International Union of Operating Engineers Local 4
Health & Welfare Plan Document

Trustees

Union Trustees

Michael J. Bowes, Chairman
Paul C. DiMinico
David F. Shea, Jr.

Employer Trustees

Angelo Colasante
David Marr, Jr.
James Reger

Business Manager
Michael J. Bowes

Administrator
Gregory Geiman, Esq.

SECTION I:
Eligibility Rules and Coverage Options

Health and Welfare Plan

As a Participant in the International Union of Operating Engineers Local 4 Health and Welfare Plan (the "Plan" or "Fund"), you are covered by a comprehensive benefits program. The Plan is designed to protect and provide for you and your family through a broad range of unexpected events and extraordinary expenses. This document is intended to satisfy the requirements for a Plan Document and Summary Plan Description ("SPD" as specified in the Employee Retirement Income Security Act (ERISA)). You can determine your rights under the Plan by consulting this SPD. The Fund has made every effort to make this SPD as accurate as possible. This SPD was published in December 2025 and is effective for benefits on and after January 1, 2026. It replaces all issues of *The Gauge*, SPDs and Plan Documents previously published or made available. The Board of Trustees expects to continue this benefit Plan indefinitely, but reserves the right to change or terminate the Plan at any time. If the Plan is terminated, benefits will be settled according to provisions of the Plan and the Trust Agreement.

Eligibility

As an Employee, you earn eligibility for health and welfare benefits once you accumulate sufficient work hours during a calendar year as described in the *Basic Eligibility Rule*. You are then covered under the comprehensive Basic Benefits Plan for the 12-month period beginning the following March 1 through February 28 (or February 29 during a leap year).

Your eligibility for health and welfare benefits is determined as contributing employers submit remittance reports to the Funds Office. Based on these reports, the Funds Office reviews the number of hours you worked to determine whether you are eligible for coverage during the current benefit period under the Basic A, Basic B, Supplemental A, or Supplemental B Eligibility Rule. Hours you worked during an eligibility period may not be carried over to any other eligibility period.

Each participating employer remits a monthly report, which is due the 19th of the month following the month in which the work was performed. The hours reported on the 19th of the month relate to the hours you worked the preceding month. Initial eligibility ("initial" can be either the first time you become eligible or when you regain eligibility after a lapse in coverage) is earned under the Supplemental Eligibility Rule. Subsequent, consecutive eligibility is earned under the Basic Eligibility Rule.

Target Contribution Rate

Beginning in 2026, a Participant's eligibility for health and welfare benefits will be determined, in part, upon the level of the employer's contribution rate made to the Plan on the Participant's behalf for each

payroll hour in Covered Employment. If an employer fails to remit contributions during a calendar year at a level determined by the Trustees, known as the "Target Contribution Rate," a Participant will only be eligible for "B-level" coverage during the subsequent (or current) Plan year, as described herein. In the event a Participant works for multiple contributing employers or for the same employer at different contribution rates during a calendar year, the Participant's eligibility in the following Plan year will be based upon the average contribution rate at which they worked during that calendar year.

TARGET CONTRIBUTION RATE ("TCR")

March 1, 2026 (for Plan Year Eligibility 3/1/26 – 2/28/27)	$9.00
March 1, 2027 (for Plan Year Eligibility 3/1/27 – 2/29/28)	$10.00
March 1, 2028 (for Plan Year Eligibility 3/1/28 – 2/28/29)	$11.00
Beginning March 1, 2029 and each March 1 thereafter	TCR is 2/3 of H&W contribution rate in Master Document

Basic Eligibility Rule

As an Employee, you must work 1,000 or more credited hours (1,500 or more if you are a Participant in Local 4D, or 2,000 or more hours if you are a Participant in Local 4D working for an employer whose health and welfare contribution rate is not at or above the applicable TCR) during a calendar year to become eligible for comprehensive health and welfare benefits under the Basic Eligibility Rule. You are then covered under the comprehensive Basic Benefits Plan for the 12-month period beginning the following March 1 through February 28 (or February 29 during a leap year). If your employer during the prior calendar year failed to remit health and welfare contributions for your payroll hours at a rate that meets the TCR, you will be on the Basic B Plan, which has a higher medical plan deductible and higher coinsurance and Copays, as detailed more fully under Section II: Medical and Prescription Drug Coverage. Otherwise, you will be on the Basic A Plan.

If you are a Participant in Local 4D covered by an Equipment House Contract, in the calendar year in which you receive your first credited hour as a member of Local 4D, you will become eligible for comprehensive health and welfare benefits under the Basic Eligibility Rule for the 12-month period beginning the following March 1 through February 28 (or February 29 during a leap year) if you remain employed working under an Equipment House Contract as of December 31 of that same year and you work 1,000 or more credited hours in that same calendar year. Your employer must remit contributions for your hours at or above the Target Contribution Rate during the applicable work year for this provision to apply.

In all calendar years *after* the year in which you receive your first credited hour as a member of Local 4D, you will need to work 1,500 or more hours (or 2,000 or more hours if you are a Participant in Local 4D working for an employer whose health and welfare contribution rate is not at or above the TCR), if you remain a Participant in Local 4D, to become eligible under the comprehensive Basic Benefits Plan for the 12-month period beginning the following March 1.

If you work for both Local 4 and Local 4D employers in the course of a calendar year, your eligibility requirement is based upon the employer(s) for whom you worked the *majority* of your hours in that calendar year.

For example, if you worked 650 hours for a Local 4 employer and 500 hours for a Local 4D employer, then your eligibility would be based on the Local 4 rule and your 1,150 total hours would exceed the 1,000-hour threshold and you would be eligible for coverage in the next eligibility period. However, if you worked 500 hours for a Local 4 employer and 650 hours for a Local 4D employer, then your eligibility would be based on the Local 4D rule and your 1,150 total hours would not exceed the 1,500-hour threshold, and you would not be eligible for coverage in the next eligibility period.

If you work for multiple Local 4D employers in the course of a calendar year, some of which remit health and welfare contributions at or above the TCR and some of which do not, the applicable rate used in determining your eligibility will be the *average* health and welfare contribution rate remitted for your payroll hours in the preceding calendar year, up to the first 1,500 hours paid (for Basic Plan coverage) or in that calendar year (for Supplemental Plan coverage). For example, if in 2026 you worked 1,200 hours for a Local 4D employer that remitted contributions at $10/hour and then worked 800 hours for a different Local 4D employer that remitted health and welfare contributions at $7 per hour, your average contribution rate for the calendar year would be $9.40 ((1,200 x $10) + (300 x $7) / 1,500). This would be above the $9.00 TCR for 2026, and you would be eligible for the Basic A Plan beginning the following March 1, 2027.

A non-collectively bargained Employee covered under a Participation Agreement must work 1,000 or more credited hours to become eligible for comprehensive health and welfare benefits under the Basic Eligibility Rule and will then be covered under the comprehensive Basic Benefits Plan for the 12-month period beginning the following March 1 through February 28 (or February 29 during a leap year).

There are certain contributing employers who contract with Local 4 to pay benefit contributions to the Fund for a minimum number of hours per month in exchange for the Fund providing immediate eligibility for their Local 4 Employees.

All Office Employees are eligible to participate in the Local 4 Health and Welfare Fund. An Office Employee participates in the Plan if their Office employer signs a Participation Agreement with the Fund covering that Office Employee's classification. An Office Employee covered by the Participation Agreement will be eligible under the comprehensive Basic Benefits Plan on the first day of the month following employment with the Office employer provided that contributions are made on the Office Employee's behalf. Continued eligibility for a newly-hired Office Employee under the Basic Benefits Plan is contingent upon that Office Employee remaining employed and having contributions remitted on all payroll hours, until such time as the Office Employee has worked 1,000 or more hours in a calendar year. Once the newly-hired Office Employee has worked the required 1,000 or more hours in a calendar year, the Office Employee will be eligible for benefits under the Basic Eligibility Rule for the 12-month period beginning the following March 1 through February 28 (or February 29 during a leap year). Eligibility under the Basic Benefits Plan for a newly-hired Office Employee who has not yet worked 1,000 hours in a calendar year will terminate on the first day of the calendar month following termination of employment. In all cases, continued eligibility after termination of employment will be based on the Health and Welfare Fund's eligibility rules and in accordance with the applicable provisions of this SPD.

If you cannot meet the requirements of the *Basic Eligibility Rule*, you may become eligible for health and welfare benefits under the alternative requirements of the *Supplemental Eligibility Rule* below.

Supplemental Eligibility Rule

As an Employee, including in 4D covered by an Equipment House Contract, or as a non-collectively bargained Employee covered under a Participation Agreement, you will become eligible for coverage under the *Supplemental Benefits Plan* on the first day of the first month *following* the month you work 500 or more credited hours during the calendar year (700 or more credited hours if you are a Participant in Local 4D working for an employer whose health and welfare contribution rate is not at or above the applicable TCR). The applicable TCR will be the one that was in effect as of the *date you began* earning hours toward Supplemental coverage, even if you earn such coverage in January or February of the subsequent calendar year.

If you are enrolled under the Supplemental Benefits Plan, you are not eligible for weekly accident and sickness benefits or eligible to earn Disability Credit, unless you purchase these benefits through the Bridge Plan.

If you become eligible under the Supplemental Eligibility Rule and your employer remits contributions to the Plan for your payroll hours at a rate that meets the TCR, you will be covered under the Supplemental A Plan through the following February 28 (or February 29 during a leap year). All Participants enrolled in the Supplemental A Plan will pay higher prescription drug Copays and will have a prescription drug deductible. If your employer fails to remit health and welfare contributions for your payroll hours at a rate that meets the TCR, you will be enrolled in the Supplemental B Plan, which also has higher medical plan deductibles, coinsurance, and Copays, in addition to a higher prescription drug deductible and Copays, as detailed more fully under Section II: Medical and Prescription Drug Coverage.

If you are a Participant in Local 4D covered by an Equipment House Contract, and:

- You Earned Coverage under the Supplemental Eligibility Rule in the prior calendar year;
- The prior calendar year was the calendar year in which you received your first credited hour as a member of Local 4D;
- You did not earn coverage under the Basic Eligibility Rule for the 12-month period commencing on March 1 of the following calendar year; and
- Your coverage under the Supplemental Eligibility Plan (A or B) is going to terminate as of February 28 (or February 29 of a leap year) of the following calendar year.

You are eligible to remain on the Supplemental Eligibility Plan (A or B) on a month-to-month basis effective March 1 of the following calendar year provided you have worked a minimum of 160 hours in each of the months of January and February of the following calendar year and continue to work at least 160 hours per month in the following calendar year, until such time as you again become eligible for coverage under the Supplemental Eligibility Rule described above.

Examples of the Supplemental and Basic Eligibility Rules:

If you work 500 or more credited hours beginning January 1, 2026 (or 700 or more hours if you are a Participant in Local 4D working for an employer whose health and welfare contribution rate is not at or above the applicable TCR), you will become eligible under the Supplemental Eligibility Rule, as described above, on the first day of the month following the month in which you reached 500 or 700 credited hours, as applicable.

Let's assume your employer contributes at the TCR and you work 160 hours each month in March, April, May and June 2026. Your Supplemental coverage would begin on July 1, 2026, and would terminate on February 28, 2027.

Let's assume your employer does not contribute at the TCR and you work 160 hours each month in March, April, May, June, and July 2026. Your Supplemental coverage would begin on August 1, 2026 and would terminate on February 28, 2027.

If you meet the hours requirement applicable to you below in 2026, you would become eligible under the Basic Eligibility Rule for coverage under the Basic Benefits Plan starting on March 1, 2027, and continuing through February 29, 2028.

- Local 4 Participant – 1,000
- Local 4D Participant – 1,500
- Local 4D Participant (not receiving contributions at TCR) – 2,000

Basic and Supplemental Benefits Plan Coverage

Participants who earn coverage receive the following benefits depending on the level of eligibility they have earned:

Plan	Basic A	Basic B	Supplemental A	Supplemental B
Medical Plan	Coverage	Coverage (with increased deductible, coinsurance, and Copays)	Coverage	Coverage (with increased deductible, coinsurance, and Copays)
Prescription Drug Plan	Coverage	Coverage (with increased Copays)	Coverage (with increased Copays)	Coverage (with increased Copays)
Dental Plan	Coverage	No coverage	No coverage	No coverage
Hearing Plan	Coverage	No coverage	No coverage	No coverage
Vision Plan	Coverage	No coverage	No coverage	No coverage
Life Insurance	Coverage	Coverage	No coverage	No coverage
Accidental Death and Dismemberment	Coverage	Coverage	No coverage	No coverage
Loss of Time	Coverage	Coverage	No coverage	No coverage

Bridge Plan

Participants insured through the Supplemental A Plan are eligible to purchase all of the Basic A Benefits Plan benefits through the Bridge Buy-In Plan if purchased when they are first eligible for benefits under the Supplemental A Plan Eligibility Rule. Participants insured through the Supplemental B Plan are *not eligible* to purchase the Basic Benefits Plan, and Participants insured through the Basic B Plan are *not eligible* to buy up to the Basic A Plan benefits. Contact the Funds Office for premium information. Benefits under the Bridge Buy-In Plan include the same benefits as under the Basic Benefits Plan: Medical, Prescription, Dental, Hearing, Vision, Life Insurance, Accidental Death and Dismemberment, and Weekly Accident and Sickness (Loss of Time) benefits.

Disability Credit

If you are at risk of losing eligibility for Health and Welfare Plan coverage because you were unable to accumulate work hours while Totally Disabled (whether or not you were collecting Workers' Compensation) and/or because you were receiving state paid medical or family leave, you may be credited with up to six hours per day (up to 30 hours per week) for each week you were unable to accumulate work hours, up to a maximum of 1,560 hours. If Disability Credit is granted, you must use the full amount based on the dates certified. Partial credit will not be granted. However, if you have already earned eligibility for the subsequent Plan Year through work performed before the date you become Totally Disabled, you may petition to have the Plan pend the beginning of your Disability Credit until the first day of the following calendar year. You may not earn more than 52 weeks of Disability Credit in any consecutive five-year period.

You will be insured at the same level of coverage (Basic A or B) as you received as of your last Earned Coverage period.

If you believe you are entitled to Disability Credit, please contact the Funds Office, or visit www.local4funds.com, to obtain a Disability Credit application form. You must submit satisfactory proof to the Plan that you are: (1) receiving state paid medical or family leave; (2) receiving a weekly Workers' Compensation benefit; and/or (3) that you are Totally Disabled, in which case your medical provider's verification will be required. You will be considered Totally Disabled if, as the result of an illness or accidental injury, you are unable to engage in any work for pay for which you are suited by education, training or experience. You must not be performing any work of any kind for wage or profit, and you must be under the care of a medical physician or surgeon to receive weekly accident and sickness benefits once you are deemed eligible for them. Please see the definition on Page 104.

You must, however, meet the additional following criteria to receive Disability Credit: (1) be eligible under the Basic A Benefits Plan or the Bridge Buy-In Plan as of the date your disability commences or the date you start receiving state paid family leave benefits, whichever is earlier; (2) have been continuously eligible for Plan benefits for at least 12 months prior to the onset of the disability or the start of the state paid leave, whichever is earlier; and (3) apply for the Disability Credit no later than 24 months after losing Earned Coverage. You may receive medical or family leave credit for a maximum of 26 weeks.

Special Emergency Eligibility Rule

An Employee may be permitted to gain eligibility for medical benefits coverage under the Supplemental A/B Plan effective as of the first day of

the month in which they have earned 500 or 700 hours, as applicable, if the Employee has an emergency need for medical benefits coverage as a result of hospitalization of the Participant or their Dependent if all of the following requirements are met:

- The Employee has earned more than 500 or 700 hours, as applicable, since January 1st of the current calendar year and as of the date of the request for emergency eligibility; and
- The Employee will be eligible under the regular eligibility rules for the Supplemental Plan within 10 days of the request for emergency eligibility; and
- The Employee provides certification or documentation in a form acceptable to the Fund that they have no medical insurance coverage; and
- The Employee provides acceptable documentation or certification that the Employee or their Dependent has an emergency need for medical care as a result of hospitalization of the Participant or Dependent.

Benefits Buy-In Plan

If you do not have enough hours for health plan coverage, you may be able to buy into the Plan through a special arrangement referred to as the Benefits Buy-In Plan. The buy-in premium amount depends on the number of hours you worked in the previous year for which Health and Welfare contributions were paid to the Plan. The Benefits Buy-In Plan credits you with the hours you have earned to reduce your premium cost for the Plan.

The Benefits Buy-In Plan premium is based on the following formula: 1,500 hours for Local 4, 1,800 hours for Local 4D, or 2,300 hours for Local 4D not receiving contributions at the TCR, less the total of your earned hours, multiplied by the current Master Document health and welfare hourly contribution rate. Local 4D Participants whose employer did not remit contributions at the TCR in the last calendar year in which the Participant performed covered work are only eligible to buy into the Basic B Plan, with the premium to be based on the formula above.

Formula example for Local 4 member:

1,500 Hours (Cost of the Plan)
- 470 Worked Hours
=1,030 Balance of Hours
1,030 Balance of Hours
× $16.55 Example Contribution Rate
= $17,046.50 Total Yearly Cost You Will Pay ($4,261.63 is due each quarter)

Benefits can be purchased on this basis for a maximum of two consecutive years if you are not working but are looking for work as certified by your Business Agent (a Buy-In Affidavit must be completed) or until you are eligible for Supplemental Plan benefits.

If you elect to continue coverage under Benefits Buy-In or the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and later become eligible due to earned hours, any premium paid from the date you become eligible will be reimbursed.

Once your eligibility under the Benefits Buy-In Plan has terminated, you must exercise your COBRA rights in order to maintain coverage. See Continuing Your Coverage (COBRA).

Making Changes to Your Coverage/Special Enrollment Rights

Group health plans must allow individuals (who are otherwise eligible) to enroll upon certain specified events regardless of any late enrollment provisions if enrollment is requested within 60 days of the event.

Changes to your coverage once you are already enrolled are effective as of the date your change in status occurs, provided the required Proof Documents are received within 60 days of the event. For example, if you marry or have a child, your coverage extends to your new Spouse or Dependent as of the date of marriage, birth or adoption, provided the Funds Office receives the required documents within 60 days of the marriage, birth or adoption. Otherwise, the effective date of coverage will be on the first day of the month following the month in which the Proof Documents are received by the Funds Office.

To add a Dependent, the Funds Office requires a certified copy of your marriage certificate or your child's long-form birth certificate from the applicable state or local registry, or the court documents related to the adoption. See Proof Documents to Add Eligible Dependents to the Health Plan for more information.

The Fund also requires the Social Security number of each person covered by the Plan.

The Plan provides for Special Enrollment as follows:

Newly Acquired Spouse and/or Dependent Child(ren)

If you are enrolled for individual coverage and you acquire a Spouse by marriage, or if you acquire any Dependent Children by birth, adoption or placement for adoption, you may enroll your newly acquired Spouse and/or any Dependent Child(ren) no later than 60 days after the date of marriage, birth, adoption or placement for adoption. Contact the Funds Office for information on how to enroll a new Spouse or Child.

- If you are not enrolled for individual coverage and you acquire a Spouse by marriage, or if you acquire any Dependent Children by birth, adoption or placement for adoption, you will become enrolled and you may enroll any newly acquired Spouse and/or any Dependent Child(ren) no later than 60 days after the date of marriage, birth, adoption or placement for adoption.
- If you did not enroll your Spouse for coverage within 60 days of the date on which they became eligible for coverage, and you subsequently acquire a Dependent Child by birth, adoption or placement for adoption, you may enroll your Spouse together with your newly acquired Dependent Child no later than 60 days after the date of your newly acquired Dependent Child's birth or placement for adoption.

Loss of Other Coverage

If:

- You did not enroll your Spouse and/or any Dependent Child(ren) for coverage within 60 days after the date on which you or they first became eligible for coverage because you or they had health care coverage under any other health insurance policy or program or employer plan, including COBRA Continuation Coverage, individual insurance, Medicare, Medicaid or other public program; and
- You, your Spouse and/or any Dependent Child(ren) cease to be covered by that other health insurance policy or plan; you may enroll yourself and/or that Spouse and/or Dependent Child(ren) within 60 days after the termination of their coverage under that other health insurance policy or plan if that other coverage terminated because:
  - Of the loss of eligibility for that other coverage as a result of

termination of employment or reduction in the number of hours of employment, or as a result of death, divorce or legal separation; or

- Of the termination of employer contributions toward that other coverage; or
- If that other coverage was COBRA Continuation Coverage, the coverage was "exhausted." COBRA Continuation Coverage is "exhausted" if it ceases for any reason other than either the failure of the individual to pay the applicable COBRA premium on a timely basis, or for cause (such as making a fraudulent claim). For example, COBRA coverage is considered "exhausted" when the 18- or 36-month maximum coverage period expires or when the individual no longer resides, lives or works in a service area of the Plan (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual.

Also, an individual may be eligible for Special Enrollment even if they did not have other health coverage when they initially refused to enroll in the Fund. This may occur if, after subsequently obtaining other health coverage, they later lose that other health coverage.

Finally, if you or your Dependent loses eligibility for Medicaid or the Children's Health Insurance Program (CHIP), or becomes eligible to participate in a premium assistance program under Medicaid or CHIP, you may enroll yourself or your eligible Dependent in the Fund's health coverage if you request enrollment within 60 days of the loss of Medicaid or CHIP coverage, or the date you or your Dependent are determined to be eligible for a Medicaid or CHIP premium assistance program.

Participants are always eligible for enrollment, including enrollment of their eligible Dependents, upon earning the requisite number of hours.

If you have any questions about your Special Enrollment Rights, contact the Funds Office.

If You Are a Pensioner in the IUOE Local 4 Pension Plan

Earned Coverage

Regardless of your age and your Spouse's age when you retire, you, your Spouse and any eligible covered Dependents remain covered under the Plan until your Earned Coverage expires.

After you retire, you, your eligible covered Spouse and your eligible covered Dependents may remain covered under the Medical, Prescription Drug, Dental, Hearing, and Vision Plans, provided you were covered under the Health and Welfare Plan Basic A Plan for at least five out of the seven benefit periods preceding your retirement date. Only the Spouse to whom you are married when you retire is eligible for health coverage upon your retirement.

Your Weekly Accident and Sickness, Life Insurance, and Accidental Death and Dismemberment (AD&D) benefits terminate when your Earned Coverage ends. You may be eligible to convert your Life and AD&D insurance to individual policies at this time. See Life Insurance Plan and AD&D Insurance Plan for details.

Extended Coverage — Regular, Disability, or Early Retirement

Eligibility

After your Earned Coverage expires, you may purchase Extended Coverage. You are eligible to purchase Extended Coverage if you were covered under the Health & Welfare Basic A Plan for at least five out of the seven benefit periods preceding your retirement date and:

- You are eligible for Basic A benefits on the effective date of your retirement under the International Union of Operating Engineers, Local 4 Pension Plan; or
- You retire on a disability pension; or
- Your pension effective date falls on or after the date you reach age 62.

Coverage Options and Duration

Your Extended Coverage benefits and duration vary depending on your age and your Spouse's age when you retire. If you meet the Extended Coverage eligibility rules outlined above, there are three coverage options:

Regular Retirement and Disability Option: You may buy into this Extended Coverage option if:

- You and your Spouse are at least age 62 when you retire; or
- You are disabled and under age 62 when you retire.

Coverage continues for up to two years, or until you become eligible for Medicare, whichever occurs first.

Early Retirement Option: You may buy into this Extended Coverage option if:

- Both you and your Spouse are under age 62 when you retire; or
- For your Spouse, if your Spouse is under age 62 when you retire.

Coverage continues for up to 10 years, or until you become eligible for Medicare, whichever occurs first. You and your Spouse may qualify for different coverage options depending on your age, your disability status and your Spouse's age. Coverage for your Spouse and/or eligible Dependents may continue under Extended Coverage if they are otherwise eligible and you pay the appropriate premium. If your Spouse is under age 65 and Medicare eligible due to a disability when you retire, they may be eligible for up to 18 months of coverage through COBRA. See Continuing Your Coverage (COBRA) for more information.

Retirement Bridge Plan: You are eligible for continued Health and Welfare Basic Plan medical, prescription drug, dental, hearing, and vision coverage at no cost to you (but not your Dependents) if you:

- Retire on or after age 62 or on a disability pension;
- Are eligible for Basic A Plan coverage on the date of your retirement; and
- Have been eligible for coverage under the Basic A Plan in five of the most recent seven benefit periods (March 1 through February 28).

Coverage continues for up to two years, or until you become eligible for Medicare, whichever comes first. If you return to work in Covered Employment after receiving coverage under the Retirement Bridge Plan, you are permitted to maintain your Retirement Bridge coverage and then switch to either the Basic or Supplemental Plans, in accordance with Plan eligibility rules, if you work sufficient hours to earn such coverage.

The period of additional coverage will begin after you have run out the eligibility on your Earned Coverage. For example, if you were to retire on January 1, 2026, at age 62 and had earned 1,000 hours in 2025, you would be covered through your earned hours until February 28, 2027. You would then have coverage through the Retirement Bridge Plan until the earlier of February 28, 2029, or until you become eligible for Medicare. Retirement Bridge Coverage is available only to Participants, but Spouses and Dependents may be eligible to receive extended partially-subsidized coverage (50% of the cost of coverage for regular retirement and disability) if they meet the applicable criteria.

Benefits: Your Extended Coverage benefits vary depending on your coverage option:

- Regular Retirement and Disability Option – Medical, Prescription Drug, Dental, Hearing, and Vision coverage.
- Early Retirement Option – Medical and Prescription Drug coverage.
- Retirement Bridge Plan – Medical, Prescription Drug, Dental, Hearing, and Vision coverage.

Coverage Cost

Your share of the Extended Coverage cost is based on the coverage option you qualify for when you retire. The longer you work under the Plan, the lower your self-payment contribution will be for pensioner medical coverage.

- Regular Retirement and Disability Option – The premium is based on 50% of the cost of coverage, calculated as a minimum of 1,800 hours times the negotiated IUOE Local 4 Master Agreement hourly rate of contribution.
- Early Retirement Option – The premium is based on 100% of the COBRA rates, which are determined each year based on the Plan's past claims experience.
- Retirement Bridge Plan – There is no cost for pensioners on the Retirement Bridge Plan. Your Dependents are not covered under this Plan.

These costs are subject to change from time to time. For details, contact the Funds Office.

Coverage Option	Eligibility	Duration	Benefits	Coverage Cost
Regular Retirement and Disability Option ("PBI 50%")	Retired Member and Spouse age 62 to 65 Retired Member age 62 to 65 Disabled Retired Member under age 62 Eligible Dependent Children up to age 26	Up to 2 years or until Medicare eligible,	Medical, Prescription Drug, Dental, Hearing, and Vision	50% x (1,800 hours x Local 4 Master Agreement hourly contribution rate) / 12*
Early Retirement Option ("PBI 100%")	Retired Member and Spouse under age 62 Spouse under age 62 Eligible Dependent Children up to age 26	Up to 10 years or until Medicare eligible, if earlier	Medical and Prescription Drug	100% of COBRA rate (Individual or Family Rate)

**Formula produces the Two-Person Rate. Individual Rate is half the amount; Family Rate is three times the individual Rate.*

Non-Covered Employment

You immediately cease being a Participant under this Plan if you become employed by an employer who is not required to make contributions to the Plan in a category of employment that otherwise would be considered covered employment under the applicable collective bargaining agreement or Participation Agreement under which you previously worked . In this case, your coverage and your covered Dependents' coverage ends as of the date the Funds Office receives notification that you are no longer working in covered employment.

If you are an apprentice who is terminated by the Hoisting and Portable Engineers Local 4 Apprenticeship and Training Program, you are no longer a Participant as of the date of termination.

If your coverage or your Dependents' coverage ends for the reason cited here, you may continue coverage through COBRA. See Continuing Your Coverage (COBRA).

Reciprocity

To ensure continuous credit under the Health and Welfare Fund, the Plan has reciprocal agreements with many other locals of the International Union of Operating Engineers and an agreement through a National Health and Welfare Reciprocity Agreement. These agreements provide for transfer to this Fund of any contributions made on your behalf to another Fund.

Covering Your Dependents

Once you meet the Plan's eligibility requirements, your eligible Dependents are also covered under the Plan.

Eligible Dependents include:

- Your lawful Spouse, provided they are not legally divorced from you.
- Your married or unmarried child up to age 26, regardless of whether or not the child is eligible for their own employment-based health coverage (unless the child is eligible to be covered as a Participant under this Plan as discussed below).
- A physically or intellectually disabled unmarried child incapable of self-support age 26 or older, provided their disability commenced prior to attaining age 26, for whom you are at least 50% responsible for support and maintenance. See also Children Who Are Disabled.
- For Plan purposes, the term "child" or "children" includes your natural children, legally adopted children, children placed with you for adoption, stepchildren through a current marriage,* foster children, children for whom you have legal guardianship or other children who meet the Plan's eligibility requirements.

**If your stepchild is covered by the Plan and then you divorce the biological parent of the stepchild, and you are not the legal guardian or adoptive parent of the stepchild, the stepchild is no longer eligible for coverage as of the date of divorce (however, coverage for a former stepchild may be extended for up to 36-months by purchasing COBRA Continuation Coverage). See Continuing Your Coverage (COBRA).*

Child means your natural child, legally adopted child, child placed with you for adoption, stepchild (through a current marriage), child for whom you are given legal guardianship or foster child. Your children between age 19 and age 26 can be covered under your Plan, regardless of where they live or their marital status or whether you can claim them as a tax Dependent. Dependents between age 19 and age 26 can enroll in your Plan even if they are eligible for their own employment-based health coverage. Participants who are covering a stepchild will be subject to an annual Dependent eligibility audit to ensure that they remain married to the stepchild's biological parent. Failure to return the annual audit form may result in termination of coverage for you and/or the stepchild.

Children are generally not eligible for Dependent coverage under this Plan if they are eligible for coverage as a Participant. However, children that have begun work under this Plan as a covered Employee that have not yet earned eligibility under the applicable Basic Plan may be allowed to retain coverage as a Dependent under a parent or guardian's Basic

Plan coverage until they have earned their own applicable Basic Plan eligibility in accordance with the Plan Document. This allowance terminates as of March 1 of the year after one full calendar year has passed since the child worked their first credited hour. For example, if a child works their first credited hour in October 2026, this allowance will terminate on March 1, 2028.

Spouse is defined as an individual to whom you are legally married under the laws of the state where the marriage occurred.

In order to determine whether your Dependents qualify under the Plan, you are required to provide a birth certificate or proof of marriage, parentage, adoption or guardianship status; the Dependent's Social Security number (required by law) or status of total disability; or any other documentation that the Funds Office may deem necessary. See Proof Documents Required to Add Eligible Dependents to the Health Plan below.

The Plan also covers your Dependent Children if they are required to be covered under a Qualified Medical Child Support Order (QMCSO). See Qualified Medical Child Support Orders (QMCSOs).

For information on when coverage ends, or to continue coverage for a former Spouse or for a Dependent Child beyond the Plan's age limits, see Continuing Your Coverage (COBRA).

