present form, some other form or at all. In the event of Fund termination, the Fund shall pay the debts of the Fund first and use such remaining monies to effectuate the purpose of the Fund, such as providing benefits to you and your Dependents through some mechanism.

Assignment Disallowed

Benefits cannot be assigned to any third party.

PCORI Fee

The Trustees, having reviewed FAQ About Affordable Care Act Implementation Part XI (Q8), conclude the Patient Centered Outcomes Research Institute (PCORI) Fee is not an excise tax or similar penalty imposed on trustees in connection with a violation of federal law or a breach of their fiduciary obligations, and therefore, resolve that Plan assets should be used to pay the PCORI Fee to the Federal government.

Your ERISA Rights

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

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at Ohio Laborers Benefits and at other specified locations, all documents governing the Fund, Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA);
- Obtain, upon written request to Ohio Laborers Benefits, copies of documents governing the operation of the Fund, Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description (Ohio Laborers Benefits may make a reasonable charge for the copies); and
- Receive a summary of the Fund's annual financial report, which the Plan Administrator is required by law to provide to each participant.

Continue Group Health Plan Coverage

You also have the right to continue health care coverage for yourself, Spouse, or Covered Dependents if there is a loss of coverage under the Fund as a result of a qualifying event (you or your Covered Dependents may have to pay for such coverage; review this Summary Plan Description and any documents governing the Fund on the rules governing your COBRA Continuation Coverage rights).

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Fund participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Fund, called fiduciaries of the Fund, have a duty to do so prudently and in the interest of you and other Fund participants and beneficiaries. No one, including your employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Fund's claims and appeals procedures *(see page 97)*. In addition, if you disagree with the Fund's decision or lack thereof concerning the qualified status of a Medical Child Support Order, you may file suit in federal court. If you believe that Fund fiduciaries have misused the Fund's money, or if you believe that you have been discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you

may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

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

Cincinnati Regional Office
1885 Dixie Highway, Suite 210
Ft. Wright, KY 41011-2664
Telephone: (859) 578-4680
Fax: (859) 578-4688

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

- Calling (866) 444-3272; or
- Visiting the Web site of the EBSA at www.dol.gov/ebsa.

Other Federal Legislation

Pediatric Vaccines

Under ERISA, a Group Health Plan may not reduce its coverage of the costs of pediatric vaccines (as defined under Section1928(h)(6) of the Social Security Act as amended by Section 13830 of OBRA 1992) below the coverage it provided as of May 1, 1993.

Woman's Health and Cancer Rights Act of 1998

Under federal law, Group Health Plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits in connection with certain reconstructive surgery. If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultant with the attending physician and the patient, for:

- 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 of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided by the Fund. See the Medical Benefits, Schedule of Benefits beginning on page 3 of this SPD for the applicable deductibles and coinsurance. If you would like more information on WHCRA benefits, call the Ohio Laborers Benefits at (614) 898-9006 or (800) 236-6437.

Newborns and Mothers' Health Protection Act of 1996

The Newborns and Mothers' Health Protection Act of 1996 includes requirements mandating certain benefits for Maternity Care. This mandate specifies the minimum length of post-delivery Hospital stays for newborns and mothers. Under this Act, Group Health Plans and Health Insurance Issuers generally may not, under Federal law, 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 vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mental Illness Parity Act of 1996

The Mental Illness Parity Act of 1996 establishes a new federal mandate by requiring limited parity in the provision of mental health benefits. This Act requires Group Health plans that provide mental health benefits the same aggregate lifetime dollar limit and the same annual dollar limit, if any, used generally for other medical benefits. However, the Act does not require such plans to provide mental health benefits if the Plan decides not to do so. A health plan need not comply with this requirement if it realizes a one percent or greater increase in health plan costs due to this parity requirement. In 2008, Congress enacted the Paul Wellstone and Pete Domenic Mental Health Parity and Addiction Equity Act, which amended the Mental Health Parity Act of 1996 to require a Group Health Plan to ensure that financial requirements and treatment limitations applicable to mental health/substance use disorder benefits are no more restrictive than those requirements and limitations placed on medical/surgical benefits.