Proof Documents Required to Add Eligible Dependents to the Health Plan

It is the policy of the IUOE Local 4 Health and Welfare Fund to require Proof Documents validating the relationship between our Participant and their Dependents for whom they seek coverage under the Health Plan.

The following is a list of the Proof Documents required by the Plan.

- Lawful Spouse: To add your lawful Spouse to your Health Plan coverage the Fund must receive a certified copy of your marriage certificate. The document will be verified, a copy will be retained at the Funds Office and the original will be mailed back to the Participant.
- Biological Child of the Participant and/or the Biological Child of the Participant's Legal Spouse: To add a biological child to the Health Plan, the Fund must receive a certified copy of the long-form birth certificate. The document will be verified, a copy will be retained at the Funds Office and the original will be mailed back to the Participant. The short/abstract certificate is not acceptable.
- Legally Adopted (or Legal Guardianship) Child: To add to the Health Plan a legally adopted child or child for whom the Participant was given legal guardianship, you are required to provide the court documents relative to the adoption/guardianship of the child, as well as certified copy of the long-form birth certificate from the city/town hall. The document will be verified, a copy will be retained at the Funds Office and the original will be mailed back to the Participant. The short/abstract certificate is not acceptable.
- Disabled Child: If your child is totally disabled, you are also required to provide an Attending Physician's Statement (to be completed by your child's physician). Please contact Blue Cross Blue Shield of Massachusetts at 1-800-460-7690 to obtain the form.

The Plan will not add a Dependent Spouse or child to the Health Plan without the submission of the required documentation by the Participant, which is considered part of a completed request for enrollment. For new Participants the information must be received by the Funds Office within 60 days of the activation of the Health Plan coverage in order for the Dependent Spouse or child to have the same Health Plan effective date as the new Participant; otherwise, the effective date of the Dependent Spouse or child will be on the first day of the month following the month in which the documents are received by the Funds Office.

See Making Changes to Your Coverage/Special Enrollment Rights for details on the applicable coverage effective dates for newly added Dependents.

Social Security Number Requirement

Participants must submit copies of their Social Security number as well as the Social Security numbers of all Dependents who will be covered under the Plan.

Why are the Social Security numbers of all Plan Participants required?

Each quarter, an electronic file containing the demographic information (including the Social Security number) of all Plan Participants is submitted to the Centers for Medicare and Medicaid Services (CMS), as required by law. The numbers are also required to be reported under Massachusetts law for purposes of meeting state health insurance requirements.

Children Who Are Disabled

Your covered child who is physically or mentally incapable of self-support as of age 26 may continue to be covered under the Plan while remaining disabled and unmarried, as long as your own coverage remains in effect. To continue coverage of a child under this provision, the Funds Office must receive proof of the child's disability within 31 days after coverage would otherwise terminate. Any continued coverage is available only to the extent permitted under provisions of the Plan.

You may be required to provide satisfactory proof of continuance of your child's mental or physical disability and have your child examined or to permit an examination at any time or times after receiving proof of your child's ongoing disability. When your child ceases to be so disabled, coverage with respect to that child shall cease at the end of the month in which they are no longer disabled.

When Your Coverage Ends

Your coverage under the Health and Welfare Plan terminates at the earliest of the dates shown in the following chart:

For you as an active Participant, coverage ends at the earliest date:	For your Dependents, coverage ends at the earliest date:
• You no longer meet the Plan's eligibility requirements; • You enter Non-Covered Employment, or you are an apprentice who has been terminated from the Hoisting and Portable Engineers Local 4 Apprenticeship and Training program; • The Plan terminates; • You enter active duty with the uniformed services. If the period of active duty exceeds 30 days you have two options. You may (1) run out your Earned Coverage and elect COBRA coverage for up to 24 months, or (2) freeze your Earned Coverage and enroll in a government-sponsored plan; • If you are available for work and notify your employer or IUOE Local 4 within 14 days from the date of your release from the uniformed services (or within 90 days from such date, if your uniformed service lasted more than 180 days), your coverage will be reinstated. (You should also notify the Funds Office, even though not required to do so, to help address benefits issues on your return in a timely manner.) If you do not notify your employer or IUOE Local 4 that you are available for work within 14 or 90 days of your date of release from the uniformed services, as applicable, you must once again meet the Plan's eligibility requirements before becoming eligible for coverage. • Coverage for an Office Employee of an Office employer who became initially eligible for coverage in the Health and Welfare Plan under the terms of a Participation Agreement will terminate at the end of the eligibility period as defined in the Plan.	• Your coverage ends; • You are divorced (this change affects your Spouse's and covered stepchildren's coverage only); • Your Dependent Child no longer meets the definition of a Dependent under the Plan. If this happens because of age, coverage terminates at the end of the month in which the child reaches age 26; • The Plan terminates; • Your Dependent Child begins active duty with the uniformed services. If the period of active duty exceeds 30 days, the Plan will offer COBRA coverage to the Dependent Child, as outlined in this chart to the left.

If You Enter Active Military Duty

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), you and your Dependents have the right to continue your group health care coverage for up to 24 months if you are on a leave of absence for active duty in the uniformed services of the United States. This coverage is similar to COBRA coverage, except that COBRA coverage for those not in the military service generally continues for up to 18 months. If your leave is for less than 31 days, your premium payment will be the contribution or premium (if any) that you would normally pay while working under the Plan, rather than the full COBRA premium. For more information about filing for coverage under USERRA, contact the Funds Office.

If you report back within 90 days of your discharge date if your period of military service was more than 180 days, or within 14 days from the date of discharge if the period was 31 days or more, but less than 181, your coverage will be reinstated. You may be charged for coverage at the COBRA rate if you ran out your Earned Coverage prior to entering the service. Contributing employers are permitted to make voluntary contributions on behalf of any Participant who is serving or who has served in qualified military service, regardless of whether the Participant worked for that employer.

If you wish to have coverage under USERRA, follow the procedures for the election of COBRA/Buy-In coverage.

Pensioners and Their Eligible Spouses

If you are a pensioner or the eligible Spouse of a pensioner and you are covered under Extended Coverage or Earned Coverage, your coverage under the Plan terminates:

- Once your Earned Coverage runs out; or
- If you are enrolled in Extended Coverage, at the earlier of the date you become eligible for Medicare or two years from the date your Earned Coverage ends.

Your Dependent Children who were also covered under your Plan who lost coverage due to your termination of employment (retirement) will be offered COBRA and may be eligible for Extended Coverage options.

Loss of Benefits

You or your Dependents may also experience a reduction or termination in benefits in any of the following circumstances:

- You fail to follow the Plan's procedures, including the Plan's Utilization Management procedures;
- You fail to pay required buy-in premiums, including the cost of Extended Coverage or COBRA continuation coverage;
- You fail to reimburse the Fund for a claim that was paid in error or otherwise paid but later retracted and denied;
- You suffer injuries for which a third party is responsible, and you or your attorney fail to sign the Plan's subrogation agreement;
- You fail to return your annual Dependent eligibility audit form or falsify the form, or you fail to notify the Funds Office of a change in Dependent status within a reasonable period of time;

- You receive reimbursement for a covered expense from another plan which is primary to this Plan while also receiving primary reimbursement from this Plan;
- You receive a judgment or settlement or otherwise receive payment from any person or entity with respect to the illness, injury or other condition which gives rise to expenses this Plan pays and you fail to honor your subrogation agreement with the Fund;
- You are found to have committed a fraudulent act against the Plan including, but not limited to, the fraudulent filing of a claim for reimbursement; or
- The Plan is amended or terminated, but this applies only with respect to expenses incurred after the amendment or termination becomes effective.

Upon Your Death

If you die while you are a Participant, your eligible Dependents remain covered for the duration of your Earned Coverage. At that point, your eligible Dependents may elect to continue coverage under COBRA for up to 36 months. See Continuing Your Coverage (COBRA).

If you die while you are a Participant and before you retire, your surviving Spouse may elect to purchase the Extended Coverage available to eligible pensioners (see Extended Coverage for details) if the surviving Spouse has been eligible for coverage under the Basic A Plan for five of the most recent seven benefit periods. Such an election would be as an alternative to an election of COBRA coverage, and could continue for up to 10 years or until the Spouse is Medicare eligible, if earlier, as long as all required payments are made.

Paying the Cost of Benefits

If You Are an Active Participant

Payments are made to the Fund on your behalf by your employer as a result of agreements negotiated between the International Union of Operating Engineers, Local 4 and various employers and employer associations.

These contributions, together with any deductibles, Copays and coinsurance you may incur, are used to pay for your benefits. There is no other cost to you and your family for coverage under the Health and Welfare Plan as long as you remain an active Participant and meet the Plan's eligibility requirements. Participants who elect Benefits Buy-In or Bridge Plan coverage will incur a premium cost for electing these plans.

If You Are a Pensioner

If you are a pensioner or the covered Spouse of a pensioner, you pay your share of the cost of extended or COBRA coverage each month. When you become eligible for extended or COBRA coverage and choose to buy-in to the Plan, you receive coupon sheets for each year of your extended or COBRA coverage. You should submit your monthly premium in a timely manner. If you fail to pay for your coverage within the 30-day grace period, your coverage will be terminated as of the last day of the month for which you have submitted payment. To meet the requirements of the grace period your check must be postmarked no later than 30 days after the original due date. There is no cost for pensioners eligible for Retirement Bridge Coverage.

If You Are a COBRA Participant

If your coverage is through COBRA, you pay your share of the cost of COBRA coverage each month. If you fail to pay for your coverage within the 30-day grace period (45-days for your first COBRA payment), your

coverage will terminate as of the last day of the month for which you have submitted payment.

To meet the requirements of the grace period your check must be postmarked no later than 30 days after the original due date.

If You Buy In

If you do not have enough hours, you may be eligible to buy into the Plan. The Benefits Buy-In Plan credits you with hours you have earned to reduce your premium cost for the Plan. The premium is based on the following formula: 2,300 hours (for Local 4D not receiving contributions at the TCR), 1,800 hours (for Local 4D) or 1,500 hours (for Local 4), less the total of your earned hours, times the Master Agreement hourly contribution rate for the IUOE Local 4 Health and Welfare Plan.

This annual amount is then converted to a quarterly premium rate. Health benefits can be purchased on this basis for a maximum of two consecutive years if you are not working but looking for work as certified by your Business Agent or until you are eligible for Supplemental Benefits Plan coverage if working.

Continuing Your Coverage (COBRA)

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This section explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The Plan's Administrator at the Funds Office is responsible for administering COBRA continuation coverage.

COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of Medical, Prescription Drug, Vision, Hearing and/or Dental Plan coverage when such coverage would otherwise end because of a qualifying event. Actual coverage depends on which COBRA Plan you purchase. Specific qualifying events are listed later in this section. COBRA continuation coverage is offered to each person who is a qualified beneficiary.

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

A qualified beneficiary is someone who loses coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, Participants, Spouses of Participants and Dependent Children of Participants may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are a Participant, you become a qualified beneficiary if you lose your coverage under the Plan because one of the following qualifying events occurs:

- Your hours of employment are so reduced that your eligibility terminates;
- Your employment or your participation as an apprentice in the Hoisting and Portable Engineers Local 4 Apprenticeship and Training Program ends for any reason other than your gross misconduct; or
- You enter Non-Covered Employment.

If you are the Spouse of a Participant, you become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events occur:

- Your Spouse dies;
- Your Spouse's hours of employment are so reduced that eligibility terminates;
- Your Spouse's employment or participation as an apprentice in the Hoisting and Portable Engineers Local 4 Apprenticeship and Training Program ends for any reason other than gross misconduct;
- Your Spouse enters Non-Covered Employment;
- Your Spouse becomes enrolled in Medicare (Part A, Part B or both); or
- You become divorced from your Spouse.

COBRA refers to you and your covered Dependents as qualified beneficiaries. A qualified beneficiary is an individual who, on the day before a qualifying event occurs, is covered under the Health and Welfare Plan.

Dependent Children become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events occur:

- The parent-Participant dies;
- The parent-Participant's hours of employment are so reduced that eligibility terminates;
- The parent-Participant's employment or participation as an apprentice in the Hoisting and Portable Engineers Local 4 Apprenticeship and Training Program ends for any reason other than gross misconduct;
- The parent-Participant enters Non-Covered Employment;
- The parent-Participant becomes enrolled in Medicare (Part A, Part B or both);
- The parent-Participant becomes divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a Dependent Child.

The Plan offers COBRA continuation coverage to qualified beneficiaries only after the Plan's Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Participant, commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the Participant in Medicare (Part A, Part B or both), the employer must notify the Plan's Administrator of the qualifying event within 60 days. For the other qualifying events (divorce of the Participant and Spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to the Plan's Administrator at the Funds Office.

Once the Plan's Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the

qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin either the date of the qualifying event or on the date that Plan coverage would otherwise have been lost.

The term "you" as it is used throughout this COBRA section refers to you or other qualified beneficiaries under COBRA.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Participant, enrollment of the Participant in Medicare (Part A, Part B or both), divorce or a Dependent Child losing eligibility as a Dependent Child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is related to entry into military service, COBRA continuation coverage lasts for 18 months; USERRA coverage lasts for 24 months.

When the qualifying event is the expiration of Earned Coverage, entering Non-Covered Employment or termination from the Hoisting and Portable Engineers Local 4 Apprenticeship and Training Program, COBRA continuation coverage lasts for up to 18 months.

There are two ways in which an 18-month period of COBRA continuation coverage can be extended, as described in the next section.

Disability Extension of 18-Month Period of Continuation Coverage

If the Social Security Administration determines that you or any of your covered family members is disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months.

You must make sure that the Plan Administrator is notified in writing of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. You must provide a copy of the Social Security determination to the Plan's Administrator at the Funds Office.

You must also notify the Fund in writing within 30 days of the date the Social Security Administration determines that you are no longer disabled. Verbal notice is not binding until you confirm it in writing.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving the initial 18 months of COBRA continuation coverage, the Spouse and Dependent Children (only) in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the Spouse and Dependent Children if the former Participant dies, enrolls in Medicare (Part A, Part B or both) or gets divorced, if the event that occurs would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first qualifying event (e.g., reduction in work hours) not occurred. The extension also is available to a Dependent Child when that child stops being eligible under the Plan as a Dependent Child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan's Administrator at the Funds Office.

Verbal notice is not binding until you confirm it in writing.

If you become covered by Medicare while you are an active Participant and you later experience a qualifying event (for example, you experience a reduction in your hours), your Dependents may be eligible for continued coverage until the later of:

- 36 months from the date you first become covered by Medicare, or
- The maximum coverage period for the qualifying event (18 months in the case of a reduction in hours).

How to Continue Coverage Through COBRA

Both you and the Fund have responsibilities if qualifying events occur that make you or your covered Dependents eligible for continued coverage.

You or your covered Dependents must notify the Plan's Administrator (as noted previously) in writing within 60 days of the date of the qualifying event, when one of the following events occurs:

- You become divorced;
- Your Dependent Child is no longer considered an eligible Dependent as defined by the Plan; or
- You become entitled to Medicare.

To continue your coverage under COBRA, be sure to notify the Administrator in writing no later than 60 days after the date of your divorce, the date your covered Dependent(s) is no longer eligible for coverage or the date you become entitled to Medicare. If you do not notify the Plan Administrator within 60 days of one of these events, you forfeit your COBRA rights.

Additionally, you must notify the Plan's Administrator no later than 60 days after a qualified beneficiary entitled to receive COBRA coverage has been determined by the Social Security Administration (SSA) to be disabled and before the end of the 18-month COBRA period, and no later than 30 days after the SSA determines that a qualified beneficiary is no longer disabled.

When you notify the Administrator that one of these events has occurred, the Administrator will give you and/or your qualified beneficiary an election form to complete. The election form explains a qualified beneficiary's right to continued coverage under COBRA.

Election Period

You and your covered Dependents have 60 days in which to elect continued coverage, beginning on the later of the date:

- Your coverage terminates because of the qualifying event, or
- You or your covered Dependents are notified of the right to elect continued coverage.

You have 45 days from the date you elect continuation coverage to pay your initial COBRA premium. If payment is not received within this time period, COBRA coverage will be canceled retroactively to the last day of the previous month.

If you or your eligible Dependent has provided notice to the Administrator of a divorce or legal separation, a beneficiary ceasing to be covered under the Plan as a Dependent, or a second qualifying event, but are not entitled to COBRA, the Administrator will send you a written notice stating the reason why you are not eligible for COBRA. This will be provided within 14 days of receiving your notice.

Type of Coverage

While you are receiving continuation coverage, your benefits under COBRA remain the same as the applicable benefits offered to similarly situated active Employees, including any changes that are made to the Plans.

Participants covered under the Supplemental A/B Benefits Plans are eligible for COBRA coverage for those benefits, but are not eligible for continuation of Dental, Vision or Hearing benefits unless they purchased the Bridge Plan during the period that they were covered under the Supplemental Plan. No Participants are eligible for Weekly Accident and Sickness benefits (Loss of Time), Life Insurance, or AD&D Insurance through COBRA.

Cost of Continued Coverage

In most cases, you and your covered Dependents will be required to pay 102% of the full group cost for continued coverage. If you or a qualified beneficiary is eligible for extended COBRA coverage due to disability (as determined by the Social Security Administration), you or your qualified beneficiary must pay 150% of the full group cost for continued coverage from the 19th through the 29th month of coverage.

You must pay for coverage in monthly installments, and you must make your first payment no later than 45 days after the date you elect to continue coverage. Subsequent payments will be due on the first day of each month, with a 30-day grace period. Premium rates are effective each March 1 for the following 12-month period. If the cost of these benefits for active Employees changes in the future, these cost changes may affect the cost of your continuation coverage. You will be notified in advance of any changes in the cost of coverage.

If a health care provider requests confirmation of coverage and (1) you or your eligible Dependents have elected COBRA but have not yet paid the premium (and the grace period is still in effect); or (2) you or your eligible Dependents are within the COBRA election period but have not yet elected COBRA, COBRA coverage will be confirmed to your health care provider but with notice that the premium has not been paid and that no claims will be paid until the amount due has been received by the Plan's Administrator. Additionally, your provider will be informed that if the amount due is not received by the end of the grace period, your coverage will terminate retroactively.

Other Coverage Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Termination of Continued Coverage

Your right to purchase continued group coverage may end before the expiration of the maximum coverage period if:

- Any required premium is not paid on time;
- The Fund terminates any of the Plans for all Participants;
- You or your covered Dependent(s) becomes entitled to Medicare (except that if a covered Participant becomes entitled to Medicare, their covered family members may continue coverage for up to 36 months from the date of the initial qualifying event); or
- You or your covered Dependent(s) become covered under another group health plan (as a Participant or otherwise); or
- The employer that you worked for before the qualifying event has stopped contributing to the Plan, and the employer establishes one or more group health plans covering a significant number of the employer's Employees formerly covered under the Plan, or the employer starts contributing to another multi-employer plan that is a group health plan.

If continuation coverage is terminated before the end of the maximum coverage period, the Administrator will send a written notice as soon as practicable following the determination that continuation coverage will terminate. The notice will set out why continuation coverage will be terminated early, the date of termination, and rights, if any, to alternative individual or group coverage.

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

Coverage under COBRA is provided as required by law. If the law changes, your rights will also change.

Here is a summary of continuation coverage provisions under COBRA.

You may purchase continued coverage if you lose coverage because:	For up to:
Your employment ends or your hours are reduced.	18 months for you and your eligible Dependents
You become entitled to Medicare	36 months for your eligible Dependents
Your Dependent Child exceeds the maximum age covered under the Plan.	36 months for your Dependent Child
You divorce from your Spouse.	36 months for your Spouse
You divorce from your Spouse and your stepchild no longer qualifies for coverage as a Dependent under the Plan.	36 months for your former stepchild
Your death.	36 months for your eligible Dependents
You are disabled for Social Security disability benefit purposes at any time during the first 60 days of COBRA coverage. You must notify the Administrator in writing within the initial 18-month coverage period and within 60 days of the date of Social Security's disability determination to be covered on this basis.	29 months for you and your eligible Dependents

You may be able to enroll in Medicare instead of COBRA continuation coverage after your group health plan coverage ends.

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage.

However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare even if you are not enrolled in Medicare. For more information visit www.medicare.gov/medicare-and-you.

If You Have Questions

If you have questions about your COBRA continuation coverage rights, contact the Plan's Administrator at 1-888-486-3524. Or you may contact

the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available at www.dol.gov/ebsa.

Keep Your Plan Administrator Informed of Address Changes

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

Qualified Medical Child Support Orders (QMCSOs)

The Plan will provide coverage for a child if required to do so by a Qualified Medical Child Support Order (QMCSO) in accordance with ERISA Section 609(a)(2)(A). A QMCSO is a court order or administrative notice that meets certain legal requirements. If you have obtained or received a QMCSO that requires the Plan to cover a child, you should immediately provide the Funds Office with a copy. The Plan has procedures to determine whether the order or other document is a QMCSO. A copy of the Plan's QMCSO procedure is available upon request.

Federal and State Laws That May Affect Your Medical Benefits

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a Copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an Emergency Medical Condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as Copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these

cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the Copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, or for more information about your rights under federal law, you may contact the Employee Benefits Security Administration ("EBSA") at www.dol.gov/ebsa or 1-866-444-EBSA.

In accordance with the Transparency in Coverage and No Surprises Act, the Plan provides a link – accessible at its website, Local4Funds.org – to allow you to access files containing the in-network negotiated rates for all items and services that are covered through Blue Cross Blue Shield of Massachusetts, Carrum, Progyny, and Lyra. Please contact the Funds Office with any questions.

Newborns' and Mothers' Health Protection Act

This act requires group health care plans to provide a minimum hospital stay for the mother and newborn child of 48 hours after a vaginal delivery and 96 hours after a cesarean section. Federal law does not, however, prohibit the mother's or newborn's attending physician, in consultation with the mother, from determining that a shorter length of stay is appropriate.

The Plan requires admission certification of your maternity stay only if the minimum length of stay (48 or 96 hours, as applicable) is exceeded. A stay exceeding the minimum length requires authorization and is subject to review for medical appropriateness.

Under the Plan, a pregnancy-related hospital stay is treated like an illness, as required by federal law.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Under this Act, Participants may have the right to continue their group health care coverage for up to 24 months while they are on a military

leave of absence, and may be eligible to have their coverage reinstated if they report for work within a specified period following such leave. For more information about filing for coverage under USERRA, contact the Health and Welfare Fund.

Women's Health and Cancer Rights Act

Coverage under a group health care plan for a Participant or Dependent who is receiving benefits in connection with a mastectomy, who elects breast reconstruction, must include the following benefits in a manner to be determined in consultation with the attending physician and patient, 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 at all states of the mastectomy, including lymphedemas.

Coverage of breast reconstruction may be subject to deductibles and coinsurance limitations consistent with those established for other medical benefits under the Plan.

Family and Medical Leave Act (FMLA)

Under this federal law, you may have the right to take up to 12 weeks of unpaid leave for your serious illness, after the birth or adoption of a child, or to care for your seriously ill Spouse, parent or child. FMLA leave requires certain employers to maintain health coverage during the leave period. In addition, under the FMLA, you may be able to take up to 26 weeks of unpaid leave during any 12-month period to care for a military service member.

Contributing employers to the Plan are required to continue making contributions to the Plan on your behalf during a qualifying leave of absence under the FMLA unless the Employee has already met their requirement for eligibility for the period of the FMLA leave. If you think that this law may apply to you, please contact your employer or the Funds Office.

Massachusetts Paid Family and Medical Leave Act (MA PFMLA)

If you work primarily in Massachusetts, you may be eligible to take paid leave under the MA PFMLA:

- up to 20 weeks per year for your serious health condition;
- up to 12 weeks per year related to the birth, adoption, or foster care placement of a child, or because of certain reasons related to a family member's being called to active military duty;
- up to 12 weeks per year to care for a family member with a serious health condition; or
- up to 26 weeks per year to care for your family member who incurred an illness or injury during active military duty.

If you qualify, you will receive partial wage replacement from the Massachusetts Department of Family and Medical Leave. During your MA PFMLA leave, your earned medical coverage will be maintained under the Fund. Additionally, if you are an active member and receive benefits under the MA PFMLA, you will be credited with up to six (6) hours per day during your leave.

The Massachusetts Department of Family and Medical Leave is responsible for determining whether you are eligible for MA PFMLA leave. If you think this law may apply to you, please contact the Department by visiting www.mass.gov/paid-family-and-medical-leave-benefits or calling (833) 344-7365.

Maine Paid Family and Medical Leave Act

Covered individuals who meet the state's income threshold and who work in Maine for an employer that has negotiated a new collective bargaining agreement with Local 4 on or after January 1, 2026 may be eligible for up to 12 weeks of medical leave and up to 12 weeks of family leave (but no more than 12 weeks in the aggregate) in a benefit year. If you qualify, you will receive partial wage replacement from the Maine PFML Authority. During your Maine PFMLA leave, your medical coverage will be maintained under the Fund. Additionally, if you are an active member and receive benefits under the Maine PFMLA, you will be credited with up to six (6) hours per day during your leave.

SECTION II:
Medical and Prescription Drug Coverage

Medical Plan

The Medical Plan is designed to give you and your family access to high-quality, affordable health care with a choice of physicians, medical facilities and other types of providers. Your share of the cost varies, depending on where you receive care. Although you will have some out-of-pocket costs, you are well protected against catastrophic medical costs while still being covered for more routine care.

Important Note:

Benefits are payable only for eligible Participants and only for services that the Plan deems are medically necessary.

To get the most out of the Plan, you should understand how the Plan operates. If you have questions about eligibility, call the Funds Office Monday through Friday, 8:00 a.m. to 4:00 p.m., at 1-888-486-3524. If you have questions about benefits or the status of claims, call Blue Cross Blue Shield of Massachusetts (BCBSMA) at 1-800-401-7690. You can also access information about the Plan at www.local4funds.org. Email inquiries are also welcome but should not include protected information such as your Social Security number or any other health plan identification number. Although the Fund uses secure systems, it cannot guarantee the security of incoming systems that are not equally secure.

If you do not follow the Plan's utilization management procedures, you may pay a penalty or, in some cases, no benefits may be payable at all. To be sure you make the most of your benefits, see the sections of this Plan that apply to your situation before you receive care. See What You Should Know Before You Receive Care, below.

What You Should Know Before You Receive Care

The Medical Plan consists of an exclusive provider organization (EPO) plan through BCBSMA. An EPO is a managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan's network (except in an emergency). The EPO may have a different name in other states.

Out-of-network services are not covered, other than for emergency care. You will only receive coverage if you see a provider within the extensive BCBS EPO Advantage Blue network. You are not required to have a primary care physician or obtain a referral to see a specialist, though it is recommended that you have a doctor who can help guide your care. You will retain coverage under the BCBS national PPO network for emergency medical care.

In addition, you have access to the Carrum Health program for the following procedures at participating centers of excellence: hip and knee replacement surgery, spinal fusion surgery, bariatric surgery, other orthopedic and spine procedures, cardiac surgery, virtual oncology support and guidance for all diagnoses, comprehensive treatment for breast, colon, prostate, and thyroid cancer, and CAR-T cell therapy. Carrum is also available for substance use treatment for alcohol and opioids, and can provide access for you in one of its centers of excellence for detox, residential treatment, partial hospitalization (PHP), or intensive outpatient

(IOP) services. When these services are approved and performed through Carrum, they are covered at 100%, meaning there is no out-of-pocket cost to the Participant such as deductibles, Copays, or coinsurance.

The Plan's utilization management provisions apply in many cases. If you fail to follow these provisions before you receive care, a penalty may apply or, in some cases, no benefit is payable under the Plan. See Utilization Management Requirements for details.

When you require these types of services:	The Plan's EPO network is:	Find EPO network providers at:
Medical and Outpatient Mental Health and Substance Use Disorder	BCBS EPO Advantage Blue	1-800-401-7690 www.bluecrossma.com
Transplants	BCBS EPO Advantage Blue; Blue Distinction Centers for Transplants (BDCT)	1-800-401-7690 www.bluecrossma.com
EAP (Employee Assistance Program)	Lyra Health	1-844-926-2482 local4funds.lyrahealth.com
Prescription Drug	Optum Rx	1-855-241-2213 or www.optumrx.com
Hearing	TruHearing	1-888-934-4744 www.TruHearing.com/IUOELocal4
Dental	BCBS (Dental Blue)	1-800-241-0803 or www.bluecrossma.com
Vision	EyeMed	1-866-723-0514 www.eyemed.com
Fertility Services	Progyny	1-866-606-9789 www.progyny.com
Inpatient Mental Health and Substance Use Disorder, including Partial Day Hospitalization/ Intensive Outpatient Services (IOP)	BCBS EPO Advantage Blue Carrum Health	1-800-401-7690 www.bluecrossma.com 1-888-729-3511 https://my.carrumhealth.com/register

To access a list of BCBS EPO preferred network hospitals and/or physicians or other types of providers, go to www.bluecrossma.com or call BCBSMA at 1-800-401-7690. A copy of the network provider list can be given to you free of charge.

Service Area

The Medical Plan service area is nationwide. This means that there are preferred network providers available throughout the United States through all local BCBS plans.

Deductibles, Coinsurance and Copays

For most services, you are required to meet a deductible and pay coinsurance (a percentage of the claim) or to not meet a deductible and pay a flat dollar Copay. When a Copay applies, generally you will not have to meet a deductible. Additionally, there are certain circumstances when a deductible or coinsurance is waived. For example, if you need hip and knee replacement surgery, spinal fusion surgery, bariatric surgery, other orthopedic and spine procedures, cardiac surgery, certain oncology care, or treatment for substance use disorder, and you use Carrum Health, your cost share may be waived 100%.

Deductible

Your deductible is the amount you must pay each calendar year before benefits are payable under the Plan, as shown in the following chart.

Calendar-Year Deductible	In-Network Only	Out-of-Network
Basic/Supp A per individual	$250	Not covered
Basic/Supp A per family	$500	Not covered
Basic/Supp B per individual	$1,500	Not covered
Basic/Supp B per family	$3,000	Not covered

Charges for all family members are taken into account when determining whether you have met the calendar-year family deductible, but only $250 or $1,500 of in-network eligible charges per person, as applicable, must be satisfied before benefits are payable for that person.

Assume you are insured under the Basic A Plan covering yourself, your Spouse and two children. If you incur $300 in covered charges, you have met the $250 individual deductible for all care relating to yourself, plus you have contributed $250 toward your family deductible, but you have not met your family deductible. In this case, your Spouse and/or children must incur eligible charges of at least $250 before your family deductible is met for the year.

Amounts you pay toward your deductible accrue toward your annual out-of-pocket maximum.

Coinsurance

The Plan covers some services that are subject to coinsurance, which is a percentage of the allowed charge. The percentage the Plan does not cover is your responsibility; this amount is called your coinsurance. Services subject to coinsurance are usually subject to the calendar-year deductible. The amount of coinsurance you pay counts toward meeting your annual out-of-pocket maximum. Additionally, as noted, coinsurance may be waived for certain surgeries or procedures when you utilize Carrum Health.

Copays

You are generally required to pay a per-visit Copay for all in-network services when a deductible does not apply. A Copay is a set dollar amount. You usually pay a Copay at the time you receive care. In some cases, a provider will bill you for your Copay amount after the Plan has paid its share of the cost. Here are some examples of services for which you must pay a Copay:

- In-network physician office visits (medical care in a provider office including allergy injections);
- In-network physical therapy and chiropractic care; and
- In-network independent labs (not hospital affiliated).

Amounts you pay for medical and prescription Copays count toward your annual out-of-pocket maximum (see below).

You may owe more than one Copay per visit if, for example, you have lab work done as part of an office visit. In this case, the lab and the physician office will each charge a separate Copay. If you visit a physician who has an office in a hospital, you may incur a Copay for the physician office visit and coinsurance for any hospital-billed diagnostic X-ray and lab. The calendar- year deductible will apply if the services are not diagnostic X-ray and lab.

Depending on the doctor's contractual relationship with the hospital, some hospitals also charge you a clinic fee when you visit that physician in the hospital-based or clinic-based office. Your liability for these facility charges may be subject to your calendar-year deductible and coinsurance in addition to your office visit Copay. Some physicians who have hospital offices also maintain separate, freestanding offices. If you have a choice of where to see your physician, you will usually pay less if you visit your doctor in a freestanding office instead of a hospital. You should discuss this with your doctor to arrange the best plan for your situation.

Out-of-Pocket Maximum

Your out-of-pocket maximum is the most you or your family pay for covered medical and prescription expenses during a calendar year. Once you reach your out-of-pocket maximum, the Plan pays 100% of covered eligible expenses for the rest of that calendar year.

Your out-of-pocket maximum includes most amounts you and your covered Dependents pay for eligible expenses during a calendar year, including your coinsurance amounts. It does not include:

- Expenses the Plan does not cover;
- Charges that exceed the reasonable and customary charge for covered services;
- Reductions in benefits and penalties you must pay because you fail to comply with the utilization management provisions; and
- Services with separate, individual benefit maximums, such as Holistic Benefits.

If you have:	Your Plan A out-of-pocket maximum is:	Your Plan B out-of-pocket maximum is:
Individual Coverage	$5,000	$6,850
Family Coverage	$10,000	$13,700

You may not carry over from year to year amounts you pay toward your annual out-of-pocket maximum.

No Lifetime Benefit Maximum

The Medical Plan does not have an overall lifetime benefit maximum. Separate maximums and limits apply to certain benefits, as specified in this SPD.

Utilization Management Requirements

Many aspects of the Plan incorporate the benefits of utilization management. The Plan uses the medical policy provisions of BCBSMA and/or Carrum Health in conjunction with its facilities and/or providers ("Carrum"), as appropriate. Although Plan terms ultimately control the provision of benefits, for the Plan to continue to operate efficiently and successfully, you must do your part. This means that you and your covered Dependents should comply with all aspects of the Plan's utilization management provisions.

The utilization management provisions are designed to ensure that you receive the care you need in the most appropriate setting and at the most competitive price.

Before you use your medical benefits, be sure you understand how the Plan's utilization management provisions work. In many cases, if you do not follow these procedures, you may pay a penalty. In some cases, no benefits are payable if you fail to follow Plan procedures.

Utilization management is the approach that the Plan uses to evaluate the necessity and appropriateness of many different services. This approach employs a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy or efficiency of, health care services, procedures or settings.

These techniques include:

- Pre-authorization review;
- Concurrent review;
- Discharge planning;
- Post-payment review;
- Individual case management; and
- Disease state management.

The Plan's utilization management policies are designed to encourage appropriate care and services (not less care). The Plan understands the

need for special concern about underutilization, and shares this concern with Participants and providers.

The Plan does not offer incentives to providers to encourage inappropriate denials of care and services. In addition, review procedures also apply equally to non-emergency inpatient mental health and substance use care. See Mental Health/Substance Use Disorder Care.

Pre-authorization Review

All inpatient admissions and/or outpatient surgeries, home infusion therapy, and home health care must be preapproved or pre-certified in advance by BCBSMA and/or Carrum, as applicable, in order for the services to be covered. Similarly, all inpatient admissions for mental health and/or substance use disorder and for partial day hospitalizations/intensive outpatient services (a sub-classification of inpatient benefits) must be pre-approved or pre-certified in advance by BCBSMA or Carrum, as applicable, in order for the services to be covered. (This pre-approval is not required when the inpatient admission is for emergency care or maternity services.) For proposed admissions in an in-network facility, the facility may start the review process for you, but it is your responsibility to ensure that the pre-approval or pre-certification takes place.

Many inpatient admissions and/or outpatient surgeries (especially those set up through Carrum, which also require a consultation with the provider, sharing of medical records, and other pre-conditions based on the type of admission or surgery) are pre-planned and pre-authorized well before admission.

If your physician recommends hospitalization for non-emergency treatment, home infusion therapy, or home health care, or if your physician recommends hospitalization for mental health and/or substance use disorder, or for partial day hospitalization/intensive outpatient services, you or your physician must contact BCBSMA at 1-800-327-6716 before your scheduled admission/treatment and follow the steps outlined below:

- Clinical information will be obtained from your physician and the request will be reviewed against clinical criteria.
- You, your physician, and the provider/hospital will be notified of the decision regarding your treatment, usually within two working days of receiving all necessary information. If the request is approved, you will also be advised of the number of days authorized. In most cases, you will be mailed a written notification on the business day following the completed review.
- If you do not receive written authorization before your scheduled admission/ treatment date, call BCBSMA at 1-800-327-6716 to be sure your admission/treatment has been approved.

If you do not pre-certify your inpatient admission before you receive care, the Plan may apply a penalty by reducing its payment by $250 or it may deny the admission altogether if the admission is determined to not be medically necessary. You should make every effort to notify BCBSMA as soon as possible after an emergency admission. If an admission is denied, the out-of-pocket costs do not count toward meeting an out-of-pocket maximum. Any recommendations BCBSMA makes during a pre-hospital review are suggestions, not medical advice. While all treatment decisions remain the responsibility of the patient and physician, you may be required to pay the full cost of care if you fail to follow the steps outlined in this section when your physician recommends hospitalization.

Emergency Admissions

If you are admitted to the hospital in an emergency, you, your physician or a family member must call BCBSMA on the first business day after your admission. BCBSMA will then review your admission and confirm in writing the number of authorized hospital days.

Concurrent Review and Discharge Planning

Concurrent review means that while you are an inpatient, BCBSMA and/or Carrum, as applicable, will monitor and evaluate the clinical necessity and appropriateness of the health care services you are receiving and make sure you still need inpatient coverage in that facility. In some cases, they may determine that you will need to continue inpatient coverage in that facility beyond the number of days initially thought to be required for your condition.

In other cases, based on medical necessity determination, BCBSMA and/or Carrum, as applicable, may determine that you no longer need inpatient coverage in that facility or that you may no longer need inpatient coverage at all. When this is the case, they will call the facility within 24 hours of the coverage determination to let the facility know of the decision and to discuss plans for continued coverage in a health care setting that better meets your needs. For example, your condition may no longer require inpatient coverage in a hospital but still may require skilled nursing coverage. If this is the case, your physician may decide to transfer you to an appropriate skilled nursing facility. Your physician will discuss any proposed plans with you. All arrangements for discharge planning will be confirmed in writing with you.

If you choose to stay in the facility after you have been notified that inpatient coverage is no longer medically necessary, no further benefits will be provided. You must pay all charges for the rest of that inpatient stay, starting from the date the written notification is sent to you.

If you are hospitalized, it is your responsibility to be aware of the number of hospital days approved for your stay and, if extra days are necessary, to confirm with your physician that the Plan has approved them.

Post-Payment Review

All of the benefits described in this benefit description will be provided only when they conform to BCBSMA and/or Carrum's medical technology assessment guidelines. These are guidelines that BCBSMA and Carrum use to assess whether a technology improves health outcomes such as length of life or ability to function, and BCBSMA performs these reviews monthly following the receipt of a claim. (Even though Carrum bundle bills for medical services, you may require some additional post-operative care that is not part of the bundle payment and requires post-payment review.)

Your claims are reviewed against these guidelines, and if a BCBSMA or Carrum network provider has not complied with these guidelines, you are held harmless from any denial based on medical necessity. You also cannot be balance billed for services provided by an out-of-network provider while you receive services at an inpatient hospital or an outpatient surgery center, unless you have consented. If you receive non-emergency nonconforming services out-of-network you will be responsible for the full cost.

Maternity Admissions

When you are admitted to the hospital for delivery, if unforeseen circumstances require a hospital stay of more than two days for a vaginal delivery or more than four days for a cesarean section, you, your physician or a family member must call BCBSMA for approval of these additional days.

Also, if your newborn stays in the hospital after your discharge you must call to have the medical necessity of your newborn's continued hospitalization approved.

Second Surgical Opinion

If your doctor recommends any elective, non-emergency surgery, the Plan covers a second surgical opinion from any in-network specialist you choose, if you wish to get another opinion. The benefits will be paid at the Copay or coinsurance level associated with the provider's contract status and this benefit description. BCBSMA will determine whether your surgery meets clinical criteria.

Home Health Care

When you are hospitalized, you may be able to recover at home, with access to the proper medical assistance. In some cases, you may be able to avoid hospitalization completely. BCBSMA will work with your physician to locate trained health care specialists who can provide necessary medical care in your home.

If your physician determines that you could shorten your stay in the hospital (or avoid hospitalization) if health care services are provided in your home, they may call for home health care agency referrals.

If you receive home health care, the home health care agency will work with your physician and the hospital discharge planning staff to develop a treatment plan. BCBSMA is available to review the treatment plan, arrange for home health care services and help ensure a smooth transition.

Benefits are provided for childbirth classes and reimbursed directly to you on a fee schedule basis upon submission of a receipt to BCBSMA. The BCBSMA website at www.bluecrossma.com provides information under its Living Healthy Babies section concerning pre-natal and post-natal care and information on child care.

Please also see the summary of the Newborns' and Mothers' Protection Act regarding minimum hospital stays.

Individual Case Management

Individual case management is a flexible program for managing benefits in some situations. Through this program, BCBSMA and/or Carrum, as applicable, work with your health care providers to make sure that you get medically necessary services in the least intensive setting that meets your needs. Individual case management is for a patient whose condition may otherwise require inpatient hospital care. Under individual case management, coverage for services, in addition to those described in this benefit description, may be approved to:

- Shorten an inpatient stay by sending you home or to a less intensive setting to continue treatment;
- Direct you to an alternative setting when an inpatient admission has been proposed; or
- Prevent future inpatient stays by instead providing outpatient benefits.

BCBSMA and/or Carrum, as applicable, may, in some situations, present a specific alternative treatment plan to your attending physician. This treatment plan will be one that is medically necessary for you. BCBSMA and/or Carrum, as applicable, will need the full cooperation of everyone involved: the patient (or guardian); the hospital; the attending physician; and the proposed setting or health care provider. Also, there must be a written agreement between the patient (or family or guardian) and BCBSMA and/or Carrum, as applicable, and between the provider and BCBSMA and/or Carrum, as applicable, to furnish the services approved through this alternative treatment plan.

The Trustees reserve the right at any time to request that you undergo an in-depth medical exam to determine that your treatment is medically necessary.

If you or a covered family member is seriously ill or injured, BCBSMA is available to work with you, your family and your physician to develop an effective long-term treatment plan. If you qualify for individual case management, BCBSMA monitors your progress, coordinates delivery of services and provides information about available treatment alternatives.

Disease State Management

Disease state management is a voluntary program designed to assist individuals diagnosed with specific chronic health conditions. Patients who participate in the program are assigned a care manager who provides educational materials, locates community resources and answers questions relating to the disease. Additionally, care managers work with attending physicians to coordinate a patient's care.

Among other conditions, the BCBSMA disease state management program currently includes the following chronic diseases:

- Asthma and COPD;
- Diabetes;
- Heart failure/coronary artery disease;
- Chronic renal failure;
- Low back pain;
- Cystic fibrosis;
- Multiple sclerosis;
- Parkinson's disease; and
- Rheumatoid arthritis.

If you have been diagnosed with one of these conditions or any other chronic condition, you may be contacted about participating in a voluntary program.

Disease state management is a voluntary program. No penalty applies if you choose not to participate.

How to Appeal a Utilization Management Decision

If you or your physician disagrees with a decision regarding hospital admission, partial hospitalization, case management, or an outpatient procedure or treatment, you may appeal the decision by following the process outlined in How to File Claims and Appeal Denied Claims.

Utilization Management Checklist

Use this checklist to realize maximum benefits from the Medical Plan

- Get prior authorization from BCBSMA for all non-emergency, non-maternity hospital admissions, all non-emergency hospital/inpatient admissions for mental health and/or substance use disorder, and for partial day hospitalization or intensive outpatient services.
- Have your physician or a family member call BCBSMA on the first business day after an emergency hospital admission.
- If you require a maternity hospitalization beyond the standard number of days, or if your newborn requires continued hospitalization after you are discharged, call BCBSMA for approval.
- Request prior authorization for home health care or home infusion services.

For questions about how a particular procedure is covered, or whether a hospital or other provider belongs to a network, contact BCBSMA (see chart on Page 38). For questions about eligibility, contact the Funds Office.

Wellness Program: Local 4 Life

Local 4 Life is a voluntary program for eligible Participants or Dependents who wish to make changes to improve their health. The Local 4 Health and Welfare Plan has teamed up with a squad of nurses, diabetes educators, registered dietitians, and health coaches at TrestleTree to bring you and your families individualized physical and mental wellness plans to fit your individual needs. TrestleTree, can help you lower your HbA1C, blood pressure, weight, or cholesterol, to stop smoking, and to work on stress management. They can fit you with glucometers, blood pressure cuffs, scales, and any other tools you might need to start the journey to better health. Local 4 Life offers you individualized lifestyle coaching (stress, nutrition, exercise, weight, smoking cessation) and chronic condition management (diabetes, hypertension, metabolic syndrome). There is no member cost share for the coaching or for any durable medical equipment if you are signed up for the Local 4 Life program. You can get started today by contacting the Funds Office at 508-533-1400 or TrestleTree at 1-866-523-8185.

Fitness Reimbursement

A Participant who enrolls in a qualified health club or fitness facility, or who purchases qualified home fitness equipment, may receive up to $175 per calendar year (per family) toward the amount incurred. The reimbursement *does not apply* to martial arts, gymnastics facilities, tennis, aerobic, or pool-only facilities, personal training, social clubs, or sports teams.. To receive reimbursement, Participants must send a fitness reimbursement form and a copy of the health club agreement, as well as any receipts, to BCBSMA c/o Local Claims Department, P.O. Box 986030, Boston, MA 02298, no later than March 31 of the year following the year in which the fees were incurred. Forms can be downloaded from the Funds' website, www.local4funds.org, or claims can be filed on your MyBlue account.

Weight Loss Reimbursement

A Participant who enrolls in certain Weight Watchers programs, a hospital-based weight-loss program, or certain nutritional programs, may receive up to $175 per year (per family) toward the weight loss program. Food, books, videos, or scales do not qualify for the weight loss program. To receive reimbursement, Participants must send a weight loss reimbursement form, as well as any receipts, to BCBSMA c/o Local Claims Department, P.O. Box 986030, Boston, MA 02298, no later than March 31 of the year following the year in which the fees were incurred. Forms can be downloaded from the Funds' website, www.local4funds.org, or claims can be filed on your MyBlue account.

Medical Plan Benefit Chart

Covered services include but are not limited to those listed here. All benefits are subject to specific limitations, coinsurance, deductibles, exclusions and specified payment maximums as described elsewhere in this SPD and subject to the medical policy provisions of BCBSMA.

**In all instances on the following Medical Plan Benefit Chart, the first dollar amount or percentage indicates your cost share if on Basic or Supplemental Plan A; the second dollar amount or percentage indicates your cost share if on Basic or Supplemental Plan B.*

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
Calendar-Year Deductible (does not apply to services that are subject to a Copay)	$250 per individual/$500 per family for Plan A $1,500 per individual/$3,000 per family for Plan B	
Calendar-Year Out-of-Pocket Maximum (includes coinsurance, deductible and medical and prescription (combined) Copays)	Once you pay $5,000 ($6,850 for Plan B) for individual coverage or $10,000 ($13,700 for Plan B) for family coverage in coinsurance, deductible, and Copay costs for medical and prescription (combined), you receive 100% coverage for most services subject to coinsurance for the balance of the year. Services subject to specific limits, such as Holistic Benefits, do not count toward the out-of-pocket maximum.	
Acute Hospital Facility Care		
Inpatient Admissions for Medical and Surgical Care (including maternity) Room and board (up to the average semi-private room rate), intensive care confinement, and all ancillary and special services billed by the hospital Admissions (other than maternity) must be preauthorized by BCBSMA	10%/30% coinsurance after you pay your deductible	Not covered; 10%/30% coinsurance after deductible if BCBSMA determines admission is a medical emergency

Maternity Admissions

You do not need to pre-authorize your normal maternity hospital admission. You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. An extended maternity admission is covered if medically necessary and pre-authorized. Covered services include well newborn care, routine circumcision, and semi-private room and board and special services for the mother and newborn. Newborn hearing screening tests covered to age 3 months with $0 Copay in-network.

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK

All Admissions

Inpatient ancillary charges billed by a hospital include: use of operating rooms and other surgical treatment rooms; use of recovery and delivery rooms; anesthesia and its administration (when administered by an Employee of the hospital); diagnostic lab and X-ray services; chemotherapy and radiation therapy; radium, radioactive isotopes and X-ray therapy; renal dialysis; medical supplies such as casts, splints and trusses; blood or blood plasma and its administration; oxygen and equipment for its administration; use of durable medical equipment while you are in the hospital such as inhalators, suction machines, respirators, oxygen tents and hyperbaric oxygen chambers; drugs and medicines you receive while you are an inpatient; and physiotherapy. Private rooms are covered only if you must be isolated to prevent contagion.

If you do not pre-authorize your inpatient admission before you receive care, the Plan may deny your admission if it is later determined not to have been medically necessary. You should make every effort to notify BCBSMA as soon as possible after an emergency admission.

The Plan will not cover services determined to be medically unnecessary. If it is determined that your admission to the hospital is not medically necessary, your claim will be denied. If this occurs, you will be responsible for the full cost of your care, and amounts you pay for such services will not count toward meeting the out-of-pocket maximum.

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
Outpatient Facility Care Includes outpatient facility charges and medical services billed by the outpatient department of a facility including: chemotherapy and radiation therapy; renal dialysis; IV therapy; cardiac rehabilitation; ambulatory surgery; emergency medical services; medical and surgical supplies; therapeutic radiology; CT, MRI and other scans; and physical therapy. (Does not include outpatient diagnostic lab and X-ray.)	10%/30% coinsurance after you pay your deductible	Not covered
Emergency Room Facility and physician charges	10%/30% coinsurance after you pay your deductible	10%/30% coinsurance after you pay your deductible
Ambulatory or Inpatient Surgery Surgical day care unit of a hospital or freestanding ambulatory surgical facility or as an inpatient. Inpatient procedures must be pre-authorized by BCBSMA and other care must meet BCBSMA medical policy guidelines.	10%/30% coinsurance after you pay your deductible	Not covered

Covered surgical procedures include: routine circumcision of an infant; voluntary sterilization procedures (with no cost share for women); termination of pregnancy; endoscopic procedures; cataract surgery; and surgical procedures (including emergency and scheduled surgery). These surgical services include (but are not limited to): the incision, excision or electro cauterization of any part of the body; the manipulative redirection of a fracture or dislocation; the suturing of a wound; or the removal by endoscopic means of a stone or other foreign object from the body. If two or more procedures are performed during the course of a single operation through the same incision, or in the same operative field, eligible charges for the additional procedures will be reduced by 50%. An assistant surgeon's eligible charges shall not exceed 20% of the primary surgeon's eligible charge.

Reconstructive surgery is non-dental surgery that is meant to improve or give back bodily function or correct a functional physical impairment that was caused by a birth defect, a prior surgical procedure or disease or an accidental injury. This also includes surgery to correct a deformity or disfigurement that was caused by an accidental injury. This includes reconstructive surgery for a mastectomy and election of breast reconstruction in connection with the mastectomy. As required by federal law, these benefits are provided for: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedemas. These services will be furnished in a manner determined in consultation with the attending physician and patient.

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
Ambulance		
Ambulance service for medically necessary transport to the nearest facility equipped to provide the service required	10%/30% coinsurance after you pay your deductible	Not covered unless medical emergency, and then 10%/30% coinsurance after you pay your deductible
Extended Care Facility		
Extended Care Facility Inpatient care in a skilled nursing facility and/or rehabilitation hospital for skilled services limited to 100 days per calendar year; must be pre-authorized by BCBSMA	10%/30% coinsurance after you pay your deductible and amounts above per-admission limits	Not covered

If you require skilled nursing care or rehabilitation care, but not the extensive technological support of an acute care hospital, the Plan covers your inpatient care in an extended care facility. An extended care facility is an institution (or part of an institution) licensed to provide convalescent or skilled nursing care to resident patients and is or could be certified as an extended care facility under Medicare.

Extended care facility benefits will be restored for each new period of confinement. A new period of confinement begins at least 60 days after your last confinement. To be eligible for extended care facility benefits, you must be admitted to the extended care facility for non-routine care at the recommendation and under the supervision of your physician, and services must be preauthorized by BCBSMA.

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
Home Health Care		
Skilled care; must be pre-authorized by BCBSMA	10%/30% coinsurance after you pay your deductible	Not covered

To be covered under the Plan, home health care must be:

- Under the order and direct supervision of your physician;
- In lieu of continued hospital or extended care facility services;
- Furnished by a licensed home health care agency, a hospital or a licensed visiting nurse association; and
- Pre-authorized by BCBSMA.

When you meet these requirements, the Plan covers the following home health care services:

- Part-time (less than an eight-hour shift) skilled nursing visits by a registered nurse (RN) or licensed practical nurse (LPN), but not by someone who is a family member or resident of your household;
- Medical social work;
- Physical therapy, speech/language therapy (to restore speech to someone who has lost existing speech function as the result of a disease or injury) and occupational therapy;
- Nutritional consultation services;
- Part-time or intermittent home health aide services provided by a home health aide and under the supervision of an RN (up to four hours per visit);
- Medical supplies and equipment suitable for home use; and
- Enteral infusion therapy and basic hydration therapy furnished by a coordinated home health agency, including the infusion solution, preparation of the solution and equipment for its administration and the necessary part-time nursing furnished by a home infusion therapy provider.
- These benefits are provided only when the patient is expected to reach a defined medical goal set by the patient's attending physician and, for medical reasons, the patient is not reasonably able to travel to another treatment site where medically appropriate care can be furnished for the patient's condition. No benefits are provided for meals, personal comfort items and housekeeping services; custodial care; or private duty nursing.

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
Hospice Care		
Hospice care services must be pre-authorized by BCBSMA	10%/30% coinsurance after you pay your deductible	Not covered

Hospice care is an alternative to hospital confinement, designed to meet the physical and emotional needs of the terminally ill patient and their family. Hospice care aims to help both the patient and family cope with terminal illness and to control its pain and symptoms. Hospice care benefits are available to patients who are diagnosed as terminally ill and have six or fewer months to live, and services must be pre-authorized by BCBSMA. Hospice care may be delivered in the patient's home, in a specialized hospice care center or by a hospital.

Inpatient hospice care benefits are payable when there are no suitable caregivers available to provide home hospice care and it is determined by the hospice agency that home hospice care is impractical because the patient is unmanageable by the persons who regularly assist with home care. Inpatient hospice care is also payable for respite care, which allows short-term inpatient stays necessary for the patient to give temporary relief to a caregiver who regularly assists with home care. Inpatient respite care is limited to individual stays of no more than five consecutive days.

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
Professional Care (services billed by physician's office)		
Physician Office Visit (office or hospital setting) Covered services include: evaluation and management codes billed by a physician; in-office consultations; second surgical opinion; immunizations; allergy serum and injections; in-office surgery; and machine tests, when performed in the office, including urgent care and CVS MinuteClinic offices. You may incur additional charges for diagnostic lab and X-ray services if they are billed on a different date or by another provider, or if your physician refers you to a hospital or an out-of-network provider. Flu shots performed as a stand-alone procedure incur no Copay when performed in-network.	$15/$50 Copay	Not covered

Preventative Care

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
Routine Adult Physical Covered annually You may incur charges for diagnostic lab or X-ray services if they are for diagnosis or treatment of a condition that is secondary to the physical.	No cost to you	Not covered

Participants may substitute their Department of Transportation (DOT) physical in lieu of their covered physical. The following preventive services are among those covered annually for adults:

- History and risk assessment;
- Chest X-ray;
- EKG;
- Urinalysis;
- Basic and comprehensive metabolic panel;
- Complete blood count;
- Fasting lipoprotein profile (total cholesterol, LDL, HDL and triglycerides);
- Annual women's preventive health services as recommended by the Department of Health and Human Services, including well-woman visits, contraceptive counseling, and domestic violence screening;
- Obesity screening;
- Depression;

- Diabetes;
- Tobacco use (including two cessation attempts per year);
- Alcohol misuse;
- Counseling for risk of diet-related chronic disease;
- Chlamydial infection test;
- Fecal occult blood test;
- Prostate specific antigen test;
- Routine immunizations including hepatitis (type A and B) for patients with increased risk or family history, influenza and pneumococcal vaccines, Lyme disease, and tetanus-diphtheria (Td) booster (once every 10 years). Flu shots performed as a stand-alone procedure incur no Copay when performed in network; and
- COVID-19 vaccination (for members over age 18)

Cancer screening via sigmoidoscopy (every five years) or colonoscopy (every 10 years) is covered. Breast cancer screenings, including 3D mammography, covered once per calendar year; cervical cancer screenings, including Pap smears, once per calendar year; and lung cancer screenings for adults ages 50-80 who have a 20-pack-per- year smoking history and currently smoke or have quit within the past 15 years. The Plan covers these services as a hospital and/or surgical benefit, but the deductible and Copay are waived when the services are billed as routine screening services. Routine PSA blood test (every year) is covered after age 39.

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
Routine Child Physical Covered based on this schedule: • First year of life: ten (10) visits • Second year of life: three (3) visits • Age 2: two (2) visits • Age 3 and older (until age 19): one (1) visit per year You may incur charges for diagnostic lab or X-ray services if they are for diagnosis or treatment of a condition that is secondary to the physical.	No cost to you	Not covered

The following preventive services are among those covered as part of a routine child physical:

- Medical history;
- Physical examination;
- Measurements;
- Sensory screening;
- Assessments;
- Hereditary and metabolic screening (at birth only);
- Appropriate immunizations;
- Tuberculin tests; and
- Hematocrit, hemoglobin or other appropriate blood tests.

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
Routine Gynecological Exam Covered annually beginning at age 16	No cost to you	Not covered
Medical and Surgical Care		
Physician Inpatient or Outpatient Medical Care When you receive physician services at a hospital or in an emergency room	10%/30% coinsurance after you pay your deductible (Waived if eligible care is approved and utilized through Carrum Health*)	Not covered, except for emergency room services determined to be a medical emergency; then 10%/30% coinsurance applies after deductible
Physician Maternity Care Includes global maternity fee for most pre-natal and inpatient care	10%/30% coinsurance after you pay your deductible	Not covered

Laboratory tests and screenings that are part of your pre-natal care are covered with no Copay, including screenings for gestational diabetes, preeclampsia, and iron deficiency anemia. Breastfeeding support is covered at no cost. Birthing centers are covered at the same level as inpatient hospital benefits. Childbirth education classes are reimbursed based on a fee schedule (contact BCBSMA for details). Family planning services for contraception are covered under the Preventive Care benefits. Voluntary sterilization for women is covered at no Copay when services are provided by an in-network provider. Voluntary sterilization for men is covered after a Copay when performed in-office or after a deductible and coinsurance if performed in a facility. The Plan does not cover routine screening ultrasounds; maternity ultrasounds must be medically necessary to be covered. Midwives are covered only in a birthing center.

**Plan Participants have access to Carrum Health for the following procedures at participating centers of excellence: hip and knee replacement surgery, spinal fusion surgery, bariatric surgery, other orthopedic and spine procedures, cardiac surgery, virtual oncology support and guidance for all diagnoses, comprehensive treatment for breast, colon, prostate, and thyroid cancer, and CAR-T cell therapy, as well as for treatment for substance use disorder. When these services are performed through Carrum, they are covered at 100%, meaning there is no out-of-pocket cost to the Participant such as deductibles, Copays, or coinsurance. Some restrictions may apply. Certain travel costs that are made through Carrum may also be covered for you and one adult companion, subject to applicable IRS limits described in IRS Publication 502. Coverage for travel costs is Dependent on numerous factors, including distance to the facility. Please contact Carrum for more details. To receive coverage through Carrum, services must be scheduled and pre-authorized by Carrum. Services must be deemed medically necessary and not otherwise excluded by the Plan. Any medical services not performed at the participating facility, or which are not part of the pre-authorized services, including pre- and post-surgery care, are subject to the Plan's usual coverage limits and cost-sharing rules. For more information, please contact Carrum at 1-888-855-7806, Monday-Friday 9 am-8 pm EST, go online to www.carrum.me/local4, or download the Carrum Health app on your smart phone.*

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
Physician Surgery Care Inpatient or outpatient, including charges for surgery, anesthesia, surgical pathology, supplies, casts and diagnostic testing performed as part of a surgical procedure performed at a hospital or an ambulatory surgical facility	10%/30% coinsurance after you pay your deductible. No coinsurance if you receive care through Carrum Health.	Not covered

The Plan covers charges for services of a licensed surgeon, assistant surgeon and anesthetist for a surgical procedure involving the:

- Incision, excision or electro-cauterization of any part of the body;
- Manipulative redirection of a fracture or dislocation;
- Suturing of a wound; or
- Removal by endoscopic means of a stone or other foreign object from the body.

If two or more procedures are performed during the course of a single operation through the same incision, or in the same operative field, eligible charges for the additional procedures will be reduced by 50%. An assistant surgeon's eligible charge shall not exceed 20% of the primary surgeon's eligible charge.

Covered surgery benefits also include: biopsy of tumors and cysts; voluntary sterilization for men (women are covered with no cost share); circumcision of newborn; correction of congenital (non-dental) anomalies; treatment of burns; insertion of prosthetic devices; assistant surgeon if complexity requires one; dental surgery related to an accidental injury (other than chewing); gastric bypass, if deemed medically necessary according to BCBMSA criteria; initial placement of contact lenses or initial lens implant required because of cataract surgery; and surgery related to temporomandibular joint (TMJ) disorders. Routine screening colonoscopy or routine screening sigmoidoscopy services are excluded from application of the calendar-year deductible.

If you receive care in an EPO hospital from a non-contracting radiologist, anesthesiologist, pathologist or emergency room physician, your services are covered at the in-network rate, since you have no control over who treats you in these situations. Contact BCBSMA if your claim has not been processed at the in-network level of benefits in this situation.