Consolidated Appropriations Act, 2021

The Consolidated Appropriations Act, 2021 included rules concerning healthcare price transparency and the No Surprises Act. This SPD shall be interpreted consistent with the requirements of the Consolidated Appropriations Act, 2021 and are not intended to create a right to a benefit, or to expand any benefit, provided by the Fund unless required by the Consolidated Appropriations Act, 2021.

Glossary

Unless otherwise noted, the following definitions apply to all coverage. Any word in the male gender equally applies to the female gender unless a distinction is specified.

Accidental Injury – Bodily injury sustained by a Member as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity or any other cause) for care which the Member receives. Such care must occur while this Plan is in force. It does not include injuries for which benefits are provided under any Workers' Compensation, Employer's liability or similar law.

Active Member – A member who is eligible for benefits under Class 1 and is currently receiving Contractor contributions or who is receiving his or her benefits under the Fund based on banked hours and does not meet the eligibility requirements for Class 2, 3, or 4 coverage.

Alcoholism – A condition classified as a mental disorder and described in the International Classification of Diseases, Ninth Revision, Clinical Modification, or the most recent version, (ICD-9-CM), as alcohol dependence, abuse or alcoholic psychosis.

Ambulance Services – A state-licensed emergency vehicle which carries injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.

Authorized Service(s) – A Covered Service rendered by any provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by the Claims Administrator to be paid at the Network level. The Member may be responsible for the difference between the Out-of-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Coinsurance, Copayment or Deductible. For more information, see the Claims Payment section *(starting on page 65)*.

Behavioral Health Care – Includes services for mental health disorders, and Substance Abuse.

Benefit Period – The period of time specified in the *Schedules of Benefits* during which Covered Services are rendered, and benefit maximums, Deductibles, Coinsurance limits, and Out-of-Network Coinsurance limits are accumulated. The first and/or last Benefit Periods may be less than 12 months depending on your initial eligibility date and the date your coverage terminates. Generally, this is one calendar year (January 1 through December 31). For Short-Term Disability benefits, the Benefit Period is the maximum amount of benefits available.

Centers of Excellence (COE) Network – A network of health care facilities selected for specific services based on criteria such as experience, outcomes, efficiency, and effectiveness. For example, an organ transplant managed care program wherein Members access select types of benefits through a specific network of medical centers. A network of health care professionals contracted with Anthem or one or more of its affiliates, to provide transplant or other designated specialty services.

Coinsurance – If a Member's coverage is limited to a certain percentage, for example 80%, then the remaining 20% for which the Member is responsible is the Coinsurance amount. The Coinsurance may be capped by the Out-of-Pocket Maximum.

Concurrent Care Claim – A claim that is reconsidered after it is initially approved (such as recertification of the number of days of a Hospital stay or ongoing course of treatment to be provided over a period of time or number of treatments) and the reconsideration results in reduced benefits or a termination of benefits (other than by Fund amendment or termination).

Congenital Anomaly – A condition or conditions that are present at birth regardless of causation. Such conditions may be hereditary or due to some influence during gestation.

Contraceptives – Oral, injectable, implantable, or transdermal patches for birth control.

Contractor or Subcontractor – Contractor or Subcontractor means any person, firm or corporation, who or which is a member of the Ohio Contractors Association, Labor Relations Division, and any person, firm or corporation, who as a Contractor becomes signatory to the Labor Agreement and is engaged in either "Highway Construction," "Heavy Construction," "Railroad Construction," "Sewer, Waterworks and Utility Construction," "Industrial and Building Site," and

"Sewage Plant, Waste Plant, Water Treatment Facilities Construction," "Hazardous Waste Removal," and "Lead Abatement Work," as defined within the jurisdiction.

Coordination of Benefits – A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing an authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

Copayment – A cost-sharing arrangement in which a Member pays a specified charge for a Covered Service, such as the Copayment indicated in the Schedule of Benefits for an Office Visit. The Member is usually responsible for payment of the Copayment at the time the health care is rendered. Copayments are distinguished from Coinsurance as flat dollar amounts rather than percentages of the charges for services rendered and are typically collected by the provider when services are rendered.