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
Lab and X-Ray		
Lab or X-Ray In-office charges billed by your physician (on a date different from your office visit)	$15/$50 Copay	Not covered
Lab or X-Ray Billed by an independent lab or X-ray facility	$15/$50 Copay	Not covered
Lab or X-Ray Billed by any provider or facility as part of a covered physical	No cost to you	Not covered
Lab or X-Ray Billed by the outpatient department of a hospital	10%/30% coinsurance after you pay your deductible (see below for the definition of diagnostic lab and X-ray services)	Not covered

Covered diagnostic lab and X-ray services include the following types of services when billed by the outpatient department of a hospital: laboratory services; X-rays; ultrasound imaging; bone density tests; machine tests; and follow-up mammography. Covered services in this category do not include MRI or PET scans.

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
Routine Mammogram Imaging and radiologist review charges, when performed at any site Routine mammogram, including 3D imaging, covered annually after age 35	No cost to you	Not covered
Routine Pap Test Laboratory charges when performed at any site	No cost to you	Not covered
MRI, CT and PET Scans Imaging charges by freestanding sites	$50/$150 Copay	Not covered
MRI, CT and PET Scans Imaging charges in outpatient department of hospital	10%/30% coinsurance after you pay your deductible	Not covered unless emergency and then 10%/30% coinsurance after you pay your deductible

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
Organ Transplants		
Hospitalization and Physician Care Services that are pre-authorized by BCBSMA are covered when related to the following human-to-human organ or tissue transplants: heart; lung; heart-lung; liver; kidney; pancreas (when the condition is not treatable by insulin therapy); kidney-pancreas; bone marrow (for leukemia); cornea; and skin and bone.	10%/30% coinsurance after you pay your deductible when services are delivered by an EPO network hospital and physician.	Not covered.
Organ Procurement From Living and Non-Living Donors	10%/30% coinsurance after you pay your deductible when delivered by an EPO network hospital and physician.	Not covered.
Transportation and Lodging of Patient and Accompanying Family Members (one for adult, two for minor child)	Up to $200 per day, up to $10,000 lifetime.	Not covered.
Lifetime Maximum	Two of each transplant type	

The following special limitations apply to the organ transplant benefit:

- The Plan does not cover organ transplant services considered to be experimental or investigational. For details see What the Medical Plan Does Not Cover or see Important Terms for a definition of experimental and investigational.
- If both the donor and recipient are covered under this Plan, the Plan covers eligible medical expenses incurred by the donor.
- No benefits are provided for the harvesting of the donor's organs (or tissue) or stem cells when the recipient is not a Participant.

- If the donor has medical insurance, this Plan will coordinate benefits with the primary plan and this Plan will be secondary payer, subject to this Plan's benefit limits.
- If both the donor and recipient are covered under this Plan, eligible medical expenses incurred by each person are treated separately.

- The Plan covers the reasonable and customary cost of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removing the organ and the hospital's charge for storing or transporting the organ.
- Immunosuppressive therapy is covered.

See What the Medical Plan Does Not Cover for other limitations or exclusions.

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
Outpatient Cardiac Rehabilitation Service Includes Phase II and III of a multi-phasic program for persons with documented cardiovascular disease	10%/30% coinsurance after you pay your deductible	Not covered

When provided in a hospital or other setting that meets the standards of the Massachusetts Commission of Public Health or a comparable health commission in another state, outpatient cardiac rehabilitation services are covered at the same level as other outpatient hospital services.

Covered cardiac rehabilitation services include Phases II and III of a multi-phasic program for persons with documented cardiovascular disease. This program provides medically necessary treatment designed to restore the patient to optimal physiological health.

- Phase I is the inpatient phase, which begins at the time of the cardiac event and continues through hospital discharge. Benefits for Phase I are covered under the inpatient hospital care portion of the Plan.
- Phase II is the outpatient convalescent phase that begins after hospital discharge and usually extends for a period of three to 12 weeks.
- Phase III is the outpatient phase that addresses multiple risk reduction, adjustment to illness and therapeutic exercise. Phase III follows the convalescent phase and usually extends for a period of 12 to 26 weeks.

The Plan does not cover Phase IV benefits, which are designed to maintain rehabilitated cardiovascular health.

To be covered, treatment must begin within 26 weeks after the diagnosis of cardiovascular disease or an event related to cardiovascular disease. An event related to cardiovascular disease includes, at a minimum:

- Angioplasty;
- Cardiovascular surgery; or
- Myocardial infarction.

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
Physical Therapy		
Physical Therapy Must be prescribed by a physician and performed by a licensed physical therapist or physician		
When provided by a freestanding physical therapy provider	$15/$50 Copay	Not covered
When provided through a rehabilitation hospital on an outpatient basis	$15/$50 Copay	Not covered
When provided through an acute care hospital on an outpatient basis	$15/$50 Copay	Not covered

Covered physical therapy is intended to provide rehabilitation to regain normal movement and strength. The Plan does not cover the following services: recreational or educational therapy; maintenance or palliative rehabilitation therapy; exercise programs; or hippotherapy (exercise on horseback). Occupational therapy services and speech therapy services are covered to the same extent and limitation as physical therapy services. Short-term rehabilitation for PT and OT is limited to 100 visits per calendar year (unlimited for autism).***

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
Chiropractic		
Chiropractic Care and Acupuncture Coverage is limited to 20 visits per service per year	$15/$50 Copay	Not covered

To be covered under the Plan, chiropractic services must be rendered by a board-certified chiropractor (DC) and services (including diagnostic services and all other treatments) must be medically necessary to treat an illness or injury.

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
Alternative Care (Holistic Medicine)		
Acupressure, Homeopathy, Massage Therapy Coverage is limited to $1,000 per calendar year for the services listed above	$15/$50 Copay	Not covered

Covered providers must be licensed in the state where they are rendering care and carry malpractice insurance. There are times when the Plan will require you to seek a referral from a licensed physician in order to approve treatment. You must file a subscriber claim form for reimbursement of alternative care treatments. Claim forms can be obtained by contacting BCBSMA or by accessing the Funds' website.

You may have to file your own claim to be reimbursed for alternative care benefits. Alternative care does not include naturopathic medicine; hormone, hair, saliva or fecal testing; supplements and minerals; or services not rendered by an MD unless services are acupressure, homeopathy or massage therapy.

***Hinge Health provides 12-week digital exercise therapy programs for back and joint pain, neck, shoulder, hip, or knee pain, as well as women's pelvic health. Eligible members have access to wearable sensors, personalized exercise therapy programs designed by a dedicated physical therapist, unlimited 1-on-1 health coaching to support goal setting and behavior change, and motion tracking technology to provide real time feedback. Participants and Dependents must be insured under the IUOE Local 4 Health and Welfare Plan to be eligible. Contact Hinge Health online at hinge.health/local4.

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
Durable Medical Equipment		
Durable Medical Equipment and Prosthetic Appliances Purchase, or rental up to the purchase price Amounts you pay for these services do not count toward your annual out-of-pocket maximum.	10%/30% coinsurance after you pay your deductible	Not covered

Durable medical equipment must serve a medical purpose and have no other essential value in the absence of an illness or injury. Equipment must meet BCBSMA medical policy guidelines.

Covered services include: non-dental braces; canes; crutches; commodes; wheelchairs; artificial limbs and eyes; breast prostheses and surgical bras following mastectomy; oxygen and equipment for its administration; inhalators; suction machines; respirators; hyperbolic oxygen chambers; breast pumps (with no cost share); insulin pumps; and CPAP machines.

Replacement of artificial limbs and eyes limited to prescription change or the appliance must be over five years old.

These benefits are provided for the least expensive equipment of its type that meets the patient need. If BCBSMA determines that the patient chose a prosthesis or other equipment that costs more than what the patient needs for their medical condition, benefits are provided only for those charges that would have been paid for the least expensive prosthesis or equipment that meets the patient need. In this case the patient must pay the provider's charges that are more than the claim payment.

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
Medical and Surgical Supplies		
Medical and Surgical Supply Charges including: bandages and casts; splints; surgical trays; therapeutic or diagnostic infusion supplies; and ostomy and catheter supplies (bandages, splints and casts provided as part of the physician office visit are covered under the office visit Copay)	10%/30% coinsurance after you pay your deductible. No coinsurance if you receive care through Carrum Health.	Not covered
Mental Health/Substance Use Disorder Care		
Inpatient Mental Health Facility Charges*	10%/30% coinsurance	Not covered
Inpatient Substance Use Facility Charges*	10%/30% coinsurance. No coinsurance if you receive care through Carrum Health.	Not covered
Inpatient Mental Health Professional Charges*	10%/30% coinsurance	Not covered
Inpatient Substance Use Professional Charges*	10%/30% coinsurance. No coinsurance if you receive care through Carrum Health.	Not covered
Outpatient Mental Health Counseling In-office or hospital outpatient	$15/$50 Copay in the office, virtually, or hospital outpatient, other than for eight (8) counseling sessions through the EAP, Lyra Health (inclusive of one (1) cancellation), which are provided at no cost to you. You are not required to utilize the counseling sessions through the EAP prior to utilizing the outpatient mental health counseling benefit.	Not covered

Integrated Cognitive Behavioral Therapy (ICBT) is covered if pre-authorized by BCBSMA. Please contact BCBSMA for covered providers that provide ICBT.

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
Partial Day Hospitalization/Intensive Outpatient Services (IOP)* These services are used in lieu of full inpatient care. These services use an inpatient setting but the patient is discharged to home at the conclusion of each day of care	$15/$50 Copay. No cost share if you receive care through Carrum Health.	Not covered
Neuro-Psych Testing In-office or hospital outpatient Behavioral and developmental screenings, including for autism, are covered with no cost share under the Preventive Care benefits.	$15/$50 Copay	Not covered
Employee Assistance Program (EAP), administered by Lyra Health	No cost for Participant or covered Dependent when using EAP services through Lyra Health.	

The Employee Assistance Program (EAP) provides a qualified and confidential source of help for Participants and covered Dependents experiencing personal problems. In many instances, you may resolve these problems without the services of the EAP. Sometimes, however, it may be in your best interest to seek outside assistance. EAP benefits are available to you and your eligible Dependents at no charge. Any calls you make to the EAP are completely confidential. Under no circumstances will your name or information about your situation be passed on to your employer or the Union office.

While the EAP may not solve your problems, it is a reasonable place to start dealing with problems that may be overtaking your life. For several major problems and conditions, skilled and experienced professionals are available to help. You can call the EAP at Lyra Health for a broad range of problems including:

- Stress;
- Anxiety;
- Depression;
- Marital problems;
- Family Counseling;
- Financial difficulties; and
- Alcohol and drug abuse.

EAP counselors are available 24/7/365 by calling 1-844-926-2482 or by going to www.local4funds.lyrahealth.com. Lyra Health provides online self-help content, coaching via text or phone, individual and group therapy, and medication management for eligible Participants and Dependents. Lyra Health provides up to eight (8) virtual counseling sessions at no cost to you (inclusive of one (1) cancellation). If additional counseling is necessary, if in-person counseling is preferred, or if you might benefit from prescription medication, Lyra Health will work to place you with an appropriate provider on its network. If you need long-term care, Lyra will also work to place you in a treatment facility in the BCBSMA network. Lyra will also place you with work-life services, if necessary, including financial advice, legal referrals, and child, elder, and pet care referrals. Regular medical plan cost sharing applies.

*All inpatient admissions, including partial day hospitalization/intensive outpatient care, must be pre-authorized or pre-certified by BCBSMA or Carrum. See page 33 regarding Pre-authorization Review.

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
Fertility Benefits Medically necessary fertility treatment options, including: artificial insemination (IUI), bloodwork and testing, fresh IVF cycle, frozen embryo transfer (FET), frozen oocyte transfer (includes fertilization of previously frozen oocytes and transfer), IVF freeze-all, pre-authorized fertility medications (via Progyny Rx), PGT-A (PGS, or Pre-implantation Genetic Screening) to assess embryo viability, PGT-M (PGD, or pre-implantation genetic diagnosis), pregnancy gap coverage (pregnancy monitoring coverage until the in-network fertility clinic releases the member into the care of the member's OBGYN medical provider), and tissue transportation (transportation of member's previously frozen reproductive tissue to in-network facilities). Fertility preservation covered under certain conditions if deemed to be a medical necessity (see page 101 for definition). Call Progyny at 1-866-606-9789 or visit progyny.com/benefits.	10%/30% coinsurance after you pay your deductible. All services must be provided by Progyny.	Not covered

Progyny's benefit has the following exclusions:

Home ovulation prediction kits, Dependent Child/children, services and supplies furnished by an out-of-network provider or not listed as covered in the Progyny Member Guide, all charges associated with a gestational carrier program for the person acting as the carrier, including but not limited to laboratory tests, and treatments that are outside the standard of care and considered experimental by the American Society of Reproductive Medicine.

What the Medical Plan Does Not Cover

1. Confinement, surgical procedures or treatments that occur before the effective date of coverage. The Plan does cover confinements, surgical procedures or treatments as of the effective date of coverage, regardless of when treatment began.
2. Any job-related accidents or illnesses which Workers' compensation would cover, regardless of whether such coverage was in force or whether you applied for or received Workers' Compensation benefits.
3. Services to the extent that payment under the Plan is prohibited by any law to which any Participant or family member is subject at the time expenses were incurred.
4. Charges which would not have been incurred had the coverage not existed or charges for services rendered by parents, siblings, Spouses, children or children-in-law.
5. Charges in excess of what is reasonable and customary for the locality in which services are performed or in excess of the Plan's negotiated fees, if lower.
6. Plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies that improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent needed to improve the function of a part of the body that is:
   - A result of a severe birth defect;
   - A direct result of disease or surgery previously performed; or
   - To treat a disease or injury.
7. Eyeglasses, hearing aids, or examinations for prescription or fitting, unless otherwise stated (see Vision Plan for information on vision care benefits and Hearing Plan for information on hearing care benefits).
8. Dental treatment or services, unless the expense is the result of an injury to sound, natural teeth (other than chewing) as a result of injury (see Dental Plan for information on dental benefits).

9. Routine foot care including treatment for weak, strained, unstable and flat feet; bunions (unless cutting procedures are involved); and cutting or removal of corns and calluses.
10. Expense of travel except when specifically covered under the BDCT Transplant Network program or under Carrum Health (subject to the applicable IRS limits described in IRS Publication 502).
11. Any expense or charge that results from an act of declared or undeclared war.
12. Any expense or charge resulting from commission of a felony or attempt to commit a felony unless the injuries are the result of a medical condition or unless the covered person is a victim of the commission of a felony or attempt to commit a felony or the victim of domestic violence.
13. Any expense for care, services and supplies that are not medically necessary or not recommended by a physician.
14. Nutritional and mineral supplements and vitamins, unless otherwise stated.
15. Wigs or hair prostheses, unless prescribed due to loss of hair resulting from chemotherapy or radiation therapy.
16. Any special diets or nutritional counseling, regardless of whether prescribed by a physician, unless as the result of illness, injury, eating disorder, or otherwise stated.
17. Any expense for experimental treatment still under clinical investigation by health professionals and determined as not covered by BCBSMA Medical Policies, unless excepted under 42 U.S.C. s. 300gg-8 as a clinical trial for the treatment of cancer or another life-threatening disease. The fact that the experimental treatment is the only available treatment for a particular condition will not result in benefits if the procedure or treatment is considered to be experimental or still under clinical investigation. A case-by case exception can be made to consider coverage of medically necessary diagnostic tests such as laboratory, pathology, or X-ray services or office visits that are not otherwise covered when provided under a qualified clinical trial (see Important Terms for a definition of experimental or investigative).
18. Any expense for acupuncture, acupressure, homeopathy or massage therapy, unless the provider is licensed in the state in which they practice and carries malpractice insurance.
19. Any expense for or in connection with sex transformations or any treatment related to sexual dysfunction.
20. Charges levied by a physician for their time spent traveling, for broken appointments, for transportation costs, or for advice given by telephone or other means of communication, other than telehealth services covered by the Plan.
21. Surgery that is intended to allow you to see better without glasses, or other vision correction including radial keratotomy, laser and other refractive eye surgery (see Vision Plan for information on vision care benefits).
22. Corrective shoes, orthotics, or pillows and any other supportive devices for the feet or back.
23. Any expenses in connection with appetite control or any treatment of obesity, except for surgery to treat morbid obesity, when the patient meets the BCBSMA criteria; morbid obesity is defined as being more than 100 pounds over normal weight for at least five years.
24. The reversal of voluntary sterilization.
25. Durable medical equipment for non-medical use (regardless of whether prescribed by a physician), such as heating pads, whirlpool baths, exercise equipment or devices, ramps or handrails, air conditioners, purifiers, humidifiers, or items of furniture.

26. Any expense incurred after coverage ends, regardless of when treatment began.
27. Chelation therapy, except for the treatment of acute arsenic, gold, mercury, or lead poisoning.
28. Any expense or charge for services or supplies that are provided or paid for by the federal government or its agencies, except for: The Veterans' Administration, when services are provided to a veteran for a disability that is not service-connected;
    - A military hospital or facility, when services are provided to a retiree (or Dependent of a retiree) from the armed services; or
    - A group health plan established by a government for its own civilian Employees and their Dependents.
29. Any loss, expense or charge that is incurred while the Participant is on active duty or training in the armed services, National Guard, or reserves of any state or country and for which any governmental body or its agencies are liable.
30. With respect to organ transplants, the Plan will not cover transplants deemed experimental or investigative by standard medical guidelines, nor will it cover:
    - Any transplant expense when approved alternative remedies are available;
    - Any animal organ or mechanical equipment, devices or organ(s), except as specifically noted;
    - Anything that is otherwise excluded under the Plan's limitations; and – Any expenses incurred by a donor associated with a body organ transplant if the recipient is not covered under this Plan.
31. Any expense related to court-ordered or any random drug testing, unless part of medical care.
32. Home births, except for an emergency or unplanned delivery that occurs at home prior to being admitted to a hospital or a home birth that occurs outside of Massachusetts; services provided by a doula or a midwife that is not a certified nurse midwife.

Prescription Drug Program

When your physician prescribes a prescription drug, you have several options. Your share of the cost of prescription drugs depends on where you buy your drug, what type of drug you are buying, whether you have the Basic or Supplemental Benefits Plan coverage, whether you are on the "B" level of either Plan, and whether you have reached your out-of-pocket maximum for the year.

In all instances on the following Prescription Drug Program Charts, the first dollar amount indicates your cost share if on Basic or Supplemental Plan A; the second dollar amount indicates your cost share if on Basic or Supplemental Plan B.

Basic Benefits Prescription Program: (These benefits apply only if you are covered under the Basic Eligibility Rule)

	Retail Program: **for a 30-day supply for immediate drug needs or short-term medications, maintenance drugs or supplies are subject to a stepped Copay that will be doubled after 2 fills for maintenance drugs when not purchased through CVS retail pharmacies or Optum Rx Home Delivery Program.**	**Mail Service Program:** **for a 90-day supply for maintenance or long-term medications purchased through Optum Rx Home Delivery Program.**	**Maintenance Choice Program:** **for maintenance or long-term medications purchased at CVS retail pharmacies for 90-day supplies.**
Subject to $250 individual/$500 family annual prescription deductible (RxD) for Supplemental Plan A and to $500 individual/$1,000 family annual prescription deductible for Supplemental Plan B.			
When your prescription falls into this category:	And you buy it from a participating retail network pharmacy, you pay:	And you buy it from the mail service program, you pay:	And you buy it from a CVS retail pharmacy, you pay:
Tier 1: Generic drug	$10/$30 Copay for 30-day supply	$20/$60 Copay for 90-day supply	$20/$60 Copay for 90-day supply
Tier 2: Brand-name drug on formulary*	$30/$90 Copay for 30-day supply	$60/$180 Copay for 90-day supply	$60/$180 Copay for 90-day supply
Tier 3: Brand-name drug not on formulary	$50/$150 Copay for 30-day supply	$100/$300 Copay for 90-day supply	$100/$300 Copay for 90-day supply
Specialty Drugs (max. 30-day supply)	$200/$600 Copay, potentially reduced to the manufacturer's required amount (typically between $5 and $10) if you choose to utilize the available Copay assistance provided by the manufacturer.		

The Trustees adopted a prescription coupon card program through Optum. This program will be at point of purchase at Optum Specialty Pharmacy. Drug manufacturers offer coupons, also known as Copay cards, to help consumers reduce their Copay of costly specialty medications. If you are using a specialty medication, contact Optum Specialty Pharmacy to check if your prescription has a coupon card program. As soon as you sign up for a manufacturer coupon and share the details with Optum Specialty Pharmacy, the cost share is automatically adjusted for the medication and applies the coupon value at the point of sale. This helps lower your cost share and both the Participant and Plan will save. For any such specialty medication where third-party Copayment assistance is used, you will not receive credit toward your maximum out-of-pocket or deductible for any Copayment or coinsurance amounts that are covered by the manufacturer Copay card or coupon.

*In order to be considered a Tier 2 drug, the drug must be listed on the Optum formulary (preferred drug list). The formulary is a list of preferred prescription medications that have been chosen because of clinical effectiveness, cost and safety. The Optum formulary changes often to reflect the most current developments. If you would like a copy of the most up-to-date version of the formulary to take with you to a doctor's appointment, call Optum at 1-855-241-2213, or go to www.optumrx.com.

Supplemental Benefits Prescription Program: (These benefits apply only if you are covered under the Supplemental Eligibility Rule)

	Retail Program: for a 30-day supply for immediate drug needs or short-term medications, maintenance drugs or supplies are subject to a stepped Copay will be doubled after 2 fills for maintenance drugs when not purchased through CVS retail pharmacies or Optum Rx Home Delivery Program.	**Mail Service Program:** **for a 90-day supply for maintenance or long-term medications purchased through Optum Rx Home Delivery Program.**	**Maintenance Choice Program: for maintenance or long-term medications purchased at CVS retail pharmacies for 90-day supplies.**
Subject to $250 individual/ $500 family annual prescription deductible (RxD) for Supplemental Plan A and to $500 individual/ $1,000 family annual prescription deductible for Supplemental Plan B.			
When your prescription falls into this category:	And you buy it from a participating retail network pharmacy, you pay:	And you buy it from the mail service program, you pay:	And you buy it from a CVS retail pharmacy, you pay:
Tier 1: Generic drug	$20/$60 Copay for 30-day supply, after you pay your RxD	$40/$120 Copay for 90-day supply, after you pay your RxD	$40/$120 Copay for 90-day supply, after you pay your RxD
Tier 2: Brand-name drug on formulary*	$60/$180 Copay for 30-day supply, after you pay your RxD	$120/$360 Copay for 90-day supply, after you pay your RxD	$120/$360 Copay for 90-day supply, after you pay your RxD
Tier 3: Brand-name drug not on formulary	$100/$300 Copay for 30-day supply, after you pay your RxD	$200/$600 Copay for 90-day supply, after you pay your RxD	$200/$600 Copay for 90-day supply, after you pay your RxD

Specialty Drugs (limited to 30-day supply) $200/$600 Copay, potentially reduced to the manufacturer's required amount (typically between $5 and $10) if you choose to utilize available Copay assistance provided by the manufacturer.

Making Sense of Rx Levels

- Tier 1: This is the lowest Copay and applies to most generic drugs.
- Tier 2: This is the mid-level Copay and applies to brand-name drugs on the formulary list (preferred drugs).
- Tier 3: This is the highest Copay and applies to brand-name drugs that are not on the formulary list (non-preferred drugs). Most Tier 3 drugs have an approved generic equivalent covered at Tier 1 or an alternative brand-name drug covered at Tier 2.

If you need help in determining what tier your prescription falls into, call Optum Rx.

Stepped Copay – The first two fills of a maintenance drug or supply are covered at the standard Copay if purchased at any in-network retail pharmacy. After two fills you will be charged two times the in-network retail pharmacy Copay for any additional fills of the same maintenance drug or supply purchased at a retail store unless you purchase maintenance drugs or supplies at 90-day rates through either Optum Rx Home Delivery Program or at CVS retail pharmacies.

Maintenance Drugs or Supplies – A maintenance drug or supply is one that is considered long term. Examples include blood pressure pills, diabetic or cardiac medications, birth control pills, or diabetic test strips. Maintenance drugs should be purchased at 90-day rates at Optum Rx Home Delivery or CVS retail pharmacies to avoid a stepped Copay.

Diabetic Meter Program – Participants can receive a free blood glucose meter and free test strips if they are diagnosed with diabetes. Call Optum Rx at 1-855-241-2213 to sign up to receive a meter and test strips. You may receive one meter as part of your pharmacy benefit every three years.

Continuous Glucose Monitors

Eligible Participants may receive a continuous glucose monitor (CGM) if prescribed by a physician. CGMs are subject to Pre-authorization. Eligible Participants will be entitled to one Dexcom receiver per year, and an annual supply of sensors and transmitters for the CGM, at applicable Plan Copays.

Smoking Cessation Drugs – The Plan includes coverage for all FDA-approved prescription and over-the-counter drugs for smoking cessation such as Chantix and Zyban. These drugs are available at no Copay for a 90-day treatment regimen when prescribed by a health care provider. If you need additional medication and have a prescription from your doctor, you can purchase additional medication using the Optum Rx discount, but you will pay the full cost of the prescription.

How to Use the Prescription Drug Program

To make the most of the prescription drug program, buy your prescription from a participating pharmacy. Or, if your physician prescribes maintenance medications, use the Optum Rx Home Delivery Program or CVS retail pharmacies.

To Fill Your Prescription at a Participating Retail Network Pharmacy

- Present your Optum Rx ID card to the pharmacist along with your prescription.
- Pay the Copay that applies to your prescription. Pharmacists at participating pharmacies have instant online access to the Plan formulary.

To Fill Your Prescription at a Non-Participating Pharmacy

- You must pay the full cost of the prescription when you fill it.
- Call Optum Rx or access the Funds' website or Optum app to receive a claim form.
- Mail your completed claim form along with your receipt to Optum Rx at the address shown on the form.
- Optum Rx will reimburse you for the cost of your prescription up to the negotiated amount they would have paid at a network pharmacy, less the applicable Copay.

Dispense as Written Rules

When a generic is available but the pharmacy dispenses the brand drug per the physician's request or based on the member's own preference, the member will pay the applicable brand Copay plus the difference between the brand discount and the generic discount.

To Fill Your Prescription Through the Mail Service Program

- Ask your physician to prescribe up to a 90-day supply of your maintenance medication(s).
- The first time you use mail order for each prescription, be sure to request two prescriptions: one for a 30-day supply that you can fill at a local participating pharmacy, and one for a 90-day supply that you can order by mail.
- Use the mail service claim form in your Optum Rx handbook, print it from the Fund's website at www.local4funds.org or call Optum Rx for a new form.
- Mail the completed form and prescription(s) with credit card information or a personal check for your Copay and/or deductible, if applicable, to the address shown on the form.
- To order refills, use the return envelope you receive back with your prescription, or call Optum Rx at 1-855-241-2213 to re-order by phone. Or re-order online at www.optumrx.com.
- Specialty drugs are limited to a 30-day fill and may not be purchased through the Mail Service Program.
- You can also set up your prescription so that Optum Rx will automatically re-order for you and contact your doctor when the prescription is about to expire.
- If you choose to re-order yourself, re-order your prescription three weeks in advance of the date your current prescription runs out. You can also sign up for refill reminders via phone, text or email from Optum Rx.
- If you have questions about the refill process, you can call Optum Rx for 24-hour assistance.

Purchase Non-Covered Drugs at a Discount

Drugs that are not covered by the Plan may be purchased at 100% of the Optum Rx discounted rate through the Optum Rx Price Edge program. Contact Optum Rx to estimate the cost of a purchase. When a drug is not covered by the Plan, Optum Rx will process the claim with the best coupon discount available at the time of purchase.

Preventive Drugs

Drugs that are considered preventive under the Patient Protection and Affordable Care Act (ACA), such as statins, contraceptives, smoking

cessation drugs, breast cancer prevention drugs, and bowel preparation agents, may be available to you at no cost if you meet certain criteria.

Drugs That Require Pre-authorization

You or your physician must contact Optum Rx to initiate Pre-authorization if your physician prescribes:

- Continuous glucose monitors and/or glucose sensors;
- Diabetic GLP-1 medications (only covered if patient has confirmed Type 2 Diabetes diagnosis);
- Retin A for adults (covered only if the patient meets acne criteria);
- Opioids;
- Infant formula (covered only if deemed Medically Necessary);
- Compounded medications costing more than $300.00;
- ADHD/ADD drugs for those aged 19 or older;
- Oral allergy serums;
- Cialis 2.5mg and 5mg for daily Benign Prostatic Hyperplasia use;
- Antifungal medications such as Lamisil tablets;
- Testosterone;
- Crinone;
- Solaraze;
- Eucrisa;
- Santyl;
- Voltaren Gel;
- Praduxin;
- Zonalon;
- Metformin 1000mg ER; and
- Other drugs, as the Plan deems necessary.

To request Pre-authorization, your physician must complete the Optum Rx prior authorization form. If you fail to request Pre-authorization for any of these drugs, your claim will be denied and the Plan will not cover the drugs. You will be responsible for paying the full cost of the drugs. To find a list of drugs that require prior authorization, visit the Member Portal at optumrx.com and view the "Drug List Tool" under the "Member Tools" drop-down. This tool allows you to search for drugs by name, alphabetically, and/or by therapeutic class. Medications will list the formulary placement as well as prior authorization requirements.

What the Prescription Drug Program Does Not Cover

The Prescription Drug Program does not cover:

- Non-federal legend drugs, other than insulin. A legend drug must bear the following phrase on its packaging: "Caution: "(USA) federal law prohibits dispensing without a prescription. However, non-federal legend drugs that are considered preventive under the ACA, such as aspirin and fluoride, may be available to you at no cost if you meet certain criteria;
- Drugs utilized for purposes for which the efficacy or safety has not been established or for a use not approved by the FDA;
- Therapeutic devices or appliances, support garments, and other non-medical substances;
- Drugs labeled "Caution—limited by federal law to investigational use," or experimental drugs, including compounded medications for non-FDA approved use;
- Medication for which the cost is recoverable under any Workers' Compensation or occupational disease law or any state or

governmental agency or medication furnished by any other drug or medical service for which no charge is made to you;

- Medication to be taken by or administered to you, in whole part, while you are a patient in a licensed hospital, rest home, sanatorium, extended care facility, skilled nursing facility, convalescent hospital, nursing home, or similar institution that operates on its premises or allows to be operated on its premises a facility for dispending pharmaceuticals (the Medical Plan, rather than the Prescription Drug Program, covers prescription drugs in these cases);
- Any prescription refilled in excess of the number of refills specified by your physician or any refill dispenses after one year from the physician's original order;
- Fertility medications (all fertility medications are to be processed through ProgynyRx as part of pre-approved medically necessary fertility treatments only);
- Erectile dysfunction medications, unless otherwise noted;
- Diet medications;
- Nutritional supplements, other than preventive drugs such as iron for children ages 6-12 months, folic acid for women through age 50, and vitamins D2 and D3 for adults through age 65;
- Cosmetic products for drugs for cosmetic uses, unless otherwise noted;
- Injectable allergy serums (which would be covered if necessary and as appropriate under the Medical Plan);
- Respiratory therapy supplies other than spacers and peak flow meters (which would be covered if necessary and as appropriate under the Medical Plan);
- Weight loss medications including, but not limited to, Wegovy, Saxenda, and Zepbound, unless the medication is deemed medically necessary for an FDA-approved use other than weight loss and that meets the Plan's requirements for medical necessity; and
- Any drugs or other products that are determined to not meet the Plan's requirements of medical necessity.

Optum Specialty Pharmacy

Optum Specialty Pharmacy provides 24-hour access to specialty pharmacy services and will coordinate the delivery of specialty medications to your home. Call 1-855-427-4682 or visit specialty.optumrx.com to verify your coverage of medications for:

- Cancer
- Crohn's and Ulcerative Colitis
- Fertility
- Hepatitis and liver disease
- Inflammatory arthritis and skin conditions
- Multiple Sclerosis
- Neurological conditions
- Respiratory disorders
- And more

Optum Specialty Pharmacy provides clinical expertise by specialty trained pharmacists with services including:

- An individualized patient care plan
- Verbal and/or written education about medications
- Medication self-administration training
- Communication with your physician
- Manage your account and request refills online, anywhere and anytime

- Free shipping for delivery of all medications and medication supplies
- Assistance in identifying financial assistance programs
- Clinicians available 24/7 for emergency support

Use of Rx Copay Cards

Many people look for ways to help save on high-cost brand-name medications. One way is to use Copay cards from drug manufacturers. Copay cards can lower your prescription drug out-of-pocket (OOP) costs, but there may be limits on how much you can save each year. If you use a Copay card to pay for your prescription(s), the amount covered by the Copay card will not count toward your deductible or OOP maximum. Only your OOP costs will be applied to your deductible and OOP maximum.

In the example below, your Copay card covers $350 of your medication cost of $400. Your member cost share of $50 is the only amount that counts toward your deductible and OOP maximum.

Your medication costs $400

Your Copay card covers $350

Your member cost share is $50*

**This cost share amount applies to both your deductible and OOP maximum*

SECTION III:
Dental, Vision and Hearing Coverage

Dental Plan

The Dental Plan assists you and your family in paying dental expenses if you are covered under the Basic Benefits Plan A or the Retirement Bridge Plan. These services are administered by BCBSMA (Dental Blue). Supplemental Benefits Plan Participants do not have dental coverage unless they purchase the additional benefits available through the Bridge Plan. The Dental Plan utilizes the Blue Cross Blue Shield (BCBS) Dental Blue Network of dentists. You can see if your current dentist is in the Dental Blue network by visiting https://member.bluecrossma.com/fad. If your current dentist is a member of the Dental Blue network, no action is required. When you go to the dentist, show your dental ID card. If your current dentist is not part of the Dental Blue network, consider changing to an in-network dentist. Or, call Dental Blue at 1-800-401-7690 so they can contact your dentist and try to add him or her to the network.

What the Dental Plan Covers

All covered dental services are paid as follows:

Dental Plan Summary

Maximum calendar-year benefit per covered person (not including orthodontia) age 19 and over No annual maximum applies to covered persons under age 19	$2,500		
Deductible	None		
Covered services (except orthodontia)	Type of Service	In-Network Dentist Coverage:	Out-of-Network Dentist Coverage:
	Type 1: Diagnostic and Preventive	100%	100% of Dental Blue's usual and customary charge
	Type 2: Restorative and Other Basic	80%	80% of Dental Blue's usual and customary charge
	Type 3: Major Restorative	60%	60% of Dental Blue's usual and customary charge
Orthodontia	Your in-network coverage is 50% of charges, up to a lifetime maximum benefit of $2,500 per person, for non- medically necessary orthodontia. Your out-of-network coverage is 50% of Dental Blue's usual and customary charge, up to a lifetime maximum benefit of $2,500 per person, for non-medically necessary orthodontia. Charges above $2,500 in benefits are your responsibility, unless the orthodontia is medically necessary, as determined by the Plan.		

Dental Blue In-Network Dentists – These dentists have agreed to accept a lower negotiated fee for their services. This helps reduce your coinsurance. Your routine diagnostic and preventive services are covered at 100% when you use a Dental Blue dentist. To locate a Dental Blue dentist, visit the BCBSMA website at www.bluecrossma.com or call Dental Blue at 1-800-401-7690.

Out-of-Network Dentists – These dentists do not have a contract with Dental Blue. Your routine diagnostic and preventive services are covered at 100% of Dental Blue's usual and customary charge. Dental Blue reimburses you for services with these dentists using the lesser of the dentist's actual charge or the maximum plan allowance for non-participating dentists.

Dental Surgery

Oral surgeons and periodontists generally perform dental surgery in their dental offices or at a hospital outpatient surgical day unit. There are times when such a procedure requires inpatient hospitalization.

Professional dental surgery charges (surgeon's fees, whether you incur them in a dental office or in a hospital surgical day care setting, are covered under the Dental Plan. Inpatient or outpatient hospital facility charges incurred in connection with dental surgery are paid under the Medical Plan, but use of a facility is subject to prior authorization by BCBSMA. Use of an emergency room for dental services is not covered under the Medical or Dental Plan unless the services are related to an accidental injury not related to chewing.

Pre-Treatment Estimates

You are not required to have a pre-treatment estimate, but you may choose to have your dentist request a pre-treatment estimate through Dental Blue for more expensive procedures. This ensures that you know in advance how much the Plan will pay and what your share of the expenses will be.

Covered Expenses

The following is an overview of Dental Plan benefits.

Preventive, Diagnostic and Emergency Services (Type 1)

- Preventive procedures prevent or minimize the occurrence of dental disease. Covered preventive procedures include: prophylaxis (cleaning and polishing of teeth), twice per calendar year; fluoride applications (regardless of age), twice per calendar year; sealants on unrestored permanent molars for covered Dependents through age 15, once per tooth; and space maintainers required due to premature loss of teeth for children under age 14 and not for the replacement of primary or permanent anterior teeth.
- Diagnostic procedures assist in the evaluation and identification of existing dental conditions and the dental care required. Covered diagnostic services include comprehensive oral examination (including the initial dental history and charting of teeth), once every 60 months; periodic oral evaluation, twice per calendar year; bitewing X-rays, twice per calendar year; bitewing or single tooth X-rays, as conditions indicate; full-mouth X-rays, once every 60 months.
- Periodontal maintenance once every three (3) months following active periodontal treatment. Not to exceed two (2) in one calendar year if combined with preventive cleanings.

Basic Restorative Services (Type 2)

- Basic restorations include those pertaining specifically to the repair and reconstruction of natural teeth. Fillings are covered once every 12 months per surface per tooth. Composite (white) fillings are

covered for single-surface front or back teeth. Composite (white) fillings are covered for multi-surface front teeth. Multi-surface fillings on back teeth are covered up to the amalgam (silver) allowance and the Participant pays the difference. You are responsible up to the dentist's charge. No benefits are provided for replacing a filling within 12 months of the date that the prior filling was furnished. Covered services include crowns (caps), inlays, and onlays.

- Sedative filling, once per tooth; stainless steel crowns on baby teeth, once every 24 months per tooth.
- Oral surgery includes procedures such as simple/surgical tooth removal, removal of impacted teeth and other oral surgical procedures. It also includes alveoplasty once per quadrant per lifetime.
- General anesthesia when necessary and appropriate for covered surgical services, only when provided by a licensed, practicing dentist.
- Emergency services provide treatment to relieve dental pain. Covered emergency services include oral evaluation problem focused exams twice per calendar year.
- Endodontics (root and pulp care) is the specialty that deals with procedures for the treatment of diseases of the pulp chamber and pulp canals (root canal filling) of permanent teeth, including the treatment of the nerve of the tooth, the removal of dental pulp and pulpal therapy. Root canal treatment is once per lifetime per tooth. Vital pulpotomy is limited to deciduous teeth.
- Periodontics (gum and bone care) includes the examination, diagnosis and treatment of diseases of the gums. Covered services include periodontal surgery, scalings and/or root planing, management of acute infections and lesions of the mouth and the removal or reshaping of diseased bone (osseous surgery), crown lengthening and bone grafts.
- Repair of fixed bridgework; repair or relining of partial or full dentures; repair or recementing of crowns, onlays and bridgework; and adding teeth to existing partial or full dentures are included in this category.

Major Restorative Services (Type 3)

- Major restorations are more complex than basic restorations. Covered services include crowns (caps), inlays and onlays — used when teeth cannot be restored with regular fillings due to severe decay or fractures, once each 60 months per tooth.
- Prosthodontics (teeth replacement), or procedures for the construction, placement, insertion and repair of natural teeth. This category includes fixed bridgework, partial and removable dentures once each 60 months, except in extraordinary circumstances, and dental implants in lieu of bridges and individual implants as needed. Bone grafting to support an implant is also covered here.
- Temporary partial dentures to replace any of the six upper or lower front teeth, but only if they are installed immediately following the loss of teeth during the period of healing or for the replacement of permanent teeth for covered individuals who are under 16 years.

Orthodontic Services

Orthodontic treatment provides for the proper alignment of the teeth.

Covered services include straightening of crooked, crowded or protruding teeth.

Rollover Max

Although the Plan's calendar year maximum is $2,500, up to $700 in unused benefits can be rolled over to a subsequent year, to a maximum

of $1,500 per lifetime for rollover purposes. In order to be eligible for this benefit you must have received an annual oral exam or cleaning in the prior calendar year and used less than $900 in benefits that year.

What the Dental Plan Does Not Cover

The Dental Plan does not cover:

- Treatment of teeth or gums for cosmetic purposes (including charges for whitening, bleaching agents, or personalization or characterization of dentures);
- Treatment of an injury or dental disease for which coverage would be provided by Workers' Compensation, regardless of whether such coverage was in force or whether you applied for such coverage or received Workers' Compensation benefits;
- War-related diseases or injuries or losses incurred while engaged in military, naval or air service so long as coverage is provided by the military;
- Replacement of prostheses which cannot be made serviceable less than five years after a preceding placement;
- Charges for which you or your covered family members are not required to pay, including charges for services furnished by any hospital or organization which normally makes no charge if the patient has no hospital, surgical, medical or dental insurance;
- Charges for any dental procedures that are included as covered medical expenses under the Medical Plan;
- Charges for treatment by anyone other than a dentist, except for scaling or cleaning of teeth, which may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and direction of the dentist;
- Rebase or reline of a denture more often than once in any three-year period;
- Replacement of lost or stolen dentures, bridges, space maintainers or periodontic appliances;
- Charges for periodontal splinting or myofunctional therapy;
- Appliances or restorations (not in conjunction with the orthodontic benefit) to:
  - Increase vertical dimension;
  - Restore occlusion;
  - Replace tooth structure lost by attrition;
  - Correct congenital or developmental malformations; or
  - Improve aesthetic appearance;
- Any expense or charge for treatment of craniomandibular or temporomandibular joint (TMJ) disorders (this treatment is covered as a medical expense, with limits, under the Medical Plan); and
- Services that are not generally accepted as determined by Dental Blue, services that are not described as a benefit in this Summary Plan Description, services rendered due to the requirements of a third party, fees for travel time, a method of treatment more costly than is customarily provided, fees for appointments you fail to keep, fees for dietary advice and instructions in dental hygiene, and consultations.

Vision Plan

The Vision Plan covers certain vision care expenses for you and your family. EyeMed administers vision benefits for the Plan. Participants enrolled under the Basic Benefits Plan A, the Retirement Bridge Plan, or those who have purchased Bridge Coverage or COBRA 2 or the Pension

50% Buy-In Plans are eligible for Vision Plan benefits. Participants enrolled under the Basic Benefits Plan B, Supplemental Benefits Plan, Pension 100% Buy-In, COBRA 3 or COBRA 4 Plans have no Vision Plan benefits.

Levels of Coverage

When you receive care from a panel provider: EyeMed maintains a network of panel providers who offer services and supplies at negotiated fees. When you purchase Plan items from a panel provider, your out-of-pocket costs are limited. When you purchase non-Plan items from a panel provider, you must pay the provider the difference between the Plan allowance and the actual cost of the items. You need not file any claim forms. The panel provider will inform you of the cost at the time of service.

When you receive care from a non-panel provider: You pay more for care and services, depending upon where you receive your care and what you purchase. With non-panel providers, you must pay the provider directly at the time of service and then submit your completed claim form to EyeMed, along with your receipt, for reimbursement up to the Plan allowance.

How to Use the Vision Plan

To use the Vision Plan, follow these steps:

- If you choose a panel provider, the provider will handle all paperwork and approvals.
- If you make an appointment with a non-panel provider, call EyeMed to request a claim form. Ask the provider to complete the bottom portion of the form.
- After you sign the claim form, send it together with your paid receipt to the address shown on the claim form.
- EyeMed will send a check to your home address reimbursing you up to the Plan's allowable expense.

Identification When You Use the Vision Plan

When you use your EyeMed benefits, do not use your BCBSMA ID number. All EyeMed account information is maintained under the EyeMed ID of the covered Participant.

For a list of EyeMed providers call EyeMed at 1-866-723-0514, or access the website at www.eyemed.com and utilize the "Find a Doctor" feature. Or you can call the Funds Office. BCBSMA network Medical Plan providers are not considered panel providers for purposes of the routine vision benefit provided through EyeMed.

What the Vision Plan Covers

Covered vision care expenses include eye examinations and eyeglasses or contact lenses. Eligible expenses are covered according to the following schedule:

Vision care	For you, your Spouse and your covered Dependents
Eye exam	Once every Plan year
One pair of eyeglasses or contact lenses	Once every Plan year

Your share of the cost depends on where you receive care. Here are the services the Plan covers.

When you receive this care:	From a panel provider and buy these Plan items, you pay:	From a non-panel provider, you pay:
Comprehensive eye examination	$15 Copay each Plan year	Amounts above $57
Frames	$0 Copay, 20% off balance over $200 allowance	Amounts above $160
Contact lens fitting	$0 Copay for standard fitting and two follow-up visits	Amounts above $25
Single, bifocal or trifocal lenses	$0 Copay	Single-vision lenses: Amounts above $47 Bifocal lenses: Amounts above $79 Trifocal lenses: Amounts above $113
Invisible bifocal lenses (progressives)	Standard - $0 Copay Tier 1 - $30 Copay Tier 2 - $40 Copay Tier 3 - $55 Copay Tier 4 - $100 Copay	Standard – amounts above $73 Tier 1 – Amounts above $77 Tier 2 – Amounts above $91 Tier 3 – Amounts above $100 Tier 4 – Amounts above $95
Disposable/planned replacement lenses	$0 Copay Disposable contact lenses: 100% of balance over $150 allowance Conventional contact lenses: 15% off balance over $150 allowance	Disposable or conventional contact lenses: Amounts above $120
Safety eyewear	You may choose to buy safety eyewear as an alternative to regular dress eyewear, and the Copays and coverage amounts will vary depending on what you purchase and where.	

There is no Copay for in-network scratch coating (standard plastic), solid or gradient tint, and/or standard polycarbonate. Anti-reflective coating is available at the following in-network cost share:

- $45 – Standard
- $57 – Premium Tier 1
- $68 – Premium Tier 2
- $85 – Premium Tier 3

What the Vision Plan Does Not Cover

The Vision Plan does not cover:

- Benefits for the medical treatment of eye disease or injury (these services are covered under the Medical Plan);
- Non-routine eye examinations and non-prescription eyewear;
- Vision therapy;
- Special lens designs or coatings not listed in this section;
- Replacement of lost eyewear;
- Non-prescription (plano) lenses;
- Services not performed by licensed personnel;
- Contact lenses and eyeglasses during a single benefit cycle; or
- Two pairs of eyeglasses in lieu of bifocals.

In-Network providers might offer a warranty plan that can be purchased separately, which is up to the Member.

Hearing Plan

The Hearing Plan covers routine hearing-related expenses for Participants enrolled under the Basic Benefits Plan A, the Retirement

Bridge Plan, or those who have purchased Bridge Coverage or COBRA 2 or the Pension 50% Buy-In Plans. Participants enrolled under the Basic Benefits Plan B, Supplemental Benefits Plan, Pension 100% Buy-In, COBRA 3 or COBRA 4 Plans have no Hearing Plan benefits.

What the Hearing Plan Covers

When you receive the following hearing-related services from a TruHearing Healthcare provider:	The Plan pays the following amount for you, your Spouse, and your Covered Dependents:
Examination	100%
Prescription Hearing aids	$1,300 per ear, every four years

Hearing Plan benefits are available for all insured family members.

What the Hearing Plan Does Not Cover

The Hearing Plan does not cover:

- Hearing aid batteries (unless provided at no cost by TruHearing); or
- Services provided by a provider who does not participate in the TruHearing network.

For information on participating providers, you MUST contact TruHearing at 1-888-934-4744. TruHearing will make an appointment for you to check your eligibility and send your hearing aid provider the necessary information prior to your appointment. For more information visit the website at www.TruHearing.com/local4.

Do not use your BCBSMA ID number for hearing benefit purposes, however, as it is a separate benefit from the medical benefit administered through BCBSMA (your TruHearing member ID is your date of birth and last 4 digits of your SSN).

SECTION IV:
Life and Disability Insurance

Disability – Weekly Accident and Sickness Benefits (Loss of Time)

If you are unable to work because of a non-work related disabling illness or injury (including pregnancy), and you are not eligible for or have exhausted state paid medical leave benefits, such as under the Massachusetts or Maine Paid Family and Medical Leave Act, you may be eligible to receive $500 per week in accident and sickness (Loss of Time) benefits. Required forms are available on the Funds' website. These benefits provide you with a continuing source of income while you are Totally Disabled. You are only eligible for these benefits, however, if you are a Participant enrolled in the Basic Benefits Plan A or B. If you are enrolled under the Supplemental Benefits Plan, you are not eligible unless you have purchased the Bridge Plan. If you remain Totally Disabled after you have exhausted your state paid medical leave benefits you may be entitled to receive Accident and Sickness Benefits from the Plan at the customary $500 per week for the remaining weeks up to the total 26-week maximum. For example, if you receive 20 weeks of state paid medical leave, you subsequently may be eligible to receive up to six weeks of Accident and Sickness benefits from the Fund. If you work for an employer in a state that does not have paid medical leave benefits or you are not eligible for state paid medical leave benefits, you may apply for and receive the Plan's Weekly Accident and Sickness Benefits per usual.

You will be considered Totally Disabled and able to receive weekly accident and sickness benefits if, as the result of an illness or accidental injury, you are unable to engage in any work for pay for which you are suited by education, training or experience. Once you are deemed eligible to receive these benefits, you may not perform any work of any kind for wage or profit. You must be under the care of a medical physician or surgeon.

Additionally, you cannot file a claim for Weekly Accident and Sickness Benefits if you are collecting Unemployment Compensation or Workers' Compensation benefits. After your Unemployment Compensation has ended, you may be eligible for Weekly Accident and Sickness Benefits if you meet all of the eligibility requirements at that time.

The opinion of a chiropractor as to the extent and duration of your Total Disability is not acceptable for the payment of this loss of time benefit, unless the chiropractor's diagnosis and prognosis are verified in writing by a medical physician who is licensed by the American Medical Association and the state within which the physician practices medicine. Pregnancy-related disability is based on "medical necessity" as documented by your physician.

Covered Benefits

If you are approved to receive Weekly Accident and Sickness Benefits, you will receive $500 per week for up to 26 weeks of your continuous total disability. As required by law, Social Security and Medicare taxes

are withheld from these payments. You may elect to have federal income taxes withheld.

When Benefits Are Payable

Depending on the nature of your disability, you may have to satisfy a waiting period before Weekly Accident and Sickness benefits are payable, as shown in the following chart. You receive no payments from the Plan during the waiting period.

Type of disability	Benefits begin
Accidental injury	Immediately
Anything other than accidental injury (e.g., sickness/pregnancy)	After seven calendar days

If You Become Disabled Again

Successive periods of the same disability separated by fewer than 10 days of full-time, active work are considered one continuous period of disability. If, after returning to work, you become disabled due to an illness or injury that is totally unrelated to your previous disability, it will be treated as a new period of disability.

What the Weekly Accident and Sickness Plan Does Not Cover

Weekly Accident and Sickness Benefits do not cover:

- Absence due to an illness or injury for which you are not under the care of a medical physician or surgeon;
- A period of time when you are eligible for or receiving paid state medical leave;
- Job-related accidents or illnesses for which you are entitled to Workers' compensation benefits, regardless of whether you apply for or receive those benefits;
- Absences during which you receive pension benefits from the Plan's Pension Fund;
- Combat, war or any act of war, whether declared or undeclared;
- Service in the military of a foreign country or as a mercenary;
- Illness or injury resulting from your commission of a felony unless the injuries are the result of a medical condition, unless you are the victim of the commission of a felony or an attempt to commit a felony or the victim of domestic violence;
- Intentionally self-inflicted injury or attempted suicide, whether you are sane or insane;
- Flight travel, unless injury occurs as a fare-paying passenger on a regularly scheduled airline;
- Injuries resulting from bungee jumping or from participating in an organized racing event involving motorized vehicles, such as snowmobile, motorcycle or all-terrain vehicle races; or
- Parachuting, sky-diving or scuba diving.

Life Insurance Plan – Symetra Life Insurance Company

The Plan pays as a life insurance benefit the amount of life insurance in force for you if you die while you are an insured, eligible Participant under the Plan. You name your beneficiary. Symetra underwrites the Life Insurance Plan. The terms of the Symetra policy control.

Participants enrolled under the Basic Benefits Plan A or B are eligible for life insurance benefits. If you are married and your Spouse dies, you would be eligible for life insurance benefits.

Participants enrolled under the Supplemental Benefits Plan are not eligible for life insurance benefits unless they have purchased the Bridge Plan.

Covered Benefits

The life insurance benefit amount is $50,000 if you die. Upon your death, Symetra pays the proceeds of your life insurance as a lump sum to your designated beneficiary.

Your life insurance benefit is reduced to $32,500 when you reach age 70 and you are still a Participant; it is further reduced to $25,000 when you reach age 75 as a Participant.

If your Spouse dies, the life insurance benefit amount is $2,000, providing you are married on the date of death.

Naming Your Beneficiary

You may select any beneficiary you wish, including your estate, by completing and returning your Participant and Beneficiary Form to the Funds Office. Provided you are not restricted from changing your beneficiary in accordance with a separation agreement or divorce decree, you may change your beneficiary at any time by completing and returning a new Participant and Beneficiary Form to the Funds Office.

If you do not name a beneficiary, or if no beneficiary survives you, benefits will be distributed at Symetra's discretion to one of the following:

- Your surviving legal Spouse;
- If your Spouse does not survive you, in equal shares to your surviving natural and/or adopted children;
- If no child survives you, in equal shares to your surviving parent(s); or
- If no parent survives you, to the executors or administrators of your Estate.

If you name a minor child as your designated beneficiary, you should be aware that death benefits are not payable until the child reaches age 18, unless a legal guardian of the minor's estate has been appointed. Symetra may also pay such child's share to a person who in their opinion is providing financial support and maintenance for the minor. Symetra will pay:

- $200 at your death; and
- Monthly installments of not more than $200.

Payment to any person as detailed above will release Symetra from all further liability for the amount paid.

Extension of Life Insurance (Waiver of Premium) – Symetra Life Insurance Company

If you are not able to work due to disease or injury, your life insurance (but not accidental death and personal loss coverage) may be extended if Symetra determines you are permanently and totally disabled.

If you become totally disabled before reaching age 60, your life insurance under this policy will continue until the date you attain age 70, provided that you remain totally disabled and premiums were paid when due. The life insurance benefit will be the same amount, subject to any applicable benefit reduction. To qualify for Waiver of Premium you must:

- Furnish proof satisfactory to Symetra, at least six months from the date such total disability began, that you have been totally disabled continuously from the date the total disability began; and
- Furnish such proof to Symetra no later than one year after the date the total disability begins.

Upon submission of the required proof, premiums paid on your behalf during the totally disability will be refunded. Symetra will waive the required premium payments until you are no longer totally disabled, provided that you (a) furnish proof that the totally disability has continued uninterrupted; and (b) submit to a physical exam when required, as provided below.

Benefits will end, in part, on the earliest of the following dates:

- The date you die;
- The date you no longer qualify for Waiver of Premium;
- The date Your Policy terminates;
- The date proof of total disability is not provided when due; or
- The date you reach age 70.

Physical Exam. Symetra will have the right to have a physician of its choice examine you to establish any disability. Symetra will pay for the exam. You may be examined as often as reasonably necessary during the period of disability, but not more than once a year after you have been disabled for two years.

Conversion After Extension. When any applicable extension of benefits described in this section ends, you may convert to an individual insurance policy, provided you are entitled to convert as described in the conversion privilege provision.

Accelerated Life Insurance Benefit – Symetra Life Insurance Company

If you are diagnosed with a terminal condition that is reasonably expected to result in your death in twenty-four (24) months or less, a portion of your life insurance benefit may be paid before your death. To qualify for this benefit, you must have been diagnosed as being terminally ill while insured under this policy. Payment of the accelerated life insurance benefit will reduce the death benefit by the amount received.

Please contact the Funds Office at 1-508-533-1400 or 1-888-486-3524 for a list of qualifying conditions.

Converting Your Coverage to an Individual Policy – Symetra Life Insurance Company

If your life insurance coverage ends because you are no longer eligible, you may convert your coverage to an individual life insurance policy. To convert, you must apply and pay the first premium within 30 days after your Plan eligibility terminates. No evidence of insurability will be required if you convert to an individual policy under the conversion privilege. Please contact 1-888-999-4767 (toll free); 978-762-0661 (local); or 978-762-4767 (fax).

Accidental Death and Dismemberment Insurance (AD&D) Plan – Symetra Life Insurance Company

When a covered injury results in your accidental death or dismemberment, you or your beneficiary may be eligible to receive an AD&D benefit. Symetra insures the AD&D Plan. You are eligible for this program if you meet the eligibility rules, as determined by the Trustees.

Participants enrolled under the Basic Benefits Plan are eligible for AD&D coverage. Participants enrolled under the Supplemental Benefits Plan are not eligible for AD&D coverage unless they have purchased the Bridge Plan.

Covered Benefits

Your AD&D benefit is payable according to the following schedule. AD&D death benefits are payable to the same beneficiary you name for your life insurance. Dismemberment and paralysis benefits are paid to you.

When your covered injury results in any one of the following losses within 365 days of the date of the accident, Symetra will pay a benefit according to the Accidental Dismemberment Benefit.

Accidental Dismemberment Benefit

The Participant Principal Sum is $20,000.

If injury to the Insured Person results, within 365 days of the date of the accident that caused the Injury, in any one of the losses specified below, Symetra will pay the percentage of the principal sum shown below for that Loss.

If injury to the insured person results in death within 365 days of the date of the accident that caused the Injury, Symetra will pay 100% of the principal sum.

For loss of	Percentage of Principal Sum
Both hands or both feet	100%
Sight of both eyes	100%
One hand and one foot	100%
One hand and the sight of one eye	100%
One foot and the sight of one eye	100%
Speech and hearing in both ears	100%
One hand or one foot	50%
Sight of one eye	50%
Speech or hearing in both ears	50%
Thumb and index finger of either hand	25%

If more than one loss is sustained by an insured person as a result of the same accident, only one amount—the largest—will be paid.

Paralysis Benefit

If you are injured within 365 days of the date of the accident that caused the injury, and suffer from any one of the types of paralysis specified below, Symetra will pay the percentage of the principal sum shown below for that type of paralysis:

Type of paralysis	Percentage of Principal Sum
Quadriplegia	100%
Paraplegia	75%
Triplegia	75%
Hemiplegia	50%
Uniplegia	25%

If you suffer more than one type of paralysis as a result of the same accident, only one amount, the largest, will be paid.

Seat Belt and Air Bag Benefit

Seat Belt Benefit: If an accidental death benefit is payable under the policy and the accident causing death occurs while you are operating, or riding in a properly registered Motor Vehicle and were wearing a properly fastened, original, factory-installed seat belt or, if the person is a Dependent Child, a properly installed and fastened child restraint device

as defined by state law, Symetra will pay this additional benefit. The amount payable for this additional benefit is $10,000.

Air Bag Benefit: If a seat belt benefit is payable and if you are positioned in a seat protected by a properly functioning, original, factory-installed Supplemental Restraint System that inflates on impact, Symetra will pay an additional $10,000.

Verification of the actual use of the seat belt at the time of the accident, and that the Supplemental Restraint System inflated properly upon impact, must be a part of an official report of the accident or be certified, in writing, by the investigating officer(s).

Exposure and Disappearance

If, by reason of an accident covered by the Plan, you are unavoidably exposed to the elements and, as a result of such exposure, suffer a loss for which coverage is otherwise payable, that loss will be covered under the Plan. If your body has not been found within one year of your disappearance or of the forced landing, stranding, sinking or wrecking of a conveyance in which you were an occupant, then it will be deemed, subject to all other terms and provisions of the Plan, that you have suffered loss of life within the meaning of the Plan.

Symetra Travel Assistance Program

Symetra Travel Assistance Program is a travel assistance program that offers travel medical assistance anywhere in the world with emergency referrals to hospitals and providers. Symetra Travel Assistance Program can assist with lost or stolen baggage, passports or travel documents; roadside assistance; emergency telephone interpretation; VIP concierge services; and identity theft assistance. Toll Free (within the U.S. and Canada) 1-877-823-5807. Collect/Reverse Change (outside the U.S.) +1-240-330-1422.

What the AD&D Plan Does Not Cover

The AD&D Plan does not cover any loss caused by or contributed by:

- Suicide or any intentionally self-inflicted injury;
- Sickness, disease or infections of any kind, except bacterial infections;
- Declared or undeclared war, or any act of declared or undeclared war;
- Active duty in the armed services, National Guard or organized reserve corps of any country or international authority (unearned premium for any period for which you are not covered due to your active duty status will be refunded, and loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded);
- Being under the influence of drugs or alcohol or voluntary intake of poison, drugs, gas, or fumes or intoxicants, unless taken under the advice of a physician; or
- Commission of or attempt to commit a felony.

SECTION V:
Payments, Claims and Appeals

Medical and Dental Plan Coordination of Benefits

If a covered Dependent has other health care coverage—such as through your Spouse's medical or dental plan—the benefits payable under this Plan will be reduced so that the total payments under all plans do not exceed 100% of this Plan's allowable expenses, which may result in no payment being made by this Plan. The terms of each plan determine which plan pays first. Coordination of benefits provisions apply to the Medical and Dental Plans.

Whether this Plan is primary or secondary, this Plan will consider for payment only those expenses that would be covered if this Plan were the sole plan. The exception is that this Plan's deductible can be waived to permit coordination of benefits. Participants who are covered as both enrollees and Dependents under this Plan can receive coordination of benefits, but benefits that are limited by frequency or dollar limits cannot be increased. Coordination of benefits in this case will serve to pick up out-of-pocket coinsurance and Copays; however, as previously stated, the benefits payable under this Plan will be reduced so that the total payments under all plans do not exceed 100% of this Plan's allowable expenses, which may result in no payment being made by this Plan.