Cosmetic Surgery – Any non-Medically Necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Cosmetic Surgery includes but is not limited to rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of Cosmetic Surgery.

Covered Individual or Covered Person or Covered Dependent – A Member or Dependent who is covered under the medical, prescription drug, hearing, or vision benefits under the Fund and is listed on the Enrollment/Beneficiary Card of the Member on file at Ohio Laborers Benefits.

Covered Services or Covered Expenses – Medically Necessary health care services, supplies, and expenses that are: (a) defined as Covered Services in the Member's Plan, (b) not excluded under such Plan, (c) not Experimental/Investigative (except where costs for these items and services are provided in connection with participation in a clinical trial and federal law requires these items and services be covered), and (d) provided in accordance with such Plan.

Covered Transplant Procedure – Any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined Anthem including necessary acquisition procedures, harvest, and storage, and including Medically Necessary preparatory myeloablative therapy.

Custodial Care – Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-Hospital Skilled Nursing Facility care; (c) is a level such that the Member has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Member's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Member, general maintenance care of colostomy or ileostomy, Routine Services to maintain other services which, in the sole determination of the Plan, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

Deductible – The portion of the bill you must pay before your medical expenses become Covered Services.

Dependent – An individual that is or can be covered under the Plan based on your familial or legal relationship to the individual. See page 34 for a list of individuals you can enroll as "Dependents" under the Plan and enrollment requirements.

Detoxification – The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient to a minimum.

Developmental Delay – The statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching age-appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or an injury.

Durable Medical Equipment – Equipment which is (a) made to withstand prolonged use; (b) made for and mainly used in the treatment of a disease of injury; (c) suited for use while not confined as an Inpatient at a Hospital; (d) not normally of use to persons who do not have a disease or injury; (e) not for exercise or training.

Drug Abuse – A condition classified as a mental disorder and described in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) or the most recent version, as drug dependence abuse or drug psychosis.

Emergency Medical Condition or Emergency Services or Emergency Care or Medical Emergency – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Enrollment/Beneficiary Card – Enrollment card that must be completed by the eligible Member and accepted by the Fund in order to receive benefits for the eligible Member and his or her eligible Dependents.

Experimental/Investigative – Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which the Claims Administrator determines to be unproven.

The Claims Administrator will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if the Claims Administrator, determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- Has been determined by the FDA to be contraindicated for the specific use; or
- Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- Is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by the Claims Administrator. In determining whether a Service is Experimental/Investigative, the Claims Administrator will consider the information described below and assess whether:

- The scientific evidence is conclusory concerning the effect of the service on health outcomes;
- The evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- The evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- The evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by the Claims Administrator to determine whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- Documents issued by and/or filed with the FDA or other federal, state, or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Documents of an IRB or other similar body performing substantially the same function; or
- Consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Medical records; or
- The opinions of consulting providers and other experts in the field.

The Claims Administrator has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

Freestanding Ambulatory Facility – A facility, with a staff of Physicians, at which surgical procedures are performed on an Outpatient basis-no patients stay overnight. The facility offers continuous service by both Physicians and registered nurses (R.N.s). It must be licensed by the appropriate agency. A Physician's office does not qualify as a Freestanding Ambulatory Facility.

Group Health Plan or Plan – An employee welfare benefit plan (as defined in Section 3(1) of ERISA, established by the Fund, in effect as of the effective date.

Health Insurance Issuer – The insurer known as Anthem Medicare, until further notice.

Home Health Care – Care, by a licensed program or provider, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician.

Home Health Care Agency – A provider who renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician. It must be licensed by the appropriate agency.

Hospice – A provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's Physician. It must be licensed by the appropriate agency.

Hospice Care Program – A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual, and social needs of the terminally ill Member and his or her covered family members, by providing palliative and supportive medical, nursing and other services through at-home or Inpatient care. The Hospice

must be licensed by the appropriate agency and must be funded as a Hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illnesses.