Allowable Expenses

Under coordination of benefits, allowable expenses are any expenses paid by:

- This Plan;
- Any group, blanket, franchise coverage, group service or prepayment plan providing similar benefits;
- Any governmental plan or law, including Medicare (Medicare benefits will be taken into consideration under this provision only if the expenses are covered under another plan as well as under this Plan and Medicare);
- No-fault insurance required under any law and provided through arrangements other than those already mentioned, but only to the extent of benefits required under such no-fault law; or
- Any program sponsored by or arranged through a school or other educational agency or the first-party medical expense provisions of any automobile policy.

The term "plan" shall not be construed to mean any individual-type plan, student accident coverage or other student health plans when designated as an "excess only" or "always secondary" plan.

The Plan does not cover charges you incur for services when you fail to follow the rules of your primary plan. You can be reimbursed for services that are covered under this Plan that are excluded from your primary plan. If those services are subject to Pre-authorization, this Plan's rules will apply.

Order of Payment

This Plan pays first for the Participant's expenses. If your other coverage is through a Spouse's plan, that plan pays first for your Spouse.

If your children are covered by both your own and your Spouse's plan, the primary payer will be determined by the birthday rule. That is, the plan of the parent whose birth date falls first during the calendar year will pay first. When parents are separated or divorced, if there is a court decree that establishes financial responsibility for the medical, dental or other health care expenses with respect to children, benefits are determined in agreement with the court decree. Otherwise, if the parent with custody has not remarried, that parent's plan is primary. If the parent with custody has remarried, that parent's plan is primary, the stepparent's plan is secondary and the plan of the parent without custody pays third.

If these rules do not establish an order of benefit payment, the plan that has covered the person for the longer period of time is primary, except that the benefits of a plan covering the person as a laid-off or retired Employee, or Dependent of a laid-off or retired Employee, will be determined after the benefits of any other plan covering the person as a laid-off or retired Employee, or Dependent of a laid-off or retired Employee, will be determined after the benefits of any other plan covering the person as an active Employee. If you have coverage through active other employment, that coverage will be primary to this Plan if you are not actively at work with an employer contributing under this Plan.

Any plan that does not have a coordination of benefits provision is always considered primary and pays first.

In case of injuries sustained in a motor vehicle accident, the order of benefit determination is as follows:

- Primary: Any motor vehicle insurance, up to the policy's limits
- Secondary: This Plan

The IUOE Local 4 Health and Welfare Fund is a self-insured group health plan under the Employee Retirement Income Security Act (ERISA).

Therefore, the Plan is not subject to the state mandates and regulations related to PIP (Personal Injury Protection) coverage. Although the Plan maintains a reinsurance plan for covered services in excess of a stop loss limit, both PIP benefits and Med-Pay Medical Payments under the automobile policy must be exhausted before the Plan will begin paying covered medical claims and disability.

For more details regarding order of payment in case of a motor vehicle accident, contact BCBSMA.

Coordination With COBRA Continuation Coverage

If you have COBRA continuation coverage through another group health care plan, this Plan is primary to your COBRA coverage. If you have COBRA continuation coverage under this Plan in addition to coverage under another group health plan, the COBRA coverage under this Plan is secondary to coverage provided by the other group health plan.

Medicare Coordination at Age 65

At age 65, you normally become eligible for Medicare benefits. As long as you continue to work or have enough hours earned from when you were working, you continue to be covered by the Plan. Medical benefits provided by the Plan are your primary coverage (and your Spouse's, if they are eligible for Medicare), as long as you remain eligible under the Plan rules; Medicare benefits are secondary.

In this case, you have the advantage of two plans. As long as you remain eligible for this Plan based on your active hours, your medical and dental providers should continue to submit your claims to this Plan first. After this Plan pays benefits on your behalf, your provider may submit any remaining expenses to Medicare for possible payment.

You need not sign up for Medicare so long as you remain eligible for coverage under the Plan, but doing so will give you the benefit of dual coverage. If you choose not to sign up for Medicare while you remain covered by the Plan, you should stay informed about Medicare's enrollment rules so that you are able to enroll without any penalties.

Disabled Participants (as defined in federal regulations) with Earned Coverage through their active work hours receive primary coverage from this Plan and secondary coverage from Medicare until Earned Coverage expires under the terms of the Plan.

In making a decision to enroll in Medicare Part B when you become eligible, keep the following points in mind:

- Having coverage under this Plan and under Medicare provides a greater level of protection;
- You are responsible for enrolling yourself for Medicare (and your Spouse, if they are eligible for Medicare); and
- Consider how long you expect to work or how long your Earned Coverage will last. After your initial eligibility, Medicare may limit enrollment to certain times during the year, so you may not be able to enroll in Medicare when coverage under this Plan ends. The exception is if your IUOE Local 4 Health and Welfare coverage was earned based on your active work hours.

For more information about Medicare coverage, contact your local Social Security Administration office. The Plan also provides access to Via Benefits, a third-party service that can provide guidance and options on supplemental Medicare insurance. To speak with someone at Via, call 1-833-414-1408, or visit them online at my.viabenefits.com/IUOELocal4.

Coordination of Benefits With No-Fault Insurance

If a covered person is injured in an automobile accident, the injury may be covered by no-fault insurance. The Fund does not cover expenses which would be covered by no-fault insurance, even if you are required to have but do not have no-fault insurance. If you or your Dependents receive any money from an insurance claim, you must reimburse the Fund for payments it has made up to the net amount you receive from the insurance company.

Subrogation

Recovery of Medical Benefit, Loss of Time and Other Benefit Payments

Subrogation and Reimbursement* of Benefit Payments*

If you are injured by any act or omission of another person, the medical, loss of time and other benefits under the Fund will be subrogated. This means that the Fund and/or BCBSMA, as the Fund's representative and claims administrator for medical claims, may use your right to recover money from the person(s) who caused the injury or from any insurance company or other party. If you recover money, the Fund is entitled either directly or through BCBSMA to recover up to the amount of the benefit payments that it has made. This is true no matter where or by whom the recovered money is held or how it is designated and even if you do not recover the total amount of your claim against the other person(s). This is also true if the payment you receive is described as payment for something other than health care expenses. The amount you must reimburse this health plan will not be reduced by any attorney's fees or expenses you incur.

Member Cooperation

With regard to medical claims, you must give BCBSMA, as the Fund's medical claims administrator, information and help. With regard to Loss of Time and other benefit claims, you must give the Fund administrator information and help. This means you must complete and sign all necessary documents (including the Fund's Subrogation and Constructive Trust Agreement) to help BCBSMA and/or the Fund get this money back on behalf of the Fund. This also means that you must give BCBSMA and/or the Fund timely notice of all significant steps during the negotiation, litigation or settlement with any third party (such as filing a claim or lawsuit, initiation of settlement discussions, agreement to a settlement in principle, etc.) and before settling any claim arising out of injuries you sustained by an act or omission of another person(s) for which this health plan paid benefits. You must not do anything that might limit this health plan's right to full reimbursement.*

**See definitions of the terms Subrogation and Reimbursement in Section VI, Important Terms.*

Workers' Compensation

No coverage is provided for health care services that are furnished to treat an illness or injury that BCBSMA or the Fund determines was work related. This is the case even if you have an agreement with the workers' compensation carrier that releases them from paying for the claims. All employers provide their Employees with workers' compensation or similar insurance. This is done to protect Employees in case of a work-related illness or injury. All health care claims for a work-related illness or injury must be billed to the employer's workers' compensation carrier or employer liability plan. It is up to you to use the workers' compensation insurance. If BCBSMA pays for any work-related health care services for a Participant, BCBSMA, on behalf of the Fund, has the right to get paid back by the party that legally must pay for the health care claims. BCBSMA, on behalf of this Fund, also has the right, where possible, to reverse payments made to providers. If you have recovered any benefits from a workers' compensation insurer (or from an employer liability plan), the Fund and/or BCBSMA, on behalf of this Fund, has the right to recover from you the amount of benefits it has paid for your health care services or Loss of Time or other benefits. This is the case even if:

- The workers' compensation benefits are in dispute or are made by means of a settlement or compromise;
- No final determination is made that an injury or illness was sustained in the course of or resulted from your employment;
- The amount of workers' compensation due to medical or health care is not agreed upon or defined by you or the workers' compensation carrier; or
- The medical or health care benefits or Loss of Time benefits are specifically excluded from the workers' compensation settlement or compromise.
- If BCBSMA is billed in error for these services, you must promptly call or write to the BCBSMA customer service office.

Loss of Time and Other Benefits Are Recovered by the Funds Office

The Plan may withhold payment of disability (loss of time) benefits and other benefits otherwise payable in connection with accidental injuries when any party other than you or this Plan may be liable for the injuries and expenses, until such liability is legally determined. You must notify the Plan in writing immediately if you make a claim against another person or entity, and you must sign a Subrogation and Constructive Trust Agreement (Agreement). If you fail to notify the Funds Office of a claim

(including a simple demand for payment), or fail to sign the Agreement or otherwise cooperate in enforcement of this provision, the Fund may withhold all payment of any benefits as a result of the injury caused by the third party, and may recoup by offset or lawsuit, the amount already paid.

The Fund, in its sole discretion, may make payment of medical, loss of time or other benefits before a finding of liability is made, subject to the agreement of you and your counsel, if any, to hold any proceeds from litigation, settlement or judgment in trust for the Plan and to acknowledge that the proceeds are a Plan asset in a Subrogation and Constructive Trust Agreement. Under the terms of this Plan and the Agreement, the Plan's right to these proceeds will apply (a) even if the recovery is not sufficient to make you whole pursuant to state law or otherwise (sometimes referred to as the "make-whole" rule); and without any reduction for legal or other expenses incurred by you in connection with the recovery against the third party or the third party's insurer pursuant to state law or otherwise (sometimes referred to as the "common fund" rule); and regardless of any state law or common law rule that would bar recovery from a person or entity that caused the illness or injury, or from the insurer of that person or entity (sometimes referred to as the "collateral source" rule); and (b) even if the recovery was reduced due to your negligence (sometimes referred to as "contributory negligence"), or any other common law defense.

How to File Claims and Appeal Denied Claims

When you receive covered services from participating network providers, you do not have to file a claim. Network providers are responsible for filing claims and are paid directly. Network providers file claims directly to BCBSMA, Carrum Health, Lyra Health, Optum Rx, Progyny, Dental Blue, EyeMed and TruHearing.

If you receive covered health services from a provider of Holistic Benefits, for a DOT physical or for other services in which the provider will not file a claim on your behalf, you may be responsible for filing a claim with BCBSMA if the out-of-network provider will not file claims on your behalf.

Your network and out-of-network (applicable for Dental Blue, EyeMed, Optum Rx only) health care provider may submit standard claim forms or submit most claims electronically. Your out-of-network (applicable for Dental Blue, EyeMed, Optum Rx only) provider may provide you with a standard claim form, or you may submit the actual receipt to the Plan. If you have already paid all or a portion of the fees for service to the out-of-network provider, indicate the amount on the claim form or receipt.

Send Participant-submitted claims for inpatient medical or mental health and/or substance use disorder, including partial day hospitalization and intensive outpatient services to:

Blue Cross Blue Shield of Massachusetts, Local Claims Department
P.O. Box 986030
Boston, MA 02298

Send fitness reimbursement and weight loss reimbursement claims no later than March 31 of the year following the year in which the fees were incurred either through your MyBlue account, or to:

Blue Cross Blue Shield, Local Claims Department
P.O. Box 986030
Boston, MA 02298

Send Weekly Accident & Sickness/Loss of Time claims to:

IUOE Local 4 Funds
16 Trotter Drive, P.O. Box 680
Medway, MA 02053-0680

Send claims for out-of-network prescription drug providers to:

Optum Rx Claims Department
P.O. Box 650334
Dallas, TX 75265-0334

Send claims for out-of-network dental providers to:

Blue Cross Blue Shield of Massachusetts (Dental Blue)
465 Medford Street
Boston, MA 02129

Send claims for out-of-network vision providers to:

First American Administrators, Inc.
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

Providers will send claims for hearing services to:

TruHearing, Inc.
12936 S. Frontrunner Blvd. #100
Draper, UT 84020

Send Participant-submitted fertility claims to:

Progyny
Dept. LA 24452
Pasadena, CA 91185-4452

Send Employee Assistance Program (EAP) claims to:

Lyra Health, Inc.
287 Lorton Avenue
Burlingame, CA 94010
complaints@lyrahealth.com

If utilizing Carrum Health, send claims for reimbursement for cost sharing or travel expenses incurred by the Participant to:

Carrum Health
Claims Department
appeals@carrumhealth.com

You will receive a paper explanation of benefits (EOB) showing what the Plan covered unless you opt in to paperless, emailed EOBs. You may receive a bill from the provider for any remaining expense, which will be your responsibility to pay.

Benefits for covered services submitted by providers will be paid to the provider if the provider has completed the assignment of benefits section of the claim. You are responsible for payment of services and supplies not covered by the Plan to the provider of service.

To be eligible for reimbursement under the Plan, your claim must be submitted within 12 months of the date of service.

If your claim for benefits is denied, you have the right to appeal.

Claims Procedures (In General)

Claims are divided into the following categories:

- Urgent care claims;
- Concurrent care claims;
- Pre-service claims;
- Post-service claims; and
- Disability (loss of time) claims.

Special time frames apply to each type of claim, as described in the following section. Generally, vision, dental and hearing claims are post-service claims.

Urgent Care Claims

Urgent care claims encompass services that require notification or approval before receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function, or, in the opinion of a physician (or dentist) with knowledge of your medical (or dental) condition, could cause severe pain.* Provided BCBSMA receives all necessary information, taking into account the seriousness of your condition, you will receive notice within 72 hours of the benefit request. A denial of benefits may be oral, with a written or electronic confirmation to follow within three days.

If you or your representative files an urgent care claim improperly, you will be notified and advised how to correct it within 24 hours after the urgent care claim is received. This notification may be oral, unless you or your representative request written notification.

If you are required to provide additional information in order to process your claim, you will be notified of the information needed within 24 hours after the claim is received. You will then have 48 hours to provide the requested information.

You will be notified of a decision within 48 hours after receiving the requested additional information, or at the end of the 48-hour period within which you were to provide the required additional information (if it isn't received).

**For purposes of an urgent care claim, the following will be acknowledged as your authorized representative: a physician or other health care professional who is licensed, accredited or certified to perform specified health services consistent with state law, and who has knowledge of your medical or dental condition.*

Concurrent Care Claims

If you are undergoing a course of treatment that was previously approved for a specific period of time or number of treatments and your request to extend treatment is urgent as defined above, a decision will be made within 24 hours. You must, however, make your request at least 24 hours prior to the end of the approved treatment.

A determination will be made within 24 hours of the receipt of your request. If your request is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care claim and the above urgent care time frames for a decision will apply.

If your request to extend treatment does not meet the definition of urgent care as defined above, your request will be considered a new claim and decided according to post-service or pre-service time frames, whichever applies.

Pre-Service Claims

These are claims that require you to provide notice to the claims administrator for approval before receiving care. They generally are medical claims.

Provided you submit your pre-service claim properly with all required information, you or your representative will receive written notice of the claim decision within 15 days of receipt of your claim. If you submit your pre-service claim improperly, within five days of receiving your claim you will be notified how to correct your claim including needed information. The 15-day review period may be extended for an additional 15 days if necessary due to circumstances beyond the control of the claims administrator, and you will be notified of the circumstances requiring the extension of time and the date by which a decision is expected.

If you are required to provide additional information in order to process your pre-service claim, you will be notified of the information needed within 15 days of receipt of your claim and your claim will be held until all required information is received.

If an extension of the review period is due to your failure to submit information necessary to review the claim, you will have 45 days to provide the requested information. If that information is received within the 45-day time frame, you will be notified of the determination of your claim within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied or decided based on the information submitted.

Post-Service Claims

In the case of a post-service claim filed by you, you or your representative will receive written notification of the Plan's determination within 30 days after receipt of the claim or receipt of any information requested by the Plan as necessary to decide the claim.

The period may be extended an additional 15 days when necessary due to matters beyond the control of the Plan, and provided that prior to the expiration of the initial 30-day period, you or your representative is notified of the circumstances that require the extension.

If the extension is due to your failure to submit information necessary to decide the claim, the notice will specifically describe the information necessary to complete the claim and you will be allowed at least 45 days from receipt of the notice to provide the information. The claim will be decided within 15 days following the earlier of (1) the date the needed information is received or (2) the end of the 45-day period for providing the needed information.

Disability Claims (Accident & Sickness/Loss of Time)

In the case of a Loss of Time claim, a determination of disability will be made within 45 days of the date the Fund receives all necessary documentation. A benefit determination could be extended for an additional 30 days, provided that the Plan determines that such an extension is necessary due to matters beyond its control, and that the Plan notifies you before the expiration of the initial 45-day period explaining why the extension is necessary. If after this 45-day extension a determination still cannot be made, an additional 30-day extension may be required, in which case you will be notified before the end of the first 30-day extension of the circumstances for the extension and the date by which a decision is expected. The notice of extension will explain the standards upon which entitlement to a benefit are based, the unresolved issues that prevent a decision, and the additional information needed to resolve those issues. You will be given at least 45 days after receiving the notice to furnish the specified information.

Your Claim Denial Notice

If your initial claim is denied, in whole or in part, and you receive an adverse determination, you or your representative will receive written notice, which will include:

- the specific reason(s) for the denial;
- reference to the specific Plan provision(s) on which the denial is based;
- a description of any additional information or material necessary to perfect the claim and an explanation of why the information or material is necessary;
- a description of the Plan's appeal or review procedures and applicable time limits, including a statement of your right to bring a civil action under ERISA Section 502(a) following a denial on appeal;

- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a
- rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided without charge upon request;
- if the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical condition, or a statement that such explanation will be provided without charge on request;
- 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; and
- if your claim is for disability (Loss of Time) benefits, a discussion of the decision, including an explanation of the basis for disagreeing with or not following (1) the views presented by you, as the Claimant, of any health care or vocational professionals who treated or evaluated you; (2) the views of any medical or vocational experts who provided advice to the Plan in relation to your claim, without regard to whether the Plan relied upon such advice in making its determination; and (3) any Social Security Administration disability determination presented by you.

If your claim is for disability (Accident & Sickness/Loss of Time) benefits and you are not literate in English, depending on the county in which you reside, you may be eligible for assistance in the non-English language in which you are literate. Call the Funds Office at (508) 533-1400 for more information.

How to Appeal Denied Vision, Accident and Sickness/Loss of Time (Disability), Hearing, Fertility Benefit, and Employee Assistance Program Claims

To appeal a denied claim or to review administrative documents pertinent to the claim, send a written request to the Health and Welfare Plan. When submitting an appeal, state the reason you think your claim should be reviewed and include any data, documents, records, questions or comments, along with copies of all bills and claim forms relating to your claim. Review of your denied claim will take into account all comments, documents, records and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

You must file your appeal within 180 days of the date of the denial of the claim. You are encouraged to file earlier.

Appeals are divided into the following categories: urgent care claims, concurrent care claims, pre-service claims, post-service claims and disability claims. Special time frames apply to the responses to each type of appeal, as described in this section.

- Urgent Care Claims – If an urgent care claim is denied, in whole or in part, you or your representative may appeal the determination following receipt of the adverse determination. You may appeal orally or in writing. You are entitled to an expedited review. You or your representative will receive written notification of a benefit determination within 72 hours of receipt of your request for review of the denied claim.
- Concurrent Care Claims – If a concurrent care course of treatment was previously approved, any reduction or termination of the course

of treatment before the end of the time or the completion of the specified number of treatments will be deemed an adverse benefit determination. In this case, you will receive sufficient advance notification of the reduction or termination to permit you to appeal before the reduction or termination and the Plan will respond with a determination on review of the denial in a timely manner.

- Pre-Service Claims – If a pre-service claim is denied, in whole or in part, you or your representative may appeal the determination within 180 days following the receipt of the adverse determination. You will receive a determination of the review of the denied claim within 30 days of receipt of your request for review of the denial.
- Post-Service Claims – If a post-service claim is denied, in whole or in part, you or your representative may appeal the determination within 180 days following receipt of the adverse determination. You will receive a determination of the review of the denied claim within 60 days of receipt of your request for review of the denial.
- Disability (Weekly Accident & Sickness) Claims – If a disability claim is denied, in whole or in part, you or your representative may appeal the determination within 180 days following receipt of the denial. You will receive a determination within 45 days of receipt of your appeal.

A different person/entity will review your claim on appeal than the one who originally decided the claim. The reviewer will not be the subordinate of the person/entity who originally denied the claim and will not give deference to the initial denial. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you. If the appeal of the initial benefit determination is based in whole or in part on a medical judgment, including a decision that a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Fund will consult with a health care professional who has appropriate training and experience in the field of medicine involved. It is understood that you consent to this referral and the sharing of pertinent medical claim information. In such a case, the health care professional will not be the same individual (or a subordinate of any such individual) whose advice was obtained by the Fund in connection with the initial adverse benefit determination. In addition, the Fund will identify, upon request, any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

If your claim is for disability (Accident & Sickness/Loss of Time) benefits, the Plan also will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of denial of any appeal is required to be provided, to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan can deny a claim on appeal based on a new or additional rationale, it must provide you, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of denial on appeal is required to be provided, to give you a reasonable opportunity to respond prior to that date. Additionally, if you are not literate in English, depending on the county in which you reside, you may be eligible for assistance in the non-English language in which you are literate. Call the Funds Office at (508) 533-1400 for more information.

Your Appeal Denial Notice

The Plan will provide you with a written notice of a denial of any appeal, or adverse benefit determination on review, which will include:

- the specific reason(s) for the denial;
- reference to the specific Plan provision(s) on which the denial is based;
- a description of any additional information or material necessary to perfect the claim and an explanation of why the information or material is necessary;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided without charge upon request;
- if the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical condition, or a statement that such explanation will be provided without charge on request;
- If your claim is for disability (Loss of Time) benefits, a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (1) the views presented by you, as the Claimant, of any health care or vocational professionals who treated or evaluated you; (2) the views of any medical or vocational experts who provided advice to the Plan in relation to your claim, without regard to whether the Plan relied upon such advice in making its determination; and (3) any Social Security Administration disability determination presented by you; and
- a statement describing your right to bring a civil action under ERISA Section 502(a), including a description of any contractual limitations on the time in which you may bring suit and the calendar date of which such contractual limitation period expires.

If you are not satisfied with the first-level appeal decision of a post-service Hearing, Vision, Disability, Fertility Benefits, or Employee Assistance Program claim, you have the right to request a voluntary second-level appeal from the Board of Trustees. Your second-level appeal request must be submitted to the Board of Trustees within 60 days from receipt of the first-level appeal decision. An appeal decision by the Board of Trustees could be delayed to the next meeting of the Appeals Subcommittee or the next Trustees' meeting following the Plan's receipt of the request for review. If the request arrives less than 30 days before the next Appeals Subcommittee meeting or the next Trustees' meeting, the determination will be made no later than the date of the second meeting following receipt of the request, unless special circumstances require more time to review your appeal. If the Board of Trustees needs more time, you will be provided with written notification of the extension, and a decision on your appeal will be made no later than the third meeting of the Board of Trustees immediately following the receipt of the appeal. The decision on any appeal or review of your claim by the Trustees will be given to you in writing within five days after the Trustees rule on the appeal. The notice of their decision will contain all of the same information as listed above for a first-level appeal.

No civil action may be brought unless you exhaust your internal appeals within the Plan. If your appeal before the Board of Trustees is denied, you have the legal right to bring a civil action under Section 502(a) of ERISA within one year of the date of the letter informing you of the denial of the appeal by the Trustees.

How to Appeal Denied Prescription Drug Claims

You, your provider, or an appointed representative like an attorney or family member can file a first-level standard or urgent appeal within 180 calendar days from the date of a decision. Otherwise, the decision will be final.

To appeal, send written comments, documents or other information to be considered to:

Optum Rx
c/o Appeals Coordinator PO Box 2975
Mission, KS 66201

Phone: 1-888-403-3398
Fax: 1-877-239-4565

First level appeals can take up to 30 calendar days from when your request is received. You will receive written notice of the decision. In some cases, rush appeals can be reviewed, and a decision could be made within 72 hours. Generally, you can request an urgent decision for these reasons:

- Life, health or ability to function would be in jeopardy based on layperson's judgment; or
- You may be subject to severe pain without the treatment or care requested in the opinion of a clinician who is aware of your condition.

You may request an urgent appeal by calling the number above. You do not need to go through the internal appeal review if:

a. Optum Rx fails to meet our internal appeal process timelines, or
b. you have an urgent care situation and you have requested an external review, or
c. Optum Rx decides to waive the internal appeal process requirements.

If your appeal is denied, you will receive a notice from Optum Rx that includes (1) the specific reason for the denial; (2) a description of any additional information or material necessary to perfect the claim and an explanation of why the material is necessary; (3) if an internal rule, guideline, or protocol was relied upon, a statement of the specific rule, guideline, or protocol, or a copy of such, without charge and upon request; (4) if the denial is based on a medical necessity or experimental treatment or similar exclusion or limitation, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical condition, or a statement that such explanation will be provided without charge on request; (5) reference to the specific Plan provision on which the denial is based, if applicable; and (6) a statement describing your right to bring a civil action under ERISA Section 502(a), including a description of any contractual limitations on the time in which you may bring suit.

If you are not satisfied with the first-level appeal decision, you have the right to request a second-level appeal to an independent medical examiner. Your second-level appeal request must be submitted to Optum Rx, in the same manner as detailed above, within 60 days from the receipt of the first-level appeal decision. The notice of the second-level appeal decision will contain all of the same information as listed above for a first-level appeal.

No civil action may be brought unless you exhaust your internal appeals within the Plan. If your second-level appeal is denied, you have the legal right to bring a civil action under ERISA Section 502(a) within one year of the date of the letter informing you of the denial of the second-level appeal.

You or your prescriber can get appeals information, including additional information on external appeal rights, by calling the Optum Rx appeals

coordinator at 1-800-460-5685. You are not required to bear any costs, including filing fees, when requesting a case to be sent for external review.

How to Appeal Denied Medical, Dental, or Inpatient Mental Health/ Substance Abuse Claims with BCBSMA

Please note: Rhode Island residents should also review the section entitled How to File an Appeal and Appeals Process for Rhode Island Residents or Services. BCBSMA has assumed responsibility for the process of reviewing denied medical, inpatient mental health/substance abuse, and dental claims. If you are denied coverage or payment for services you received, you disagree with how your claim was paid, or you have a complaint about the care or service you received, you should first call the BCBSMA phone number on the back of your ID card. If you still disagree with the decision after your phone conversation with a BCBSMA representative, you may request a review of your grievance first through the BCBS Internal Formal Grievance Review.

Internal Formal Grievance Review

To request a formal review of your grievance, put your grievance in writing and mail, fax or email it to BCBSMA at one of the following addresses: (mail) Member Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126; (fax) 617-246-3616; (email) grievances@bcbsma.com. You will receive confirmation of receipt of your grievance by mail or fax within 15 calendar days, or immediately if the grievance is sent by email. Alternatively, you may submit your grievance by phone by calling the BCBSMA Member Grievance Program at 1-800-472-2689.

Once your request is received, BCBSMA will research the case in detail. They will ask for more information if it is needed. BCBSMA will let you know in writing of the decision or the outcome of the review. If your grievance is about termination of your coverage for concurrent services that were previously approved by BCBSMA, the disputed coverage will continue until this grievance review process is completed. This continuation of your coverage does not apply: to services that are limited by a dollar or visit maximum and that exceed that benefit limit; to non-covered services; to services that were received prior to the time that you requested a formal grievance review; or when a grievance is not received on a timely basis, based on the course of treatment.

All grievances for denied medical or inpatient mental health/substance abuse claims must be received by BCBSMA within 180 days, and all grievances for denied dental claims must be received by BCBMSA within one (1) year, of the date of treatment, event, or circumstance that is the cause of your dispute, such as the date you were told of the service denial or claim denial.

Your request for a formal grievance review should include: the name, ID number and daytime phone number of the member asking for the review; a description of the problem; all relevant dates; names of health care providers or administrative staff involved; and details of the attempt that has been made to resolve the problem. If BCBSMA needs to review the medical records and treatment information that relate to your grievance, BCBSMA will promptly send you an authorization form to sign if needed. You must return this signed form to BCBSMA to allow for the release of your medical records. You also have the right to look at and get copies (free of charge) of records and criteria that BCBSMA has and that are relevant to your grievance, including the identity of any experts who were consulted.

You may choose to have another person (authorized representative) act on your behalf during the grievance review process. You must designate this person in writing to BCBSMA, or, if you are not able to do so,

a person such as a conservator, a person with power of attorney, or a family member may be your authorized representative or may appoint another party to be the authorized representative. (When you are an inpatient, a health care provider may act as your authorized representative to ask for an expedited grievance review. In this case, you do not have to designate the health care provider in writing.)

All grievances are reviewed by professionals who are knowledgeable about BCBSMA and the issues involved in the grievance. The professionals who will review your grievance will not be those who participated in any of Blue Cross Blue Shield's prior decisions regarding the subject of your grievance, nor do they work for anyone who did. When a grievance is related to a medical necessity denial, at least one grievance reviewer is an individual who is an actively practicing health care professional in the same or a similar specialty who usually treats the medical condition or performs the procedure or provides treatment that is the subject of your grievance.

The review and response for BCBSMA's internal formal grievance review will be completed within 30 calendar days from the day you tell BCBSMA that you disagree with its answer and would like a formal grievance review. With your permission, BCBSMA may extend the 30-calendar-day time frame to complete a grievance review. This will happen in those cases when BCBSMA and the member agree that additional time is required to fully investigate and respond to the grievance.

BCBSMA may also extend the 30-calendar-day time frame when the grievance review requires a review of your medical records and BCBSMA requires your authorization to get these records. The 30-day response time will not include the days from when BCBSMA sends you the authorization form to sign until it receives your signed authorization form (if needed). If BCBSMA does not receive your authorization within 30 working days after your grievance is received, BCBSMA may make a final decision about your grievance without that medical information. In any case, for a grievance review involving services that have not yet been obtained by you, BCBSMA will ask for your permission to extend the 30-day time frame if it cannot complete the review within 30 calendar days of receipt of your grievance.

Once the grievance review is completed, BCBSMA will let you know in writing of the decision or the outcome. If BCBSMA continues to deny coverage for all or part of a health care service or supply, BCBSMA will send an explanation to you. This notice will include: information related to the details of your grievance; the reasons that BCBSMA has denied the request and the applicable terms of your coverage in this Health Plan; the specific medical and scientific reasons for which BCBSMA has denied the request; any alternative treatment or health care services and supplies that would be covered; BCBSMA clinical guidelines that apply and were used and any review criteria; and how to request an external review.

You have the right to look at and get copies of records and criteria that BCBSMA has and that are relevant to your grievance. These copies will be free of charge. BCBSMA will maintain a record of all formal grievances, including the response for each grievance review, for up to seven years.

Expedited Review for Immediate or Urgently Needed Services. In place of the formal grievance review described above, you have the right to request an "expedited" review right away when your grievance review concerns medical care or treatment for which waiting for a response under the grievance review time frames described above would seriously jeopardize your life or health or your ability to regain maximum function as determined by BCBSMA or your physician, or if your physician says that you will have severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance review. If you request an expedited review, BCBSMA will review your grievance

and notify you of the decision within 72 hours after your request is received, or such shorter time period as required by federal law.

External Review

You must first go through the BCBSMA internal formal grievance process as described above. The BCBSMA internal grievance review decision may be to continue to deny all or part of your coverage in this Health Plan. In this case, you may be entitled to a voluntary external grievance review. You are not required to pursue an external grievance review. Your decision whether to pursue an external grievance review will not affect your other coverage. If you receive a grievance denial letter from BCBSMA in response to your internal grievance review, the letter will tell you what steps you can take to file a request for an external grievance review. *If you decide to request an external grievance review, you must file your request within the four months after you receive the denial letter from BCBSMA.* BCBSMA will work closely with you to guide you through the external grievance review process.

You (or your authorized representative) have the right to file an "expedited" external grievance review at the same time that you file a request for an internal expedited grievance review. This right applies to a member who is in an urgent care situation or to a member receiving an ongoing course of treatment. See below for more information about requesting an expedited external grievance review.

How to Request an External Review

To request an external review, you must complete the external review request form that is provided with the grievance denial letter you receive from BCBSMA. Once your external review request form is completed, you must send it to BCBSMA as shown on the form.

You (or your authorized representative) have the right to request an expedited external review when your situation is for immediate or urgently needed services as follows:

- When your grievance concerns medical care or treatment for which waiting for a response under the standard (non-expedited) external grievance review time frames would seriously jeopardize your life or health or your ability to regain maximum function; or
- When your grievance concerns an internal grievance review final adverse benefit determination for an admission, availability of care, continued stay or health care services for which you received emergency services, while you are an inpatient.

External Review Process

When BCBSMA receives your request for an external review, your case will be referred to an external review agency to complete your external review. You (or your authorized representative) will be notified by the external review agency of your eligibility and acceptance for an external review. In some cases, the review agency may need more information about your grievance, and if so, they will request it from BCBSMA, you or your authorized representative.

The review agency will consider all aspects of the case and send a written response of the outcome. They will send the response to you (or your authorized representative) and to BCBSMA within 45 days of receiving the request. If the agency determines additional time is needed to fully and fairly evaluate the request, the agency will notify you and BCBSMA of the extended review period. In the case of an expedited review, you will be notified of their decision within 72 hours. This 72-hour period starts when the external review agency receives your case.

If the review agency overturns Blue Cross Blue Shield's decision in whole or in part, BCBSMA will send you (or your authorized representative) a notice of the review decision made by the agency. This notice will confirm the decision of the review agency. It will also tell you (a) what steps or procedures you must take (if any) to obtain the requested coverage or services; (b) the date by which BCBSMA will pay for or authorize the requested services; and (c) the name and phone number of the person at BCBSMA who will make sure your grievance is resolved.

The decision made by way of the external review process will be accepted as final.

You have the right to look at and get copies of records and criteria that BCBSMA has and that are relevant to your grievance. These copies will be free of charge.

How to File an Appeal, and Appeals Process for Rhode Island Residents or Services

You may also have the right to appeal as described in this section when your claim is denied as being not medically necessary for you. If so, these rights are in addition to the other rights to appeal that you have that are described above. The following provisions apply only to:

- A member who lives in Rhode Island and who is planning to obtain services which BCBS has determined are not medically necessary.
- A member who lives outside of Rhode Island and who is planning to obtain services in Rhode Island which BCBS has determined are not medically necessary.

BCBS decides which covered services are medically necessary for you by using its medical necessity guidelines. Some of the services that are described in this benefit booklet may not be medically necessary for you.

If BCBS has determined that a service is not medically necessary for you, you have the right to the following appeals process:

Reconsideration

A reconsideration is the first step in this process. If you receive a letter from BCBS that denies payment for your health care services, you may ask that BCBS reconsider its decision. You must do this by writing to: Member Grievance Program, Blue Cross Blue Shield, 101 Huntington Avenue, Boston, MA 02199 or via email at grievances@bcbsma.com.

You must send your request within 180 days of Blue Cross Blue Shield's adverse decision. Along with your letter, you should include any information that will support your request. BCBS will review your request. BCBS will let you know the outcome of your request within 15 calendar days after it has received all information needed for the review.

Appeal

An appeal is the second step in this process. If BCBS continues to deny coverage for all or part of the original service, you may request an appeal. You must do this within 60 days of the date that you receive the reconsideration denial letter from BCBS. Your appeal request should include any information that supports your appeal. You may also inspect and add information to your BCBS case file to prepare your appeal. In accordance with Rhode Island state law, if you wish to review the information in your BCBS case file, you must make your request in writing and you must include the name of a physician who may review your case file on your behalf. Your physician may review, interpret, and disclose any or all of that information to you. Once received by BCBS, your appeal will be reviewed by a health care provider in the same specialty as your attending provider. BCBS will notify you of the outcome of your appeal within 15 calendar days after it has received all information needed for the appeal.

External Appeal

If your appeal is denied, you have the right to present your case to an appeals agency that is designated by Rhode Island and not affiliated with BCBS. The notice you receive from BCBS about your appeal will advise you of: the name of the appeals agency that is designated by Rhode Island. To file an external appeal, you must make your request in writing to: Member Grievance Program, Blue Cross Blue Shield of Massachusetts, 101 Huntington Avenue, Boston, MA 02199 or via email at grievances@bcbsma.com. Along with your request, you must: state your reason(s) for your disagreement with Blue Cross Blue Shield's decision.

Within five working days after BCBS receives your written request for the appeal, BCBS will forward your request to the external appeals agency. BCBS will also send your entire BCBS case file. The external appeals agency will notify you in writing of the decision within 10 working days of receiving all necessary information.

Expedited Appeal

If your situation is an emergency, you have the right to an "expedited" appeal at all three levels of appeal as stated above. An emergency is defined as the sudden onset of a medical or mental condition that in the absence of immediate medical attention could reasonably be expected to result in placing your health or your ability to regain maximum function in serious jeopardy or, in your physician's opinion, would result in severe pain. You may request an expedited reconsideration or appeal by calling BCBS at the phone number shown in your letter. BCBS will notify you of the result of your expedited appeal within two working days or 72 hours of its receipt, whichever is sooner, or such shorter time period as required by federal law. If your appeal is denied, you have the right to request an expedited external appeal. The notice you receive from BCBS about your appeal will advise you of the name of the appeals agency that is designated by Rhode Island. To request an expedited external appeal, you must send your request in writing to: Member Grievance Program, Blue Cross Blue Shield of Massachusetts, 101 Huntington Avenue, Boston, MA 02199 or via email at grievances@bcbsma.com. Your request should state your reason(s) for your disagreement with the decision and include signed documentation from your provider that describes the emergency nature of your treatment.

Within two working days after the receipt of your written request and payment for the appeal, BCBS will forward your request to the external appeals agency along with your group's portion of the fee and your entire BCBS case file. The external appeals agency will notify you in writing of the decision within two working days or 72 hours, whichever is sooner, of receiving your request for a review.

External Appeal Final Decision

If the external appeals agency upholds the original decision of BCBS, this completes the appeals process for your case. But if the external appeals agency reverses Blue Cross Blue Shield's decision, the claim in dispute will be reprocessed by BCBS upon receipt of the notice of the final appeal decision.

Final Voluntary Appeal Before Fund's Board of Trustees

After you have exhausted the BCBS internal and, to the extent applicable, external appeal processes described above, you may also submit an appeal that is not based on a determination of medical necessity directly to the IUOE Local 4 Health and Welfare Fund for a final determination by its Board of Trustees. If you wish to do so, you must send your written request for review within 60 days of your receipt of the final level BCBS decision to: Board of Trustees, IUOE Local 4 Health and Welfare

Fund, P.O. Box 680 Medway, MA 02053. For assistance, call the Funds Office at 1-888-486-3524. The Plan will not assert that a claimant has failed to exhaust administrative remedies because they did not elect to submit a benefit dispute to this voluntary level of appeal.

A decision by the Board of Trustees on a voluntary appeal could be delayed until the next meeting of the Appeals Subcommittee or the next Board of Trustees' meeting following the Plan's receipt of the appeal/request for review. If the request arrives less than 30 days before the next Appeals Subcommittee meeting or the next Trustees' meeting, the determination will be made no later than the date of the second meeting following receipt of the request, unless special circumstances require more time to review your appeal. If the Board of Trustees needs more time, you will be provided with written notification of the extension, and a decision on your appeal will be made no later than the third meeting of the Board of Trustees immediately following the receipt of the appeal.

The decision on any appeal or review of your claim by the Trustees will be given to you in writing within five days after the Trustees rule on the appeal. The notice of a denial of a claim on review/appeal will include: the specific reason(s) for the determination; reference to the specific Plan provision(s) on which the determination is based; a statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge; and a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review. If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge.

Legal Action

Before you pursue a legal action against BCBS for any claim under this Health Plan, you must complete the BCBS internal formal grievance review described above. You may, but do not need to, complete an external review and/or appeal to the Fund's Board of Trustees before you pursue legal action. If, after you complete the grievance review, you choose to bring a legal action against BCBS, you must bring this action within two years after the cause of the action arises. For example, if you are filing a legal action because you were denied a service or you were denied a claim for coverage from this Plan, you will lose your right to bring a legal action against BCBS unless you file your action within two years after the date of the decision of the final internal appeal of the service or claim denial. If your final internal appeal is denied, and you file a voluntary appeal with the Board of Trustees, any statute of limitations or other defense based on timeliness will be tolled during the time the voluntary appeal is pending.

How to File Life Insurance and AD&D Claims

To file a life insurance claim, you or your beneficiary should contact the Funds Office as soon as possible after the loss occurs. For a death claim, a copy of the certified death certificate will be required. The Funds Office will file the claim with Symetra (for life insurance claims) on your own or your beneficiary's behalf.

To file a claim for:	Contact the Funds Office, or contact the insurer at:
Life & AD&D insurance	Symetra Life Insurance Company Attn: Claims Department P.O. Box 1230 Enfield, CT 06083 Phone: 1-877-377-6773 Fax: 1-877-737-3650

If Symetra denies payment of your claim, you will receive written notice within 90 days of the date the insurance company receives your claim or physician's statement, if filed later. An extension of 90 days will be allowed for processing your claim if special circumstances are involved. Symetra will notify you in writing of any extension it requires to review your claim, including the special circumstances involved and the date by which it expects to reach a decision.

If Symetra denies your claim, the notice will be written in an understandable manner and will include:

- The specific reasons for the denial;
- Specific references to the Plan provision on which the denial is based; and
- An explanation of the claim review procedure.

You may request an appeal at any time during the 60-day period following the date you receive the notice of denial.

No civil action may be brought unless you exhaust your internal appeals with Symetra. If your appeal to Symetra is denied, you have the legal right to bring a civil action under Section 502(a) of ERISA within three years of the date proof of loss must be submitted.

How to Appeal a Denied Life Insurance and AD&D Insurance Claim

Symetra, the Life Insurance and AD&D Insurance carrier, considers requests for an appeal of a denied claim when you or your duly authorized representative makes a written request for review. You may review pertinent documents and submit to Symetra a written statement of issues and comments. Review of claim denials and final decisions on appeal are Symetra's responsibility for the Life Insurance and AD&D Insurance Plans.

Symetra serves as the claims review fiduciary with respect to the Life Insurance and AD&D Insurance policies and Plans. For both the Life Insurance and AD&D Insurance Plans, the claims review fiduciary has the final discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary will be complete, final and binding on all parties.

Appealing Denied Carrum Health Claims

Carrum Health adjudicates pre-service claims as to whether a Participant can participate in its Bundled Payment Program. Coverage may be denied, in whole or in part, if a Participant refuses to complete required documentation, violates the terms of service, or if a center of excellence in Carrum's network determines that treatment for the Participant is not an appropriate option. Carrum will notify a Participant of its determination in writing within 15 days of the event giving rise to the pre-service claim denial, except that this period may be extended an additional 15 days due to matters beyond Carrum's control if written notice is provided to the Participant. Participants will be given 45 days to provide additional information necessary to adjudicate a pre-service claim, if appropriate.

If Carrum affirms denial of participation in its program, it will notify the Participant in writing, said writing to include, in part, the specific reason(s) for the adverse determination; reference to any relevant Plan provision(s); a description of any additional material or information necessary to perfect the claim; a description of the appeal process; and any rules or other criteria relied upon in making the adverse determination, as well as the right to receive copies of said rules or criteria free of charge upon request.

A Participant that has participated in Carrum's program may also submit post-service claims for any cost share or travel expenses that are not

covered under the Bundled Payment Program. Reimbursement of such expenses will be subject to applicable IRS maximums as described in IRS Publication 502. Carrum will similarly notify a Participant of its determination on such post-service claims in writing.

If a Participant wishes to appeal a pre-service or post-service claim denial by Carrum, a request for a first-level appeal must be made within 180 days following receipt of an adverse benefit determination by submitting such request by email to appeals@carrumhealth.com. If the first-level appeal is denied, a Participant has an additional 60 days following receipt of that denial in which to make a request for a second-level appeal, which is submitted to the same email address as above.

As part of the appeal process, a Participant may submit written comments, documents, records, and other information regarding their claim for benefits, all of which will be considered. Neither appeal determination will afford deference to any earlier denials and each determination will be conducted by a different individual than conducted the prior review(s). A Participant will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. A Participant will also be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by Carrum in connection with the claim as soon as possible and in sufficient time to allow the Participant a reasonable opportunity to respond within the mandated timelines.

First or second-level pre-service claim appeals will be decided no later than 15 days after receipt by Carrum. Post-service claim appeals will be decided no later than 30 days after receipt by Carrum.

If Carrum denies an appeal, it will notify the Participant in writing, said writing to include, in part, the specific reason(s) for the adverse determination; reference to any relevant Plan provision(s); a statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents and other information relevant to the claim for benefits; a statement of the Participant's right to bring a civil action under Section 502(a) of ERISA after a second-level appeal denial; and any rules or other criteria relied upon in making the adverse determination, as well as the right to receive copies of said rules or criteria free of charge upon request.

There will be no opportunity for a final appeal before the Plan's Board of Trustees, either based on medical necessity or otherwise. No action at law or in equity may be brought to recover against Carrum until all administrative remedies have been exhausted (i.e. the two levels of appeal). Any action at law with respect to claims relating to Carrum must be brought within one year from the earlier of: (1) the date of an adverse benefit determination on a second-level appeal; or (2) the accrual of any claim under or relating to Carrum that does not result in an adverse benefit determination on a second-level appeal.

Nothing herein precludes a Participant from obtaining surgery or another medical procedure utilizing the Plan's EPO network and usual coverage limits and cost-sharing rules.

SECTION VI:
Important Terms

To receive the highest level of benefits payable under the Plan, you must understand how the Plan works. Before you receive care, be sure you understand the important terms explained in this section. The following words and phrases are not intended to imply that coverage for them is available under the Plan unless specified. The schedule of benefits states the applicable coverage.

Accident: An unforeseen or unexplained sudden injury occurring by chance without intent or volition.

Alcoholism: An alcohol-induced disorder which produces a state of psychological and/or physical dependence.

Ambulatory Surgical Center: A specialized facility:

- Where coverage of such facility is mandated by law, has been licensed by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located, or
- Where coverage of such facility is not mandated by law, which meets all of the following requirements:
  - It is established, equipped and operated in accordance with the applicable laws in the jurisdiction in which it is located, primarily for the purpose of performing surgical procedures;
  - It is operated under the supervision of a licensed doctor of medicine (MD) or doctor of osteopathy (DO) who is devoted full time to such supervision, and permits a surgical procedure to be performed only by a duly qualified physician who, at the time the procedure is performed, is privileged to perform such procedure in at least one hospital (as defined) in the area;
  - It requires in all cases other than those requiring only local infiltration anesthetics that a licensed anesthesiologist administer the anesthetics and remain present throughout the surgical procedure;
  - It provides at least two operating rooms and at least one post-anesthesia recovery room and is equipped to perform diagnostic X-ray and laboratory examinations;
  - It provides the full-time services of one or more registered nurses (RNs) for patient care in the operating room and in the post-anesthesia recovery room;
  - It maintains a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications or require post-operative confinement; and
  - It maintains an adequate medical record for each patient, such record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or X-rays, an operative report, and a discharge summary.

Birthing Center: A licensed facility run by at least one physician specializing in obstetrics and gynecology. It must accept only low-risk pregnancies, extend staff privileges to physicians practicing obstetrics and gynecology at a local hospital, have at least two beds or rooms for labor and delivery, provide (or arrange) diagnostic X-rays and lab tests,

administer local anesthesia and perform minor surgery, keep records of each patient and child, be able to arrange emergency transfers to a local hospital, and have an ongoing quality assurance program. A physician or certified nurse-midwife must be present at and immediately after delivery, full-time skilled nursing services must be provided directly by a registered nurse (RN) or certified nurse-midwife, and trained staff must be present to handle emergencies and provide life support services.

Child: Includes your natural children, legally adopted children, children placed with you for adoption, stepchildren through a current marriage,* children for whom you are given legal guardianship, foster children or other children who meet the Plan's eligibility requirements, as previously described.

**If your stepchild is covered by the Plan and then you divorce the biological parent of the stepchild, and you are not the legal guardian or adoptive parent of the stepchild, the stepchild is no longer eligible for coverage as of the date of divorce.*

Clinical Efficacy: Shall mean that the treatment satisfies both of the following:

- It can reasonably be expected to improve survival, health or function or to alleviate symptoms of or stabilize that condition, and
- Its use outweighs any potential harm.

Coinsurance: The percentage amount you must pay for care, often after you satisfy your annual deductible. You pay a different level of coinsurance for in and out-of-network benefits.

Collective Bargaining Agreement: The contract(s), as amended, between the International Union of Operating Engineers, Local 4 and any employer or any employer association covering wages, hours and conditions of employment requiring contributions to this Plan.

Copay: The pre-determined fee you pay when you receive certain in-network services. Generally, you pay your Copay directly to the provider when you receive the care.

Cosmetic: A treatment will be considered cosmetic for either of the following reasons:

- Its primary purpose is to beautify, or
- There is no documentation of a clinically significant impairment, which means the decrease in function or change in physiology due to illness, injury or congenital abnormality.

Covered Employment: Covered Employment means employment by an employer at employment for which such employer has agreed to contribute to the Fund under a Collective Bargaining Agreement with the Union or Participation Agreement and shall include the employment of the Office Employees of the Union, IUOE Local 4 Annuity and Savings Fund, the IUOE Local 4 Apprenticeship and Training Fund, the IUOE Local 4 Health and Welfare Fund, and the IUOE Local 4 Pension Fund for whom contributions are required to be made by the Funds, and shall include credit for such employment associated with the administration of the Fund prior to the establishment of the Funds and shall include the Employees of any other entity for whom contributions are required to be made to the Funds.

Covered Person: A Participant or Dependent who is eligible to receive benefits under this Plan.

Custodial Care: With respect to a specific condition, means a level of care:

- If its clinical efficacy has not been generally accepted by the medical community in the United States; and
- The care is chiefly designed to assist a person in the activities of daily living; and

- The care is not required by state law to be provided by a licensed professional.

Activities of daily living include but are not limited to:

- Judgment/cognitive function
- Writing
- Reading
- Communications
- Bathing
- Eating
- Toileting
- Dressing
- Transfer from bed
- Transfer from toilet
- Bowel and bladder control
- Managing money
- Taking medications
- Using public transportation
- Sitting
- Standing
- Ambulation
- Climbing stairs
- Lifting
- Grasping
- Pushing/pulling
- Reaching
- Shopping
- Cooking
- Cleaning
- Laundry
- Using a telephone
- Driving a motor vehicle

Deductible: The annual dollar amount you and each covered Dependent must pay for eligible medical expenses before the Plan pays benefits. Your annual deductible applies to out-of-network benefits provided under the Plan and certain in-network hospital or physician benefits or durable medical equipment.

A family deductible is met when your family's total deductible expenses reach a certain level in a calendar year. Although there is a per-individual deductible, the Plan will never take more than two full individual deductibles per family. This means that family members can combine their eligible charges to meet the family deductible, but the Plan will never take more than the individual deductible from any one person.

Dental Services: Procedures involving the teeth, gums or supporting structures.

Dentist: A duly licensed dentist practicing within the scope of the dental profession and any other physician furnishing any dental services which such physician is licensed to perform.

Drug Addiction: A substance-induced disorder that produces a state of psychological and/or physiological dependence.

Drug Addiction/Alcoholism Treatment Facility: A public or private facility providing services especially for the detoxification or rehabilitation of individuals suffering from substance use disorders licensed for those services.

A comprehensive health service organization, community mental health center, or other mental health clinic or day care center that furnishes mental health services with the approval of the appropriate governmental authority, and the public or private facility or portion thereof providing services especially for the rehabilitation of individuals suffering from substance use disorders and that is licensed for those purposes.

Durable Medical Equipment: Those devices that are necessary for the alleviation or correction of defects, including arm and leg braces; artificial arms, legs and eyes; crutches; hospital beds; pressure machines, resuscitators; traction equipment; walkers; and wheelchairs. It does not mean appliances such as air conditioners, air purifiers, arch supports, articles of special clothing, corrective shoes, humidifiers or dehumidifiers, dentures, elevators, eyeglasses, hearing aids, heating pads, hot water bottles, exercise equipment or devices, whirlpool baths, ramps or handrails, items of furniture, or similar devices.

Eligible Dependents: Includes the following:

- Your lawful Spouse, provided they are not legally divorced from you.
- Your married or unmarried child up to age 26.
- An unmarried child with a physical or intellectual disability over the age of 26 who became incapable of self-support prior to age 26, regardless of current age, for whom you are at least 50% responsible for support and maintenance.

For Plan purposes, the term "child" or "children" includes your natural children, legally adopted children, children placed with you for adoption, stepchildren through a current marriage,* foster children, children for whom you have legal guardianship or other children who meet the Plan's eligibility requirements.

A Spouse is defined as an individual to whom you are legally married under the laws of the state in which the marriage occurred.

**If your stepchild is covered by the Plan and then you divorce the biological parent of the stepchild, and you are not the legal guardian or adoptive parent of the stepchild, the stepchild is no longer eligible for coverage as of the date of divorce.*

Eligible Expense: Any service or supply prescribed by a physician that is medically necessary for the treatment of any illness or injury. The service must be listed as a covered service by the Plan.

Emergency: The sudden onset of an illness or injury requiring immediate medical attention.

Emergency Medical Condition: A medical condition, including a mental health condition or substance use disorder, that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in a condition described in the Emergency Medical Treatment and Labor Act (EMTALA), including:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or unborn child, in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions; or
- Serious dysfunction of any bodily organ or part of such person.

For example, an Emergency Medical Condition may include, but is not limited to, the following conditions:

- Severe chest pain;
- Severe or multiple injuries;
- Severe shortness of breath;
- Sudden change in mental status (e.g., disorientation);
- Severe bleeding;
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis;
- Poisonings; and
- Convulsions.

Emergency Services: With respect to an Emergency Medical Condition: (1) an appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, including ancillary services routinely available to the emergency department, to evaluate whether an Emergency Medical Condition exists; and (2) such further medical examination and treatment as may be required to stabilize the individual (regardless of the department of the hospital in which the further medical examination or treatment is furnished) within the capabilities of the staff and facilities available at the hospital or independent freestanding emergency department.

The term "to stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition, to deliver a newborn child (including the placenta).

Employee: A person in a job category covered by a collective bargaining agreement or participation agreement on whose behalf an employer makes the required contributions to the Plan. An Employee is not a Participant in the Plan until earning eligibility in accordance with the Plan requirements.

Experimental or Investigational Services: Drugs, devices, medical treatments or procedures, including complications that arise as a result of any of these treatments or procedures. The Plan does not provide coverage for anything considered experimental or investigational and determined as not covered by BCBSMA Medical Policies. Also, the Plan does not cover ancillary services, drugs, devices, medical treatments or procedures that would otherwise be covered when done in support of experimental or investigational procedures. However, at the Fund's sole discretion, on a case-by-case basis, diagnostic tests such as laboratory, pathology, or X-ray services or office visits that are not otherwise covered when provided under a qualified clinical trial can be covered.

For Plan purposes, *experimental* or *investigational* means:

- The drug or device requires approval of the Food and Drug Administration (FDA) and the drug or device has not been approved when furnished (a drug or device approved for investigational use is deemed to be experimental or investigational).
- Reliable evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials; is in the research, experimental, study or investigative arm of ongoing Phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy compared with a standard means of treatment or diagnosis.
- Reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or medical treatment or procedure

is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety or its efficacy as compared with a standard means of treatment or diagnosis for the patient's medical condition.

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

Experimental or investigative shall mean any treatment unless it is generally accepted by the medical community in the United States and, as compared to accepted alternative treatments for that condition, can reasonably be expected to: (1) result in similar or improved survival, health or function, or (2) alleviate symptoms of or stabilize the condition. However, the following are not considered experimental or investigative:

- Transplants: Any human solid organ or bone marrow/stem cell transplant provided that:
  a. The condition is life-threatening;
  b. Such transplant for that condition is the subject of an ongoing Phase III clinical trial;
  c. Such transplant for that condition follows a written protocol that has been reviewed and approved by an institutional review board, federal agency or other such organization recognized by medical specialists who have appropriate expertise; and
  d. The patient is a suitable candidate for the transplant under the medical protocols used by the Plan.
- Drugs: Any drug which has been approved by the FDA, provided that it:
  a. Conforms to FDA approved use guidelines, or
  b. Conforms to usage listed in one of the Recognized National Compendia.

Extended Care Facility: An institution (or part of an institution) that is licensed to provide convalescent or skilled nursing care to resident patients and that is or could be certified as a skilled nursing facility under Medicare.

Extended care facility benefits are restored for each new period of confinement. A new period of confinement begins at least 60 days after the last confinement. To be covered for extended care facility benefits, admission to the skilled nursing facility must be for non-routine care at the recommendation and under the supervision of a physician.

Home Health Care: Part-time intermittent care by or under the supervision of a registered nurse (RN) or licensed practical nurse (LPN) other than a member or resident of the household, including:

- Visits by persons who have completed a home health aide training course under the supervision of a registered nurse, up to four hours per visit;
- Physical therapy, occupational therapy and speech therapy, provided by a licensed therapist;
- Medical supplies and equipment prescribed by a physician, and laboratory services to the extent such items would have been covered if such covered person had been hospitalized;
- A physician's home visit or office visits or both;
- Nutritional consultation; or
- Medical social work.

Each visit by an Employee of a home health agency or four hours of home health aide service shall be considered as one home health care visit.

Exclusions and limitations for home health care:

In no event shall home health care expenses include charges for:

- Services solely for custodial care;
- Transportation services;
- Any period during which the covered person is not under the continuing care of a physician;
- Injury or sickness arising out of or in the course of employment, or which is compensable under any Workers' Compensation or Occupational Disease Act or law; or
- Declared or undeclared war or act of war.

Hospice Care: If a covered person is terminally ill with a life expectancy of six months or less, covered expenses include charges of an approved hospice agency for medically necessary hospice care.

Hospice benefits are subject to the following provisions:

- The patient's physician must establish and review, at least once in each three months, a written treatment plan that describes the hospice care to be provided. The Plan may require a copy of this treatment plan.
- All services and care must be included in the treatment plan, and the covered hospice expenses are limited to the following: Covered services for hospice care are the same as those for home health care (see Home Health Care above).

Hospital: A general hospital shall be an institution that meets all of the following requirements. It:

- Is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment, and care of injured or sick persons;
- Has organized departments of medicine and surgery;
- Has a requirement that every patient must be under the care of a physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered graduate nurse (RN);
- Is duly licensed by the agency responsible for licensing such hospitals, if licensing is required;
- Is not, other than incidentally, a place of rest; a place primarily for the treatment of tuberculosis or mental or emotional disorders; a place for the aged, individuals with substance use disorders; or a place for custodial care; and
- Is accredited by the American Hospital Association.

Services rendered in the infirmary or clinic of a college, university or private boarding school shall be eligible expenses. In such instances, if a covered person is confined in a school facility that does not meet the definition of a hospital because it has no operating room, benefits may be paid, provided the charges for such confinement do not exceed the reasonable and customary charges for the disability involved.

Illness: Sickness or disease that causes loss covered by the Plan. Losses incurred by a covered person because of pregnancy, childbirth and related medical conditions are covered under the Plan to the same extent as any illness.

Injury: Bodily harm by an outside force that results from an accident and results in a loss covered by the Plan.

Inpatient: Hospital confinement for which a room and board charge is made.

Intensive Care Unit: An accommodation or part of a hospital other than a postoperative recovery room which, in addition to providing room and board is:

- Established by the hospital for a formal intensive care program;
- Exclusively reserved for critically ill patients requiring constant audio-visual observation prescribed by a physician and performed by a physician or by a specially trained registered nurse; and
- Provides all necessary lifesaving equipment, drugs and supplies in the immediate vicinity on a standby basis.

Medical Devices: Any medical device provided that it:

- Has been approved by the FDA, and
- Conforms to approved use guidelines.

Medical Emergency: See the definition of *Emergency Medical Condition* above.

Medical Necessity: All covered services and prescription drugs, except routine circumcision, voluntary sterilization procedures, transplant donor suitability testing and preventive health services, must be medically necessary and appropriate for the member's specific health needs. This means that all covered services and prescription drugs must be consistent with generally accepted principles of professional medical practice. Optum Rx makes determinations on medical necessity through its prior authorization process and any appeals by members based upon medical necessity are considered by medical examiners at Optum with appropriate experience and training. The facilities and/or providers in Carrum Health's Bundled Payment Program, in conjunction with Carrum, decide if the relevant services in that program are medically necessary for Participants on a case-by-case basis. BCBSMA or Progyny, as applicable, decides which covered services are medically necessary and appropriate for the Participant by using the following guidelines.

All health care services must be required to diagnose or treat the patient's illness, injury, symptom, complaint, or condition, and they must also be:

- Consistent with the diagnosis and treatment of the patient's condition and in accordance with BCBSMA or Progyny's medical policy and medical technology assessment guidelines and behavioral health guidelines.
- Essential to improve the patient's net health outcome and as beneficial as any established alternatives covered by this group Health Plan. (This means that if BCBSMA or Progyny determines that the patient's treatment is more costly than an *alternative treatment*, *benefits are provided for the amount that would have been provided for the least expensive alternative treatment that meets the patient's needs. In this case, a patient must pay the difference between the claim payment and the actual charge*.)
- As cost-effective as any established alternatives and consistent with the level of skilled services that are furnished.

In addition, fertility preservation (e.g. storage of eggs or sperm) may be covered as medically necessary under the fertility benefit if the patient is undergoing treatment (e.g. chemotherapy or radiation therapy) that may adversely affect the patient's ability to have children in the future, and such storage would mitigate the risk. Any such finding of medical necessity for fertility preservation would be reviewable every 12 months.