Hospital – An institution licensed by the appropriate agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment, and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "Hospital" does not mean other than incidentally:

- An extended care facility; nursing home; place for rest; facility for care of the aged;
- A custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training, or non-medical personal services; or
- An institution for exceptional or disabled children.

Incurred – A charge will be considered Incurred on the date a Covered Individual receives the service or supply for which the charge is made.

Ineligible Provider – A provider which does not meet the minimum requirements to become a contracted provider with the Claims Administrator. Services rendered to a Member by such a provider are not eligible for payment.

Infertile or Infertility – The condition of a presumably healthy Member who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual vaginal intercourse. This does not include conditions for men when the cause is a vasectomy or orchiectomy or for women when the cause is tubal ligation or hysterectomy.

Inpatient – A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Legal Guardian – An individual who is either the natural guardian of a child or who was appointed a guardian of an individual in a legal proceeding by a court having the appropriate jurisdiction.

Maternity Care – Obstetrical care received both before and after the delivery of a child or children. It also includes care for miscarriage or abortion. It includes regular nursery care for a newborn infant as long as the mother's Hospital stay is a covered benefit, and the newborn infant is an eligible Dependent under the Plan.

Maximum Allowed Amount – The maximum amount that the Plan will allow for Covered Services you receive. For more information, see the Claims Payment section.

Medical Necessity or Medically Necessary

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease, or injury and that is determined by the Claims Administrator to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Member's condition, illness, disease or injury;
- Obtained from a provider;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
- Cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member's illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate;

- Not Experimental/Investigative;
- Not primarily for the convenience of the Member, the Member's family or the provider.
- Not otherwise subject to an exclusion under this Benefit Booklet.

The fact that a provider may prescribe, order, recommend, or approve care, treatment, services, or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary or a Covered Service and **does not** guarantee payment

Medicare – The program of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Medicare Approved – The status of a provider that is certified by the United States Department of Health and Human Services to receive payment under Medicare.

Member – An employee of a Contractor covered by a Collective Bargaining Agreement in effect between the Contractor and the Union or a Local Union and as to whom Contractor contributions are made by the Contractor who is eligible for benefits under Class 1; a former employee of a Contractor who is disabled due to end stage renal disease and is eligible for benefits, as described in Class 2; or a Retired Member. A Member and his or her eligible Dependents will be eligible for benefits under the Fund and will be considered Covered Individuals after he or she meets the eligibility requirements as described on pages 18-33.

Network Provider – A Physician, health professional, Hospital, Pharmacy, or other individual, organization and/or facility that has entered into a contract, either directly or indirectly, with the Claims Administrator to provide Covered Services to Members through negotiated reimbursement arrangements.

Non-Covered Services – Services that are not benefits specifically provided under the Plan, are excluded by the Plan, are provided by an Ineligible Provider, or are otherwise not eligible to be Covered Services, whether or not they are Medically Necessary.

Non-Participating – The status of a physician or other provider that does not have an agreement with a Claims Administrator about payment for Covered Services.

Office Visit – Office Visits include medical visits or Outpatient consultations in a Physician's office or patient's residence. A Physician's office can be defined as a medical/office building, Outpatient department of a Hospital, freestanding clinic facility, or a Hospital-based Outpatient clinic facility.

Ohio Laborers Benefits *(previously known as OLFBP or Ohio Laborers Fringe Benefit Programs, also referred to as Fund Office)* **–** The office designated for day-to-day administration of the Fund, including the claims administration for non-health care claims, enrollment, and eligibility determination.

Out-of-Network Provider – A provider, including but not limited to, a Hospital, Freestanding Ambulatory Facility (Surgical Center), Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services or supplies, that does not have an agreement or contract with the Claims Administrator to provide services to its Members at the time services are rendered. Benefit payments and other provisions of this Plan may be reduced or limited when a Member uses the services of Out-of-Network Providers.

Out-of-Pocket Maximum – The maximum amount of a Member's Coinsurance payments during a given calendar year. When the Out-of-Pocket Maximum is reached, the level of benefits is increased to 100% of the Maximum Allowed Amount for Covered Services, exclusive of Copayments and other scheduled charges.

Outpatient – The status of a Covered Person who receives services or supplies through a Hospital, other facility provider, Physician, or other professional provider while not confined as an Inpatient.

Physical Therapy – The care of disease or injury by such methods as massage, hydrotherapy, heat, or similar care.

Physician – Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O., any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery; Optometrists and Clinical Psychologists (PhD) are also providers when acting within the scope of their licenses, and when rendering services covered under this Plan.

Plan – The arrangement chosen by the Board of Trustees of the OLDC-OCA Insurance Fund to fund and provide for delivery of the Employer's health benefits.

Plan Administrator – The person or entity named (Ohio Laborers Benefits) by the Plan Sponsor to manage the Plan and answer questions about Plan details. The Plan Administrator is not the Claims Administrator, with the exception of Death, Accidental Death & Dismemberment, and Short Term Disability benefits.

Plan Sponsor – The Plan Sponsor is the Board of Trustees of the OLDC-OCA Insurance Fund. It is the legal entity that has adopted the Plan and has authority regarding its operation, amendment, and termination. The Plan Sponsor is not the Claims Administrator.

Post-Service Claim – A claim for Fund benefits that is not a Pre-Service Claim. When you file a Post-Service Claim, you have already received the services in your claim.

Precertification – Procedure for reviewing and approving certain health care services prior to the services being rendered. Failure to follow Precertification procedures may result in the reduction or denial of benefits.

Prescription Drug (Federal Legend Drug) – Any medication, which by federal or state law may not be dispensed without a prescription order.

Pre-Service Claim – A claim for Fund benefits where Precertification is required before you obtain care.

Prior Authorization – Procedure for reviewing and approving certain prescription drugs. Failure to follow prior authorization procedures may result in the reduction or denial of benefits. The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

QMCSO, or MCSO – Qualified Medical Child Support Order or Medical Child Support Order – A QMCSO creates or recognizes the right of a child who is recognized under the order as having a right to be enrolled under the health benefit Plan to receive benefits for which the Member is entitled under the Plan; and includes the name and last known address of the Member and each such child, a reasonable description of the type of coverage to be provided by the Plan, the period for which coverage must be provided and each Plan to which the order applies.

An MCSO is any court judgment, decree, or order (including a court's approval of a domestic relations settlement agreement) that:

- Provides for child support payment related to health benefits with respect to the child of a Group Health Plan Member or requires health benefit coverage of such child in such Plan, and is ordered under state domestic relations law; or
- Enforces a state law relating to medical child support payment with respect to a Group Health Plan.

Residential Treatment Facility – A facility that provides care on a 24 hour a day, 7 days a week, live-in basis for the evaluation and treatment of residents with psychiatric or Chemical Dependency disorders. The facility provides room and board as well as providing an individual treatment plan for the chemical, psychological, and social needs of each of its residents. The facility meets all regional, state, and federal licensing requirements. The residential care treatment program is supervised by a professional staff of qualified Physician(s), licensed nurses, counselors, and social workers. Residents do not require care in an acute or more intensive medical setting.

Retired Members – A former employee of one or more Contractors described under Class 3 or Class 4 of the *Eligibility* Section of this booklet.

Routine Services – Services not considered Medically Necessary.

Semiprivate Room – A Hospital room which contains two or more beds.

Sickness – A Sickness or disease (including pregnancy) that causes loss covered by the Fund, which commences while the Covered Individual is eligible.

Skilled Convalescent Care – Care required, while recovering from an illness or injury, which is received in a Skilled Nursing Facility. This care requires a level of care or services less than that in a Hospital, but more than could be given at the patient's home or in a nursing home not certified as a Skilled Nursing Facility.

Skilled Nursing Facility – An institution operated alone or with a Hospital which gives care after a Member leaves the Hospital for a condition requiring more care than can be rendered at home. It must be licensed by the appropriate agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise determined by Anthem to meet the reasonable standards applied by any of the aforesaid authorities.

Spouse – The Member's legal Spouse.

Substance Abuse or Chemical Dependency – Any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal. Substance Abuse services include:

Substance Abuse Rehabilitation Services, procedures and interventions to eliminate dependence on or abuse of legal and/or illegal chemical substances, according to individual treatment plans;

Substance Abuse Services within a General Hospital Facility (a general Hospital facility that provides services, on an Inpatient, 24-hour basis, for medical Detoxification and treatment of conditions associated with the addiction to or misuse of alcohol or other drugs.

Therapeutic Equivalent – Therapeutic/Clinically Equivalent drugs are drugs that can be expected to produce similar therapeutic outcomes for a disease or condition.

Total Disability (for a Member only) – The inability to perform the substantial and material duties of his or her occupation or employment as a result of injury or Sickness.

Transplant Providers – Network Transplant Provider - A provider that has been designated as a "Center of Excellence" for Transplants by Anthem and/or a provider selected to participate as a Network Transplant Provider by a designee of Anthem. Such provider has entered into a Transplant Provider agreement to render Covered Transplant Procedures and certain administrative functions to you for the transplant network. A provider may be a Network Transplant Provider with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Transplant Providers – Out-of-Network Transplant Provider - Any provider that has NOT been designated as a "Center of Excellence" for Transplants by Anthem nor has not been selected to participate as a Network Transplant Provider by a designee of Anthem.

United States – All the states, District of Columbia, the Virgin Islands, Puerto Rico, American Samoa, Guam, and the Northern Mariana Islands.

Urgent Care – Services received for a sudden, serious, or unexpected illness, injury, or condition. Urgent Care is not considered an emergency. Care is needed right away to relieve pain, find out what is wrong, or treat a health problem that is not life-threatening.

Urgent Care Claim – A claim for medical care or treatment that would:

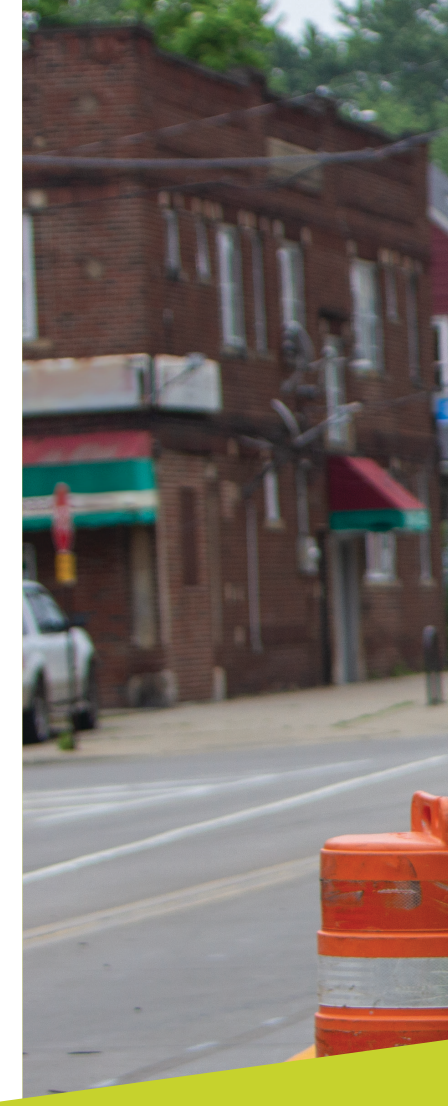
- Seriously jeopardize your life, health, or ability to regain maximum function if normal Pre-Service Claim standards were applied; or
- Subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a Physician with knowledge of your condition.

Utilization Review – A function performed by Anthem or by an organization or entity selected by Anthem to review and approve whether the services provided are Medically Necessary, including but not limited to, whether acute hospitalization, length of stay, Outpatient care or diagnostic services are appropriate.

We, Our, Us, Fund, and Plan – The OLDC-OCA Insurance Fund, and/or the Board of Trustees, and any agent authorized by the Board of Trustees to act on their behalf.

You – Participant of the Fund.

OHIO LABORERS Benefits



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