A **medically necessary** service is not a service that: is furnished solely for the patient's convenience or religious preference or the convenience of the patient's family or health care provider; promotes athletic

achievements or a desired lifestyle; improves the patient's appearance or how the patient feels about their appearance; or increases or enhances the patient's environmental or personal comfort.

Medicare: The programs established by Title I of Public Law 89-98 (70 Statutes 291) as amended, titled "Health Insurance for the Aged Act," which includes Parts A and B and Title XVIII of the Social Security Act, as amended from time to time.

Mental Hospital: An institution (other than a hospital as defined) which specializes in the diagnosis and treatment of mental illness or functional nervous disorders, which is operated pursuant to law and meets all of the following requirements. It:

- Is licensed to give medical treatment;
- Is operated under the supervision of a physician;
- Offers nursing service by a registered graduate nurse (RN) or licensed practical nurse (LPN);
- Provides, on the premises, all the necessary facilities for medical treatment; and
- Is not, other than incidentally, a place of rest; a place for the aged, people suffering from substance use disorders; or a place for convalescent, custodial or educational care.

Mental Illness: Neuroses, psychoneuroses, psychopathies, psychoses, and other mental and emotional disorders.

Non-Contributory Coverage: Group plan benefits for which the Participant enrolls and for which they are not required to make a contribution toward the cost of coverage.

Non-Covered Employees: Notwithstanding the above, a Participant shall immediately cease being a Participant for purposes of determining eligibility under these provisions if they become employed by an employer who is not required to make contributions to the Plan in a category of employment that otherwise would be considered Covered Employment, except that a Participant who is working for an employer that is not required to make contributions to the Plan at the request of and with the permission of the Union for the purpose of causing the employer to become a contributing employer, remains a Participant.

A non-covered Employee also includes an apprentice in the Hoisting and Portable Engineers Local 4 Apprenticeship and Training Program who is dismissed from the program. An apprentice who is dismissed from the program is not a Participant as of the date of termination.

Non-Covered Employment: Employment in a category of work covered by a collective bargaining agreement or a Participation Agreement for which the employer is not required to make contributions to the Plan on behalf of the Employee.

Nursing Services: Skilled services which are furnished by or under the direct supervision of skilled personnel to ensure the safety of the patient and achieve the medically desired result and for which the planning and management of a treatment plan requires the continuing involvement of a licensed nurse.

Office Employee: An Employee of the Union, the IUOE Local 4 Apprenticeship and Training Fund, the IUOE Local 4 Health and Welfare Fund, the IUOE Local 4 Annuity and Savings Fund, or the IUOE Local 4 Pension Fund for whom contributions are agreed to be made by the Union or the respective Fund.

Office employer: The International Union of Operating Engineers, Local 4; the International Union of Operating Engineers, Local 4 Hoisting and Portable Engineers Apprenticeship and Training Program; or the

International Union of Operating Engineers, Local 4 Health and Welfare, Pension, and Annuity and Savings Funds.

Other Hospital Charges: Any charges, other than charges for room and board, made by a hospital on its own behalf for necessary medical services and supplies actually administered during hospital confinement or as an outpatient in a hospital. Necessary services and supplies also include any charges, regardless of who makes them, for the administration of anesthetics during hospital confinement, but will not include any charges for special nursing fees, dental fees or medical fees from physicians not on the hospital staff.

Out-of-Pocket Maximum: The Plan limits the amount of eligible, unreimbursed medical expenses you pay in any calendar year. This is called your "out-of-pocket maximum." After a covered individual or family member reaches the out-of-pocket maximum, the Plan pays 100% of covered expenses for the rest of the calendar year for that person or any covered family member if network providers are used, including out-of-network services related to a medical emergency admission or emergency room care. The out-of-pocket maximum includes your eligible coinsurance amounts and your deductible. It does not include:

- Office visit Copays;
- Charges in excess of reasonable and customary;
- Penalties and reductions in benefits due to noncompliance with the Plan's utilization management protocols;
- Durable medical equipment or other services limited by separate maximums; and
- Expenses the Plan does not cover.

Outpatient: Any hospital expense incurred for which no room and board charge is made.

Participant: An eligible covered Employee or eligible Dependent.

Participation Agreement: An agreement between the Plan and an employer under which the employer is obligated to make contributions to the Plan.

Pediatric Care: Care provided to an individual through age 18, or less than 19 years of age.

Pharmacy: A licensed establishment where prescription drugs are dispensed by a licensed pharmacist.

Provider: Covered providers include: doctors of medicine (MD); doctors of osteopathy (DO); dentists (DMD or DDS); psychologists (EdD or PhD); podiatrists (DPM); chiropractors (DC); optometrists (OD); social workers (LICSW); advance registered nurse practitioners (NP), who are covered to the extent nurses are supervised by doctors of medicine (MD) and are acting within the scope of their license; physician's assistants (PA); and other health professionals licensed by the state in which services are being rendered and acting within the scope of their license.

Psychologist: An individual who is duly licensed or certified as a psychologist in those jurisdictions where statutory or non-statutory licensure or certification exists or, in those jurisdictions where neither exists, an individual who is duly qualified as a professional psychologist by a recognized psychological association.

Registered Nurse: An individual who has received specialized nursing training and is authorized to use the designation of RN and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

Rehabilitative Care: Necessary inpatient medical care (as prescribed by a physician) rendered in a rehabilitation hospital (as defined herein) other

than the surgical facilities requirement and, in addition, that meets the following criteria. It must:

- Be accredited by the Joint Commission on Accreditation of Healthcare Organizations and be approved for federal Medicare benefits as a qualified hospital;
- Maintain transfer agreements with acute care facilities to handle surgical and/or medical emergencies; and
- Maintain a utilization review committee.

Reimbursement: If you or your Dependent are injured and recover damages from a third party, an insurance company or any other party, then you must reimburse the Plan for payments it has made or will make in connection with the injury. Upon receipt by you or your Dependent or your legal representative, the monies recovered as a result of judgment, settlement or any other cause related to the injury shall become an asset of the Plan, and shall be held in trust for the Plan. By accepting benefits from the Plan, you or your Dependent agrees that any amounts recovered by judgment, settlement or compromise will be applied first to reimburse the Fund for 100% of benefits paid, without reduction or set-off for attorney's fees, regardless of whether you or your Dependent are made whole. These Plan assets may not be distributed without a release from the Plan. The Plan is not required to participate in your or your Dependent's claims to demand reimbursement from any person or to invoke its subrogation rights. However, the Plan, at its sole discretion and election, may request that you or your Dependent assign or subrogate your claims or any other right of recovery to the Plan so that the Plan can enforce its right to recovery.

Social Worker: An individual who is duly licensed and holding a master's degree in social work from a university approved by the National Association of Social Workers (NASW).

Special Care Facility: An institution which is not a hospital as defined, but which specializes in physical rehabilitation of injured or sick patients or the diagnosis and treatment of mental illness or nervous disorders, or which qualifies as an extended care facility and a provider of services under Medicare, but only if that institution is constituted, licensed and operated in accordance with the laws of legally authorized agencies responsible for medical institutions.

Spouse: An individual to whom you are legally married under the laws of the state where the marriage occurred.

Subrogation: The Plan's right to be substituted in place of you or your eligible Dependent with reference to a lawful claim or right that you or your Dependent have against a third party (such as another person or organization, including your own automobile insurer) who may have caused injury or illness that resulted in the Plan's payment of benefits. In the event of the Plan's payment for any benefits as a result of an illness or injury, the Plan shall, to the extent of such payment, be subrogated to all rights of recovery of you or your Dependent, and shall be entitled to immediate payment of amounts due before any distribution to you or your Dependent, or on your behalf.

Total Disability; Totally Disabled: A Participant is considered Totally Disabled if, as a result of an illness or accidental injury, the individual is unable to engage in any gainful occupation for which they are reasonably fitted by education, training or experience. You must not be performing work of any kind for wage or profit once you are determined to have a Total Disability. A covered Dependent is considered Totally Disabled if, because of an illness or an accidental injury, they are prevented from engaging in all the normal activities of a person of like age and sex who is in good health.

Transplants: This means human organ (or tissue) and stem cell ("bone marrow") transplants that are furnished according to *Blue Cross and Blue Shield medical policy* and medical technology assessment criteria. This includes one or more stem cell transplants for a member who has been diagnosed with breast cancer that has spread. For covered transplants, this coverage also includes: the harvesting of the donor's organ (or tissue) or stem cells when the recipient is a *member*; and drug therapy during the transplant procedure to prevent the transplanted organ (or tissue) or stem cells from being rejected. "Harvesting" includes: the surgical removal of the donor's organ (or tissue) or stem cells; and the related *medically necessary* services and/or tests that are required to perform the transplant itself.

Union: International Union of Operating Engineers, Local 4 and its branches.

SECTION VII:
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Protected Health Information

The U.S. Department of Health & Human Services issued the Standards for the Privacy of Individually Identifiable Health Information. Pursuant to HIPAA, these rules give you greater control over who may have access to your health information. Health plans, such as the Local 4 Health and Welfare Fund, cannot share Protected Health Information (PHI) under many circumstances without your written authorization.

The Fund does not need your authorization to use and disclose PHI for the purposes of payment, treatment or health care operations.

Some examples of how the Fund may use and disclose your PHI for these purposes are provided below:

Treatment:

To process claims for treatment rendered to you by a provider or to issue an explanation of benefits statement to you for you or anyone in your family. (Upon written request, the Plan Privacy Officer will distribute explanation of benefits forms addressed only to the Participant or Dependent.)

Payment:

For paying medical, dental or vision claims for you and your Dependents, and for utilization review or management of such claims.

Health Care Operations:

- To coordinate or manage your health care, including to coordinate benefits with another insurance program that also provides you with coverage, such as an automobile insurance carrier;
- For related administrative purposes, such as obtaining or renewing stop loss coverage, or for underwriting, premium rating, and other activities related to the creation or renewal of a contract for insurance (though the Fund will not disclose PHI that is genetic for underwriting purposes);
- To communicate with other providers of insurance benefits, such as the prescription drug program;
- To identify groups of people with similar health problems to give them information about treatment alternatives or educational programs, such as disease management programs;
- To comply with administrative requirements such as providing PHI as necessary to accountants and lawyers to enable them to provide accounting and legal services to the Fund;
- To disclose PHI to the sponsor of the Plan (Board of Trustees), such as for processing an appeal of a denial of benefits of coverage.

The Fund is permitted or required to use or disclose your PHI without your written authorization for the following purpose and in the following circumstances, as limited by law:

- To comply with local, state or federal law, or for health care oversight activities authorized by law, as for example, when a disclosure is required by subpoena or to comply with a governmental health oversight board investigating complaints against physicians or other health care providers;
- For public health activities, which generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; or reduce the risk for contracting or spreading a disease or condition;
- For research under certain circumstances, including to study treatment outcomes, costs and benefit design, after we remove information that personally identifies you;
- When the disclosure relates to victims of abuse, neglect or domestic violence;
- For law enforcement purposes, including to respond to a subpoena, warrant, summons or similar process, or in some cases to identify or locate a suspect or report a crime;
- For specialized governmental functions, such as to disclose an individual's PHI to authorized federal officials for the conduct of national security or intelligence-related activities authorized by law, including providing protection to the president or other authorized persons or foreign heads of state;
- For the duties of a coroner, medical examiner or funeral director, to identify the body of a deceased person, to determine a cause of death or to perform other authorized duties;
- For facilitating organ donation and transplants, including release of necessary medical data to organizations engaged in the procuring, banking, or transplanting of human organs, eyes, or tissue;
- To comply with Workers' Compensation laws or other similar programs to the extent necessary;
- To avert a serious threat to health or safety or to prevent or lessen an imminent threat to the health and safety of another person or the public;
- For judicial proceedings, such as in response to a court order, subpoena or other lawful process, to the extend otherwise permitted herein, after the Fund is assured efforts have been made to notify you of the request or to obtain an order protecting the information requested;
- To business associates acting on the Fund's behalf and providing services (such as legal, auditing and claims utilization review) to the Fund. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract with them;
- To the correctional institution or law enforcement official if you are an inmate of a correctional institution or under the custody of a law enforcement official, if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

We may also make other uses and disclosures, which occur as a by-product of these permitted uses and disclosures of PHI.

Notwithstanding anything herein that may be interpreted to the contrary, neither the Fund nor any of its Business Associates may use or disclose PHI for the following purposes:

- To conduct criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing or facilitating

lawful reproductive health care, in vitro fertilization or gender affirming health care services.

- To impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating lawful reproductive health care, in vitro fertilization or gender affirming health care services.
- To identify any person for either purpose described above.

This prohibition applies when the health care services at issue are considered lawful within the Commonwealth of Massachusetts or would be lawful if such services had occurred entirely within the Commonwealth.

Local 4 Health and Welfare Fund must have your written authorization to disclose PHI for any other purpose, including disclosure of PHI relating to your health and welfare claims, to someone other than you. You may revoke such an authorization at any time in writing.

You have individual rights with respect to PHI. You have the right to:

- An accounting of certain disclosures of PHI, with certain exceptions, if you submit a written request to the Fund. The Fund need not account for disclosures that were made more than six years before the date on which you submit your request, or any disclosures that were made for treatment, payment or health care operations..
- Access, Inspect and copy your PHI. You must put your request in writing. The Fund has up to 30 days to make the information available to you, and may charge a reasonable fee for the cost of copies, mailing or supplies associated with your request. If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity, subject to certain limitations.
- Amend your PHI in certain circumstances with certain limitations, such as if you believe PHI about you that is maintained by the Fund is incorrect or incomplete. You must put your request in writing and give a reason.
- Request reasonable confidential communications of PHI by alternative means or to alternative locations (for example, your workplace). The Fund may ask that you put such a request in writing.
- Request certain restrictions of use and disclosures of PHI. While you have the right to request a restriction on the Fund's use and disclosure of your PHI, the Fund is not required to agree to a restriction.
- Receive notification of any breach of your PHI that is discovered by the Fund.

You also have additional rights:

- You have the right to a paper copy of the Fund's current Notice of Privacy Practices, which describes the Fund's privacy practices in more detail. Whenever there is a material change to the Fund's Notice of Privacy Practices, the Fund will promptly revise and distribute the new Notice of Privacy Practices to Participants and Beneficiaries.
- If you believe your privacy rights have been violated, you may file a written complaint with the Fund's Privacy Officer at the following address: IUOE LOCAL 4 HEALTH AND WELFARE FUND PRIVACY OFFICER, P.O. Box 680, 16 Trotter Drive, Medway, MA 02053, 508-533-1400 or 888-486-3524, or office@local4funds.org. You may also send a written complaint to the Secretary of the United States Department of Health and Human Services. You may not be penalized or retaliated against for filing such a complaint.

If you want more information about the Fund's policies and procedures regarding privacy of your medical and other personal information, please contact the Fund's Privacy Officer at the Funds' Office.

Plan Administrative Information

Plan employer Identification Number: 04-6040880
Plan Number: 501

	Medical and Weekly Accident and Sickness Plan	Medical and Weekly Accident and Sickness Plan	Dental Plan	Prescription Drug Plan	Vision Plan	Hearing Plan	Life Insurance	AD&D	Loss of Time	Fertility Benefits
Plan Type	Health care plan, Medical	Health care plan, inpatient mental health and substance use disorder	Dental plan	Health care plan, Prescription	Health care plan, Vision	Health care plan, Hearing	Life insurance plan	Accidental death and dismember-ment plan	Health care plan, Disability	Health care plan, Fertility
Type of Administration	Contract administrator	Contract administrator	Contract administrator	Contract administrator	Contract administrator	Trust fund, self administered	Contract administrator	Contract administrator	Trust fund, self administered	Contract administrator
Funding Method	Self-insured	Self-insured	Self-insured	Self-insured	Self-insured	Self-insured	Fully insured	Fully insured	Self-insured	Self-insured
Claims Administrator for the Plan	Blue Cross Blue Shield of Massachusetts Landmark Center 401 Park Drive Boston, MA 02215-3326 1-800-401-7690	Blue Cross Blue Shield of Massachusetts Landmark Center 401 Park Drive Boston, MA 02215-3326 1-800-401-7690	Blue Cross Blue Shield Dental of Massachusetts (Dental Blue) 465 Medford Boston, MA 02129 1-800-821-1388	Optum Rx, Inc. 11000 Optum Circle Eden Prairie, MN 55344	EyeMed First American Administrators, Inc. Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111 1-866-723-0514	TruHearing, Inc. 12936 S. Frontrunner Blvd. #100 Draper, UT 84020 1-888-934-4744	Symetra Attn: Claims Department P.O. Box 1230 Enfield, CT 06083 Phone: 1-877-377-6773 Fax: 1-877-737-3650	Symetra Attn: Claims Department P.O. Box 1230 Enfield, CT 06083 Phone: 1-877-377-6773 Fax: 1-877-737-3650	International Union of Operating Engineers, Local 4 Health and Welfare Fund 16 Trotter Drive P.O. Box 680 Medway, MA 02053 1-508-533-1400 or 1-888-486-3524	Progyny Dept LA 24452 Pasadena, CA 91185-4452 1-866-606-9789

Plan Trustees

The Plan is funded through a separate trust established to make benefit payments according to the terms of the Plan.

Union Trustees	Employer Trustees
Michael J. Bowes, Chairman International Union of Operating Engineers, Local 4 16 Trotter Drive Medway, MA 02053-2299	Angelo Colasante East Coast Slurry Co. 145 Island Street Stoughton, MA 02072
David Shea International Union of Operating Engineers, Local 4 16 Trotter Drive Medway, MA 02053-2299	James Reger Mass. Aggregate and Asphalt Pavement Association 1500 Providence Highway, Suite 14 Norwood, MA 02062
Paul C. DiMinico International Union of Operating Engineers, Local 4 16 Trotter Drive Medway, MA 02053-2299	David Marr, Jr. Marr Crane & Rigging 201 Commerce Drive Braintree, MA 02184

Plan Administrator

The International Union of Operating Engineers, Local 4 Health and Welfare Plan is administered by a Board of Trustees, which consists of three union and three employer representatives. The Board of Trustees acts in accordance with the provisions of the Declaration of Trust that established the Plan.

Plan Sponsor

The International Union of Operating Engineers, Local 4 Health and Welfare Plan Board of Trustees is the legal sponsor of the Plan. The Board of Trustees maintains an administrative staff to help administer the Plan.

You may address the Plan at:

International Union of Operating Engineers, Local 4 Health and Welfare Fund
16 Trotter Drive
P.O. Box 680
Medway, MA 02053
1-508-533-1400 or 1-888-486-3524

Plan Year

The Plan is administered on a calendar-year basis from January 1 to December 31.

Agent for Service of Legal Process

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

Board of Trustees

International Union of Operating Engineers Local 4 Health and Welfare Fund
16 Trotter Drive
P.O. Box 680
Medway, MA 02053
1-508-533-1400 or 1-888-486-3524

You also may serve legal process upon any of the individual Plan trustees listed.

Authority

The Trustees have authority to control and manage the administration of this Plan and to delegate such authority as permitted by the terms of the Trust, the Plan and ERISA. The Trustees shall be the named fiduciary of the Plan, and possess the specific powers, duties, and responsibilities set forth under the Trust, the Plan and ERISA.

Rights and Duties

The Trustees shall administer and interpret the Plan and have been granted the sole and absolute discretionary power to take all action and to make all decisions necessary or proper to carry out the terms of the Plan. The determination of the Trustees as to any questions of fact, any questions involving the administration and interpretation of the Plan, and any questions regarding rights to benefits under the Plan shall be conclusive as to all parties to the Plan and their determination shall not be overturned unless said determination is arbitrary and capricious.

For life insurance, the fiduciary is Symetra Life Insurance Company; for AD&D Insurance, the fiduciary is Symetra Life Insurance Company. This means that for these benefits, the insurance companies have sole authority to make claim and eligibility determinations. All such determinations and decisions will be final and conclusive on all parties and will not be overturned unless such determinations, actions and/or decisions are arbitrary and capricious.

No local union officer, business agent, local union Employee, employer or employer representative, Funds Office personnel, consultant, attorney, agent of BCBSMA, or any other person is authorized to speak for or on behalf of the Trustees, or to commit the Trustees of this Fund on any matter relating to the Fund without the express authority of the Trustee

Future of the Plan

Although the Board of Trustees has no present intention to terminate the Plan, it has expressly retained the right to amend, modify or terminate the Plan at any time.

Any such action of the Board of Trustees will be evidenced by a written amendment which is filed with the Plan Documents and communicated to Plan Participants in the manner required by law.

If the Plan is terminated, available assets will be distributed according to the Trust Agreement and ERISA.

Missing Participant

Any benefit payable under this Plan shall be forfeited if the Trustees, after a reasonable effort, are unable to locate the Participant, Dependent or other individual to whom payment is due on a benefit claim timely filed with the Trustees.

However, any forfeited benefit payment shall be reinstated if a claim is made for such payment by such individual, or if the individual has died, their designated beneficiary or their estate, within the applicable time period described in the Plan.

Physical or Other Disability

If the Plan Administrator finds that any person to whom an amount is payable under the Plan is unable to care for their affairs because of illness or accident, or is a minor, or has died, then any payment due them or their estate (unless a prior claim therefore has been made by a duly appointed legal representative) may be paid to their designated beneficiary, an institution maintaining or having custody of such person, their estate, or any other person deemed by the Plan Administrator to be a proper recipient on behalf of such person otherwise entitled to payment.

Any such payment shall be a complete discharge of the liability of the Plan Administrator and Plan.

Transmittal of Notices

All notices, statements, reports and other communications from the Plan Administrator required or permitted under the Plan shall be deemed to have been given when delivered to the Participant, or mailed to the Participant at the address last appearing on the records of the Plan Administrator.

Controlling Law

To the extent not preempted by federal law and regulation, this Plan and all rights thereunder shall be governed by and construed in accordance with the laws of the Commonwealth of Massachusetts.

Vested Rights

No person, Participant or Dependent shall have any vested rights under the Plan and/or insurance contract(s).

Spendthrift

As, and to the extent required by ERISA and the Code, any benefits and interest in the Plan and/or insurance contract(s) shall not be anticipated, assigned, alienated, or subject to attachment, garnishment, levy, execution, or other legal or equitable process, or otherwise be subject to the claims of third-party creditors, except as provided under the terms of a Qualified Medical Child Support Order, and provided further that nothing in this provision shall prevent the Trustees, the Trustees of the International Union of Operating Engineers, Local 4 Pension Fund, or the International Union of Operating Engineers, Local 4 Annuity and Savings Plan from making a claim for offset against any benefit or interest in the Plan and/or insurance contracts.

Examinations

The Board of Trustees of the Plan has the right, through its medical representatives, to request an independent medical exam when and so often as it may reasonably require to audit or adjudicate any claim filed under the Health and Welfare Plan.

Fraud and Abuse Policy

This Plan is subject to federal laws which provide that criminal penalties may be imposed against those who receive or attempt to receive health care plan benefits by committing fraud or abuse against the Plan. State fraud and abuse laws may also apply.

In addition, the Plan may bring a lawsuit against any Participant, beneficiary or provider who obtains services or payments to which they are not entitled. The Plan may also offset future benefit payments otherwise due to a Participant or beneficiary or a future reimbursement to a medical provider.

Any person who commits a fraudulent act against the Plan may be subject to criminal prosecution, fine or imprisonment as provided by law. The following items listed may be considered fraud against or abuse of the Plan:

1. Falsifying, withholding, omitting or concealing information to obtain coverage or payment for services;
2. Misrepresenting eligibility criteria for Dependents (for example, age or Dependent Child status) to obtain or continue coverage for a person who would not otherwise meet the Dependent eligibility criteria, as defined in the Plan, and qualify for coverage;
3. Making or using any false writing or document in connection with obtaining coverage or payment for health benefits;

4. Permitting a person who is not covered under the Plan to use a Plan identification card or other Plan identifying information to obtain covered services or payment under this Plan;
5. Making false or fraudulent representations in connection with delivery of or payment for health benefits, or being untruthful to obtain payment or reimbursement under this Plan; or
6. Obtaining, or attempting to obtain, medical care or Covered Services under this Plan under false or fraudulent pretenses.

Guidelines Concerning Participation in the IUOE Local 4 Benefit Funds of a Sole Proprietor, Partner, Corporate Stockholder, Corporate Officer and/or Their Relatives

A. Definitions

Federal law requires that the Trust Funds be for the sole and exclusive benefit of the Employees. For purposes of participation in these Funds, an individual will be considered to be an Employee and must participate in the Funds if they are employed by an employer for wages under a Collective Bargaining Agreement which requires contributions to be made to the Funds on their behalf, and/or is employed by the employer for wages and the employer has executed a Participation Agreement which requires contributions to be made to the Funds on their behalf.

Certain categories of persons who have an ownership interest in an employer or who have a special relationship with an employer may be considered Employees for purposes of participation in the Trust Funds. If such persons participate in the Funds, the employers of persons in these categories must contribute to the Funds in accordance with the rules. If such persons are non-collectively bargained Employees, their employers must comply with additional rules. The categories subject to these rules are:

A person who has an ownership interest in an incorporated employer (hereafter referred to as "Owner" or "Stockholder"). A person who is an officer of or is otherwise involved in the management of an incorporated employer (hereafter referred to as an "Officer"). A person who is a relative —that is, a child, stepchild, Spouse, parent, brother, sister, son-in-law, father-in-law or other relative as determined by the Trustees in specific cases—of a Stockholder or an Officer, or a Sole Proprietor or Partner of an unincorporated employer (hereafter referred to as a "Relative").

B. Rules on Initial, Continuing, and Termination of Eligibility for Officers, Stockholders and Their Relatives

1. Eligibility to Participate

- An Owner or an Officer or Relative who works in Covered Employment will be initially eligible to participate in the IUOE Local 4 Benefit Funds under the same terms as Employees performing Covered Employment under the Collective Bargaining Agreement.
- A Sole Proprietor or Partner in an unincorporated business is an employer by law and may not participate in the Trust Funds. However, their Employees who are covered by the Collective Bargaining Agreement must be reported to the Funds and contributions must be made to the Funds on behalf of these Employees as required by the Collective Bargaining Agreement.

An Employee who is married to one of the Owners of an unincorporated business and who files a joint federal tax return with that Spouse that includes the operation of the business may not participate in the Trust Funds. All other Relatives of Sole Proprietors or Partners of unincorporated businesses are subject to these guidelines.

2. Conditions of Eligibility to Participate for Officers, Stockholders or Their Relatives

- The employer of an Officer, Stockholder or Relative as defined above who is or will be participating in the Funds must, as a condition for participation, sign a Participation Agreement and must agree to maintain records for at least seven years—the current year plus the prior six years—to document the total hours worked by each Officer, Stockholder or Relative, a description of the type of work performed and the amount of each type of work, including the total hours of work in Covered Employment.
- The employer of an Officer, Stockholder or Relative as defined above, who is participating in the Funds, must contribute to all of the Funds to which contributions are required for collectively bargained Employees under the applicable collective bargaining agreement.
- The Owner of an unincorporated business, whose Spouse is an Employee participating in the Funds, must annually submit the separate tax returns filed by the Owner and their Employee Spouse.
- If an erroneous overpayment is made to the Funds, the Trustees, in their discretion, may decide whether to retain the contributions, or whether to refund the contributions, after the deduction of the costs of correcting the error and the deduction of benefit payments made based on the erroneous overpayment.

C. Amount of Contributions; Payment of Contributions

Contributions for Owners and Officers must be made at the rate of 160 hours per month at the hourly rate set forth in the Collective Bargaining Agreement or the Participation Agreement between the employer and the Benefit Funds. All remittance reports and contributions are due in the Funds Office no later than the 19th day of each calendar month for the following month's coverage.

D. Participation Agreement; Governing Law

In order for an Owner or Officer to participate in IUOE Local 4 Benefit Funds, the employer must execute the Participation Agreement in a form acceptable to the Funds. Participating employers must also meet applicable IRC regulatory requirements.

Information Compliance

Individuals covered under the Health and Welfare Plan are required to furnish the Plan Administrator, in the manner prescribed by the Plan Administrator and at their request, information that the Plan Administrator deems necessary or desirable to administer the Plan. This includes:

- Personal data;
- Affidavits;
- Consents;
- Authorizations to obtain information; or
- Other information.

The most important provisions have been generally described in this document. You are not entitled to benefits under the Plan unless you meet all of the detailed requirements spelled out in the Plan. You must apply for benefits in order to receive any payments from the Plan as described in this document.

Also, you should be sure to keep the Plan Administrator informed of any changes in your address, because benefits cannot be paid to you if you cannot be located.

Summary Plan Description and Plan Document

This booklet is intended to satisfy the requirements of a Summary Plan Description (SPD), and a Plan Document, as specified in the Employee Retirement Income Security Act (ERISA) of 1974.

Collective Bargaining Agreements and Participating Employers

A complete list of all of the employers, employer organizations, and Employee organizations who are plan sponsors or who participate in this Plan may be obtained by a Participant or beneficiary by making a written request for a copy from the Plan Administrator, and is available for examination by Participants or beneficiaries at the Funds Office. Participants and beneficiaries also may receive, upon written request, information as to whether a particular employer or Employee organization is a Plan Sponsor or participates in the Plan.

A copy of the collective bargaining agreement may be obtained by a Participant or beneficiary by making a written request for a copy from the Plan Administrator, and is available for examination by Participants or beneficiaries at the Funds Office.

Plan Financing

All contributions to the Health and Welfare Plan are made by employers in accordance with their collective bargaining agreements with the International Union of Operating Engineers, Local 4 or Participation Agreements.

Funding of health and welfare benefits for Participants returning from military service earned in accordance with USERRA may be provided, at the Trustees' election and at their discretion, from the Fund, voluntary employer contributions, collectively bargained employer contributions or the last employer who employed the Participant prior to entry into military service. Contributing employers are permitted to make voluntary contributions on behalf of any Participant who is serving or who has served in qualified military service, in order to restore their eligibility, regardless of whether they worked for that employer.

The Funds Office will provide you, upon your written request, information as to whether a particular employer is contributing to the Plan on behalf of Employees working under the collective bargaining agreements and, if so, that employer's address. In addition to your request, the Board of Trustees sends an annual Report of Contributions to each Participant. You must notify the Funds Office immediately of any company or companies that have failed to pay for you, or that have paid incorrectly.

Your ERISA Rights

The Employee Retirement Income Security Act (ERISA) of 1974, as amended, spells out certain rights and responsibilities relating to the benefit plans described in this Plan Document. The International Union of Operating Engineers, Local 4 Health and Welfare Plan is designed to meet the legal requirements for plans established under ERISA. The Plan will be amended to comply with any applicable changes in the law or government regulations.

As a Participant in the Health and Welfare Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan Participants shall be entitled to the rights outlined in this section.

Receive Information About Your Plan and Benefits

You have the right to examine, without charge, at the Plan Administrator's office, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S.

Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

You have the right to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies. You have the right to receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You have the right to continue health care coverage for yourself, your Spouse and your Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. See ***Continuation of Coverage (COBRA)*** for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a 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 Document or the latest annual report from the Plan and do not receive it 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 administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Qualified Medical Child Support Order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

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

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory, or: Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA.