GREATER METROPOLITAN HOTEL EMPLOYERS-EMPLOYEES HEALTH AND WELFARE FUND

Summary Plan Description

And

Plan Document

Effective February 1, 2024

GREATER METROPOLITAN HOTEL EMPLOYERS-EMPLOYEES HEALTH AND WELFARE FUND

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GREATER METROPOLITAN HOTEL EMPLOYERS-EMPLOYEES
HEALTH AND WELFARE FUND

To All Plan Participants:

The Board of Trustees is pleased to present you with this updated Summary Plan Description. This booklet describes the Health and Welfare Plan in effect on February 1, 2024.

Please read this booklet carefully so that you will know for which benefits you are eligible, what you must do to qualify, and how to file a claim for benefits. We suggest that you keep this booklet in a safe place, along with your other valuable papers. If you have questions about the Plan, or if you need information about your eligibility for benefits, contact the Fund. The Board of Trustees will assist you with any matter related to the Plan.

Sincerely,

BOARD OF TRUSTEES

IMPORTANT NOTE:

This Summary Plan Description and Plan Document explains your benefits under the Health and Welfare Plan. The information contained in this booklet is accurate and up-to-date as of the time of its printing. Any Summary Material Modification issued after the date of printing is incorporated by reference into this document and controls with respect to benefits under this Plan.

GRANDFATHERED STATUS

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Greater Metropolitan Hotel Employers-Employees Health and Welfare Fund, Attn: Benefit Plan Administrator, 3001 Metro Drive, Suite 500, Bloomington, MN 55425; 952-854-0795. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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SCHEDULE OF BENEFITS

The Trustees have contracted with UnitedHealthcare to provide for a medical PPO Network, the UnitedHealthcare Choice Plus Network, so that you may individually select your health care providers. **The advantage of using providers within the UnitedHealthcare Choice Plus Network is that the cost of your medical care is more fully covered by the plan.** However, the trustees allow you to make the choice of where to get medical care, and they hope that this arrangement suits your needs. **The Plan is fully responsible for payment for Health Care Services rendered in compliance with the terms of the Plan.**

You can learn more about the UnitedHealthcare Choice Plus Network and obtain assistance in finding network providers by going to www.umr.com or calling the customer care center at 1-800-535-6373.

Service	In Network	Out of Network
Calendar year deductible	None	$200 per individual After the deductible, the Plan pays 80% of eligible expenses.
Annual out-of-pocket maximum per Person	$1,200 combined for in and out-of-network coverage.	
Medical Co-Pay (there is no copayment requirement for preventive and immunization services.)	$15.00 per visit	$15.00 per visit
A. AMBULANCE AND MEDICAL TRANSPORTATION		
Pre-authorized transfers between network hospitals for treatment initiated by a network physician	100% of the charges incurred.	No Coverage.
All other eligible transportation	80% of the charges incurred.	80% of the charges incurred.
Air Ambulance	80% of the charges incurred.	80% of the charges incurred.
B. CHIROPRACTIC SERVICES	100% of the charges incurred.	80% of the charges incurred.
C. DENTAL SERVICES (See also Dental Benefit section)		
Preventive Dental Services	See Dental Benefit section.	
Accidental Dental Services		
a. Accidental Dental Services within the Network	80% of the charges incurred.	Subject to a deductible of $50 per calendar year, and a maximum benefit of $300, 80% of the charges incurred. ($300 annual maximum does not apply to Dependent Children under Age 19).
	Treatment and repair must be completed within twelve months of the date of the Injury.	

Service		In Network	Out of Network
	Medical Referral Dental Services		
	a. Medically Necessary Outpatient Dental Services	100% of the charges incurred.	80% of the charges incurred.
	b. Medically Necessary Hospitalization for Dental Care	100% of the charges incurred.	80% of the charges incurred.
	c. Medical Complications of Dental Care	100% of the charges incurred.	80% of the charges incurred.
	Oral Surgery	100% of the charges incurred.	80% of the charges incurred.
	Treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD)	100% of the charges incurred.	80% of the charges incurred.
D.	DURABLE MEDICAL EQUIPMENT, ORTHOTICS AND PROSTHETICS	80% of the charges incurred.	80% of the charges incurred.
E.	EMERGENCY AND URGENTLY NEEDED CARE SERVICES		
	Emergency care in a hospital emergency room, including professional services of a Physician; emergency care and Urgently needed care.	100% of the charges incurred, subject to a member copayment of $50 per visit. Emergency room copayment is waived if admitted for the same condition within 24 hours.	80% of the first $2,500 and 100% thereafter of the charges incurred per calendar year.

Service	In Network	Out of Network
F. HEALTH EDUCATION		
Provider office visit/session in connection with preventive services	100% of the charges incurred.	No Coverage.
Provider office visit/session in connection with the management of a chronic health problem (such as diabetes)	100% of the charges incurred.	No Coverage.
G. HOME HEALTH SERVICES		
Physical therapy, occupational therapy, speech therapy, respiratory therapy and home health aide services	100% of the charges incurred.	80% of the charges incurred.
TPN/IV therapy, skilled nursing services, prenatal and postnatal services, child health services and phototherapy	100% of the charges incurred.	80% of the charges incurred.
Number of visits	Maximum of 120 visits per calendar year.	Maximum of 60 visits per per calendar year.
	Each day of services provided under the UnitedHealthcare Benefits and Supplemental Benefits counts toward the maximums shown above.	
H. HOME HOSPICE SERVICES		
Part-time care	100% of the charges incurred.	No Coverage.
Continuous care	100% of the charges incurred.	No Coverage.
	Limit of 30 days of continuous care and respite care combined.	
Respite care	80% of the charges incurred.	No Coverage.
	Respite care is limited to 5 days per episode, and 30 days of continuous care and respite care combined.	
Medically necessary medications for pain and symptom management	100% of the charges incurred.	No Coverage.

Service	In Network	Out of Network
Semi-electric hospital beds and other durable medical equipment	100% of the charges incurred.	No Coverage.
Emergency and non-emergency care	100% of the charges incurred.	No Coverage.

I. HOSPITAL AND SKILL NURSING FACILITY SERVICES

Service	In Network	Out of Network
Medical or Surgical Hospital Services		
a. Inpatient Hospital Services	100% of the charges incurred. Limited to 365 day maximum per period of confinement, subject to the combined day limit.	No Coverage
b. Outpatient Hospital, Ambulatory Care or Surgical Facility Services	100% of the charges incurred.	80% of the charges incurred.
Skilled Nursing Facility Care	100% of the charges incurred. Limited to 120 day maximum per period of confinement, subject to the combined day limit.	80% of the charges incurred. Limited to 120 day maximum per period of confinement, subject to the combined day limit.

Each day of services provided applies toward the 120-day maximum for Supplemental Benefits.

Service	In Network	Out of Network
J. INFERTILITY SERVICES	80% of the charges incurred. *To a $10,000 lifetime maximum*	80% of the charges incurred. *To a $10,000 lifetime maximum*.
K. LABORATORY AND X-RAY SERVICES	100% of the charges incurred.	80% of the charges incurred.

L. MENTAL AND CHEMICAL HEALTH SERVICES

Mental Health Services	**In Network**	**Out of Network**
a. Outpatient Services including family therapy	100% of the charges incurred.	80% of the charges incurred.
Group Therapy	100% of the charges incurred.	80% of the charges incurred.

Service	In Network	Out of Network
b. Inpatient Services, including Day Treatment	100% of the charges incurred.	No Coverage.
Chemical Health Services		
a. Outpatient Services	100% of the charges incurred.	80% of the charges incurred.
b. Inpatient Services	100% of the charges incurred.	No coverage.

<u>To contact TEAM, please call 651-642-0182 or 1-800-634-7710</u>. <u>See the Employee Assistance Program section for a description of other services provided by TEAM</u>.

Service	In Network	Out of Network
M. OFFICE VISITS FOR ILLNESS OR INJURY	100% of the charges incurred.	80% of the charges incurred.
N. PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY		
Rehabilitative Care	100% of the charges incurred.	80% of the charges incurred.
Habilitative Care	100% of the charges incurred.	No Coverage.
O. Injections administered in a physician's office		
Allergy injections	100% of the charges incurred.	80% of the charges incurred.
Immunizations	100% of the charges incurred.	No Coverage.
P. Special dietary treatment for Phenylketonuria (PKU)	80% of the charges incurred.	80% of the charges incurred.
Q. PREVENTIVE SERVICES		
Routine health exams and periodic health assessments	100% of the charges incurred.	No Coverage.
Prenatal services	100% of the charges incurred.	80% of the charges incurred.
Postnatal services	100% of the charges incurred.	80% of the charges incurred.
Routine screening procedures for cancer	100% of the charges incurred.	80% of the charges incurred.
Routine eye and hearing exams	100% of the charges incurred.	No Coverage.
Professional voluntary family planning services	100% of the charges incurred.	No Coverage.

Service		In Network	Out of Network
	Adult immunization	100% of the charges incurred.	No Coverage.
R.	TRANSPLANT SERVICES	100% of the charges incurred.	80% of the charges incurred.
S.	PRESCRIPTION DRUG SERVICES	Drugs and medications must be part of the CVS Caremark Pharmacy Formulary and obtained at a network Pharmacy.	
		You must present your *CVS Caremark* eligibility card. Specialty Drugs must be purchased through the Caremark Exclusive Specialty Plus Network.	
		In Network	Out of Network
	Outpatient drugs	100% of the charges incurred.	80% of the charges incurred.
		Drugs for *the treatment of organic impotence are limited to six doses per month.*	
	Prescription Drugs	*Retail or Mail Order (30 day supply)*	
		Generic – Participant co-pay of $5.00 or 10% whichever is greater but not to exceed $20.00.	
		Brand – Participant co-pay of 20% but not to exceed $50.00.	
		Retail or Mail Order – (31-90 day supply)	
		Generic – Participant co-pay of $10.00 or 10% whichever is greater but not to exceed $40.00	
		Brand – Participant co-pay of 20% but not to exceed $100.00	
	All other injections	100% of the charges incurred.	80% of the charges incurred.
	Insulin, per vial or box of insulin cartridges	100% of the charges incurred. subject to a member copayment.	80% of the charges incurred.
	Birth Control drugs and devices		
	Oral contraceptives, per three-cycle supply and Barrier devices, per device	100% of the charges incurred. subject to a member copayment.	80% of the charges incurred.
	Injectable and implantable drugs/ devices (Implantable drugs/devices are limited to one every five years.)	80% of the charges incurred.	80% of the charges incurred.
	Drugs for treatment of infertility	80% of the charges incurred.	80% of the charges incurred.

Formulary drugs for the treatment of organic impotence are limited to six doses per month.

Tobacco cessation products, as determined by UnitedHealthcare. Must be prescribed by a licensed provider and filled at a network pharmacy. Limited to a 60-day supply per calendar year. No more than a 30 day supply will be covered and dispensed at a time. Only one product will be dispensed at a time.	100% of the charges incurred. subject to a member copayment.	No Coverage.

Unless otherwise specified above, you may receive up to a 30-day supply per prescription. No more than a 90-day supply will be covered and dispensed at a time, If a member copayment is required, you must pay one member copayment for each 30-day supply, or portion thereof. If there is a generic equivalent, brand name drugs are only covered up to the charge that would apply to the generic drug, minus any required copayment.

You may also get outpatient prescription drugs which can be self-administered through CVS Caremark mail order service. Drugs ordered through this service are covered at 100% of the charges incurred, subject to a member copayment amounts stated above. For information on how to obtain drugs through CVS Caremark mail order service, refer to your enrollment material.

T. Telehealth Services - Teladoc.

Teladoc is an online service available that allows a covered person to visit a doctor using a computer, smartphone or tablet, with a front-facing camera. Teladoc provides you convenient access with board-certified doctors via phone or video within minutes for non-emergency, acute general medical needs. The Plan provides coverage for this benefit at 100%. There is no coinsurance or copayment required.

Teladoc may be used:

- When immediate care is needed.
- When considering the ER or Urgent Care center for non-Emergency issues.
- When you are on vacation or on a business trip.

Teladoc can be used for the following types of conditions:

- General medicine, including, but not limited to:
  - Colds and flu
  - Allergies
  - Bronchitis
  - Pink eye
  - Upper respiratory infections
- A refill of a recurring prescription.
- Pediatric care.
- Non-Emergency medical assistance.

In order to obtain this benefit, you must complete a medical history disclosure form that will serve as an electronic medical record for consulting Physicians. This form can be completed via the Teladoc website: www.Teladoc.com, via the call center, or via the Teladoc mobile app. Once enrolled, you may phone 1-800-TELADOC (1-800-835-2362) and

request a consultation with a Physician. A Physician will return your phone call. If you request a web-based video consultation, the consultation will be scheduled and an appointment reminder notification will be sent prior to the appointed time. If necessary, the Physician will write a Prescription. The Prescription will be called in to a pharmacy of your choice. Benefits for this service are shown in the Schedule of Benefits.

The Teladoc app works with any smartphone, tablet or computer, with a front-facing camera. You can register your account by phone, web or mobile app. To get started, you can:

- Go to www.Teladochealth.com and click “Set up account,” or
- Download the Teladoc app from the App Store or Google Play and click “Active account,” or,
- Call 1-800-TELADOC (835-2362) and an account can be set up over the phone.

SERVICES NOT COVERED

In addition to any other benefit exclusions, limitations or terms specified in this Plan, the Plan will not cover charges incurred for any of the following services, except as specifically described in this Plan:

1. Treatment, procedures or services which are not medically necessary and/or which are primarily educational in nature or for the vocation, comfort, convenience, appearance or recreation of the Plan Participant, including cognitive retraining.

2. For UnitedHealthcare coverage, treatment, procedures or services that are not provided, authorized or referred by a network physician or other authorized network provider.

3. Charges incurred for services, supplies or procedures that are Experimental or Investigative in nature. For purposes of this Plan, the use of any treatment (which includes use of any treatment, procedure, facility, drug, equipment, device, or supply) is considered to be Experimental or Investigative if the use is not yet generally recognized as accepted medical practice, or if the use requires federal or other governmental agency approval and the approval has not been granted at the time the service or supply is provided, or if the use is not supported by Reliable Evidence which shows that, as applied to a particular condition, it:

   a. Is generally recognized as a safe and effective treatment of the condition by those practicing the appropriate medical specialty;

   b. Has a definite positive effect on health outcomes;

   c. Over time leads to improvement in health outcomes under standard conditions of medical practice outside clinical investigatory settings (i.e. the beneficial effects outweigh the harmful effects); and

   d. Is at least as effective as standard means of treatment in improving health outcomes, or is usable in appropriate clinical contexts in which standard treatment is not employable.

   e. Reliable Evidence includes only:

      i. Published reports and articles in authoritative medical and scientific literature;

      ii. The written investigational or research protocols and/or written informed consent used by the treating facility or of another facility which is studying the same service, supply, or procedure; and

      iii. Compilations, conclusions, and other information which is available and may be drawn or inferred from (a) or (b), above.

      Consideration may be given to whether:

      - The treatment cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the treatment is furnished; or

- Reliable Evidence shows that the treatment is the subject of ongoing Phase I, II or III clinical trials are under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with standard means of treatment or diagnosis; or

- Reliable Evidence shows that consensus among experts regarding the treatment is that further studies or clinical trials are necessary to determine tolerated doses, its toxicity, its safety, its efficacy, or its efficacy as compared with standard means of treatment or diagnosis; or

- The mortality rate of the treatment; the cure rate and the survival rate for patients using the treatment for the particular injury, sickness or condition as compared with rates for similarly situated patients using no treatment or using existing treatments which are generally accepted by the Food and Drug Administration, and; the number of patients who have received the treatment for the same injury, sickness or condition.

Final determination of whether the use of a treatment is Experimental or Investigative shall rest solely with the Trustees.

4. While complications related to an excluded transplant are covered, services, which would not be performed but for the transplant are not covered.

5. Rest, respite and custodial care. This applies to all types of institutional care and to services provided in the home, medical equipment and drugs.

6. Services associated with non-covered services, including, but not limited to, diagnostic tests, monitoring, laboratory services, drugs and supplies.

7. Services provided which are outside the scope of practice or license of the individual or facility providing the service.

8. Cosmetic surgery to repair or reshape a body structure primarily for the improvement of the Plan Participant's appearance or self-esteem, including, but not limited to, augmentation procedures, reduction procedures and scar revision. This exclusion does not apply to services for port-wine stain removal and reconstructive surgery.

9. All services for the purpose of weight reduction, including, but not limited to, surgery hospitalization, weight loss programs and drugs.

10. Dental treatment, procedures or services not listed in this Plan.

11. Vocational rehabilitation and recreational or educational therapy.

12. Health services required by third parties, including for insurance, licensure and employment purposes.

13. Reversal of sterilization, assisted reproduction, including, but not limited to gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), and in-vitro fertilization and

treatment of infertility after reversal of sterilization, and all charges associated with such procedures; artificial insemination when not medically necessary for the treatment of a Plan Participant's medically diagnosed infertility; surrogate pregnancy and related obstetric/maternity benefits; sperm acquisition and sperm storage.

14. Non-rehabilitative chiropractic therapy.

15. Podiatric services, except as they meet criteria for medically necessary care.

16. Keratotomy and keratorefractive surgeries, eyeglasses, contact lenses and their fitting, measurement and adjustment, and hearing aids and their fitting.

17. Enteral feedings, unless they are the sole source of nutrition used to treat a life-threatening condition, nutritional supplements, over-the-counter electrolyte supplements and infant formula.

18. Growth hormones which are not for treatment of growth hormone deficiency or chronic renal insufficiency.

19. Genetic counseling and genetics studies which are not medically necessary.

20. Services provided by a Plan Participant's family member, or a resident in the Plan Participant's home.

21. Religious counseling; marital/relationship counseling and sex therapy provided in the absence of a significant mental disorder.

22. Private duty nursing services.

23. Nicotine replacement products obtained from an Out of Network provider.

24. Services that are provided to a Plan Participant, who also has other primary insurance coverage for those services and who does not provide the Plan the necessary information to pursue Coordination of Benefits, as required under this Plan.

25. The portion of a billed charge for an otherwise covered service by a provider, which is in excess of the Fair and Reasonable charges.

26. Charges for services (a) for which a charge would not have been made in the absence of insurance or health plan coverage, or (b) which the Plan Participant is not legally obligated to pay, and (c) from providers who waive copayment, deductible and coinsurance payments by the plan participant.

27. Travel and lodging incidental to travel, regardless if it is recommended by a physician.

28. Health club memberships.

29. Orthognathic treatment or procedures and all related services, except for procedures considered reconstructive surgery, or when required to directly treat a medical condition.

30. Expenses incurred as the result of any accidental bodily injury, sickness, disease, mental or nervous disorder which arises out of and in the course of any occupation or employment for wage or profit or which may be payable in whole or in part under any Workers' Compensation Law, Employer's Liability Law, Occupational Diseases Law or similar law. However, the Fund will consider advancing medical expenses payable in whole or in part under Workers' Compensation Law provided that the Eligible Employee signs a subrogation agreement with the Plan.

31. Any loss, expense or charge resulting from an eligible person's participation in a riot or in the commission of a felony or gross misdemeanor, except in the circumstances of a victim of domestic violence or where the participation in the riot or commission of the felony or gross misdemeanor is due to a mental health condition.

32. Any loss, expense or charge incurred while an eligible person is on active duty or in training in the Armed Forces, National Guard or Reserves of any state or country.

33. Any loss, expense or charge (1) for which a Third Party may be liable and (2) for which either (a) a recovery subject to the Plan's subrogation and reimbursement rights has been received (whether before or after the submission of or payment of claims by the Plan) or (b) the Plan deems it likely that recovery will be received. At the discretion of the Trustees, losses, expenses and charges excluded by this paragraph may be paid subject to the Plan's right of subrogation and reimbursement. The term "Third Party" as used in this section includes any individual, insurer, entity, or federal, state or local government agency, who is or may be in any way legally obligated to reimburse, compensate or pay for an individual's loss, damages, injuries or claims relating in any way to the injury, occurrence, condition or circumstance giving rise to the Plan's provision of medical, dental or disability benefits, including but not limited to, insurers providing liability, medical expense, wage loss, uninsured motorist or under insured motorist coverages.

34. Any loss, expense or charge incurred by an individual at a time that the individual owes payment to the Plan because of benefit payments made in reliance upon incorrect, misleading or fraudulent statements or representations by the individual, or where the individual has failed to honor the Plan's right of subrogation and reimbursement or otherwise failed to cooperate with the Plan, all as set forth in this Plan.

35. Any loss, expense or charge incurred as the result of any Injury, occurrence, conditions or circumstance for which the injured individual:

    a. Has the right to recover payment from a Third Party (at the direction of the Trustees, losses, expenses and charges excluded by this paragraph may be paid subject to the Plan's right of subrogation and reimbursement);

    b. Has recovered from a Third Party; or

    c. Has not submitted a claim for such loss, expense or charge prior to resolution of the Third Party claim.

36. Charges for any injury or condition that results from an incident occurring on any property where Lessee or Lessor or Owner of said property is responsible for injury or illness or which is otherwise covered under Homeowner's insurance. However, the Plan will consider the charges only if no insurance or other form of compensation is available to the victim providing the

Eligible Employee and/or Eligible Dependent (the individual responsible for payment of expenses) signs a Subrogation Agreement with the Plan.

37. Expenses incurred for services rendered while the individual is confined in a Hospital operated by the United States Government or an agency of the United States Government, provided, however, that if such charges are made by a Veterans Administration (V.A.) hospital which claims reimbursement for the "reasonable cost" of care furnished by the V.A. For a non-service-related disability, to the extent required by law, and subject to all the requirements of this Plan, such charges shall be considered a covered Expense.

PREFERRED PROVIDER ORGANIZATIONS (PPOs)

The Plan currently uses the following preferred provider organizations (PPOs):

UnitedHealthcare for medical care,
CVS Caremark for prescription drugs,
Delta Dental of Minnesota for dental, and
TEAM for employee assistance benefits.

The Board of Trustees reserves the right to change or discontinue service with preferred provider organizations. The Plan may receive rebates from CVS Caremark, which will be used to reduce the Plan's administrative expenses. You may obtain "in network" prescriptions from any network pharmacy. A complete list of network pharmacies is available through the Wilson-McShane Corporation.

Access on World Wide Web
See www.UnitedHealthcare.com for complete provider information.

DEFINITIONS

CHARGE: For covered services delivered by participating network providers, or UnitedHealthcare network referral providers, is the provider's discounted charge for a given medical/surgical service, procedure or item, which network providers have agreed to accept as payment in full.

For covered services delivered by non-network providers, is the provider's charge for a given medical/surgical service procedure or item, according to the Fair and Reasonable Charge allowed amount.

The Fair and Reasonable Charge is the maximum amount allowed the Plan considers in the calculation of payment of charges incurred for certain covered services. It is consistent with the charge of other providers of a given service or item in the same community, as determined by the Board of Trustees or other applicable schedule designated by the Board of Trustees of the Plan.

A charge is incurred for covered ambulatory medical and surgical services, on the date the service or item is provided. A charge is incurred for covered inpatient services, on the date of admission to a hospital. To be covered, a charge must be incurred on or after your effective date and on or before the termination date. The amount considered as a copayment is based on the provider charges for that service.

COMBINED DAY LIMIT: Your total benefit is combined, for inpatient hospitalization, skilled nursing facility care services and inpatient mental and chemical health services, and limited to 365 days per period of confinement (See Schedule of Benefits). Each day of such services provided under the UnitedHealthcare Benefits (in-network) and Supplemental Benefits (out of network) counts toward this combined day limit, for the same period of confinement.

COPAYMENT: The specified dollar amount, or percentage, of charges incurred for covered services, which the Plan does not pay, but which you must pay, each time you receive certain medical services, procedures or items. The Plan’s payment for those covered services or items begins after your copayment is satisfied. Covered services or items requiring a copayment are specified in this Summary Plan Description. The amount considered as a copayment is based on the provider charges for that service. A copayment is due at the time a service is provided, or when billed by the provider.

CONTRIBUTING EMPLOYER: Any employer who, pursuant to the terms of a collective bargaining agreement or participation agreement agrees to contribute to the Greater Metropolitan Hotel Employers-Employees Health and Welfare Fund for all hours paid to individuals employed by such Contributing Employer.

COVERED EMPLOYEE: Any employee who is covered according to the rules explained under Rules of Eligibility.

DEDUCTIBLE: The specified dollar amount of charges incurred for covered services, which the plan does not pay, but you must pay first in a calendar year. The Plan's payment for those services or items begins after the deductible is satisfied.

DEDUCTIBLE CARRYOVER: Charges incurred in the last three months of a calendar year, which are applied to any deductible for that calendar year, are carried over and applied towards any deductible for the following calendar year.

DEPENDENT CHILD: Means the employee's dependent children from birth to the end of the month in which they attain age 26.

A Dependent Child includes a son, daughter, stepson, stepdaughter or an eligible foster child.

An alternate recipient under a Qualified Medical Child Support Order is considered an eligible Dependent Child. A Qualified Medical Child Support Order (QMCSO) is a judgment, decree, or order (including approval of a settlement agreement) issued by a court of law or state administrative agency empowered to issue such document, that either (a) provides for child support with respect to a child of a participant under the Plan or provides for health benefit coverage to such a child made pursuant to state domestic relations law, and relates to benefits under the Plan, or (b) is made pursuant to a law relating to medical child support with respect to the Plan (described in § 1396g of Title 42 of U.S. Code). The Plan has adopted specific procedures regarding the determination of the status of an order as a QMCSO. Those procedures are available free of charge upon written request to the Plan Administrator.

Coverage of a Dependent Child who is not able to support themselves because of mental retardation or physical disability will not end upon their 26th birthday. Coverage will continue so long as they remain in such condition. The child must have become disabled prior to attaining the specified limiting age. Also the child must be dependent upon the

employee for support, and proof of the child's disabling condition must be given to the Plan within 31 days of attaining the age 26. A dependent child who loses eligibility for coverage under this provision because they become dependent upon someone other than the employee for their support may once again be covered under the Plan as an Eligible Dependent Child of the employee if: (1) the Eligible Dependent was first mentally retarded or physically disabled prior to reaching age 26; (2) remains mentally retarded or physically disabled and provides proof thereof; and (3) the Eligible Dependent once again becomes dependent upon the employee for support.

EMERGENCY MEDICAL CONDITION - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy;
2. Serious dysfunction of any bodily organ or part; or
3. Serious impairment of bodily functions; or
4. With respect to a pregnant woman who is having contractions:
   a. That there is inadequate time to effect a safe transfer to another hospital before delivery, or
   b. That transfer may pose a threat to the health or safety of the woman or the unborn child.

EXPENSE: The charge incurred for a covered service or supply. A Physician, as described in this Plan, must order or prescribe the service or supply. An Expense is considered incurred on the date the service or supply is received. An Expense does not include any charge for a service or supply which:

1. Is not Medically Necessary; or
2. Is in excess of the Fair and Reasonable Charge for such services or supplies.

FAIR AND REASONABLE CHARGE: The Fair and Reasonable fee or charge for the services rendered and the supplies furnished in the area where such services are rendered, or supplies are furnished, provided such services and supplies are recommended and approved by a legally qualified Physician.

FUND/PLAN: The Greater Metropolitan Hotel Employers-Employees Health and Welfare Fund.

HOME HEALTH CARE AGENCY & HOME HEALTH CARE PLAN: (Refer to Page. 42)

HOSPITAL: An institution approved or licensed by an authorized state agency and lawfully operated in the jurisdiction in which it is located **and** is included in one of the following descriptions:

1. An institution for the care and treatment of sick and injured persons, with organized facilities for diagnosis and surgery and having twenty-four hour nursing service;
2. A community mental health center or mental health clinic; or
3. A residential primary treatment facility, for treatment of alcoholism, chemical dependency or drug addiction.

However, this does not include institutions operated primarily as rest homes, homes for the aged, or institutions which are primarily custodial in nature. The term **Hospital** as used by this Plan also includes a free standing ambulatory surgical center or facilities offering ambulatory medical service twenty-four (24) hours a day, seven (7) days a week, which are not part of a **Hospital**, but which have been reviewed and approved by an authorized state agency to provide health care treatments or services.

INJURY: Any damage resulting from trauma from an external source. **Note:** This Plan does not cover injuries that are employment-related.

MEDICALLY NECESSARY: This is health care services that are appropriate in terms of type, frequency, level, setting and duration to your diagnosis or condition, diagnostic testing and preventive services. Medically Necessary care, as determined by the Plan, must be:

1. Appropriate for the symptoms, diagnosis or treatment of your medical condition;
2. Consistent with evidence-based standards of medical practice where applicable;
3. Not primarily for your convenience or that of your family, your physician, or any other person; and
4. The most appropriate and cost-effective level of medical services or supplies that can be safely provided. When applied to inpatient care, it further means that the medical symptoms or conditions require that the medical services or supplies cannot be safely provided in a lower level of care setting.

The fact that a physician, participating provider, or any other provider, has prescribed, ordered, recommended or approved a treatment, service or supply, or has informed you of its availability, does not in itself make it Medically Necessary.

The Plan has retained UnitedHealthcare as the medical network provider for the Plan. Unless otherwise stated in the Plan, in determining whether a treatment or service is Medically Necessary, the Board of Trustees will rely upon UnitedHealthcare to make such determinations consistent with UnitedHealthcare's medical policies and such medical policies are incorporated into the Plan by reference.

MEMBER: An eligible participant of the Fund.

OUT-OF-POCKET EXPENSES: You pay the specified copayments and deductibles applicable for particular services, subject to the out-of-pocket limit described below.

OUT-OF-POCKET LIMIT: You pay the copayments and deductibles for covered services, to the individual out-of-pocket limit. Thereafter, the Plan cover 100% of charges incurred for all other covered services, for the rest of the calendar year. You pay amounts greater than the out-of-pocket limit if any benefit maximums or the annual maximum amounts are exceeded. Contact the Plan for assistance in determining the amount paid for specific eligible services received.

Benefits	UnitedHealthcare Benefits (In Network)	Supplemental (Out of Network)
INDIVIDUAL CALENDAR YEAR DEDUCTIBLE	None	$200
INDIVIDUAL CALENDAR YEAR OUT-OF-POCKET LIMIT	$1,200	$1,200

The Out-of-Pocket Limits under the UnitedHealthcare Benefits and the Supplemental Benefits are combined.

PHYSICIAN: Any individual who is licensed to practice medicine by the governmental authority having jurisdiction over such licensure, and who is acting within the usual scope of his practice. However, for purposes of coverage under the Plan, **Physician** is interpreted to include a licensed psychiatrist, consulting psychologist, psychologist, chiropractor, osteopath, podiatrist, optometrist, and doctor of dental surgery provided such individual is licensed and acting within the usual scope of his practice.

PLAN: The document adopted by the Trustees which describes the benefits to be provided for Covered employees, eligibility requirements, termination rules and the rules and regulations pertaining to **Plan** administration. The **Plan** is not in lieu of and does not affect any requirements for coverage by Workers' Compensation Insurance.

QUALIFYING PERIOD: After initial qualification, an Employees qualifying periods are those three (3) month periods following your initial qualification for benefits.

SICKNESS: An illness or disease, as diagnosed by a Physician. Sickness also includes pregnancy. **Note:** This Plan does not cover sicknesses that are employment-related.

SKILLED NURSING CARE CONFINEMENT: The Plan covers the following skilled nursing facility services described below, for post acute treatment and rehabilitative care of illness or injury, following a hospital confinement. Rehabilitation services are limited to services where significant measurable progress is expected to occur within a reasonable time. Skilled nursing facility services include room and board, daily skilled nursing and related ancillary services. Respite, non-rehabilitative or custodial care is not covered.

SKILLED NURSING CARE FACILITY: This a licensed skill nursing facility, lawfully performing medical services in accordance with governmental licensing privileges and limitations, and which is recognized as an appropriate facility by the Plan, to render inpatient

post acute hospital and rehabilitative care and services to Plan Participants, whose conditions requires skilled nursing facility care. It does not include facilities, which provide minimal care, non-rehabilitative, or custodial care, ambulatory or part-time care, or which primarily provide treatment of mental or chemical health, or tuberculosis.

TOTAL DISABILITY: The inability of the Covered Employee to engage in or perform the duties of his/her regular occupation or employment.

TRUSTEES/BOARD OF TRUSTEES: The Board of Trustees of the Greater Metropolitan Hotel Employers-Employees Health and Welfare Fund.

UNION: UNITE HERE Local No. #17, its predecessors and successors.

RULES OF ELIGIBILITY

Employees, who are covered by a Collective Bargaining Agreement between the Union and a Contributing Employer and on whose behalf have had sufficient contributions paid by Contributing Employers, are eligible for the benefits described in this booklet.

HOW ELIGIBILITY IS DETERMINED

Eligibility is attained by completing the prescribed number of hours as identified in the Qualifying Schedule below.

QUALIFYING SCHEDULE

All employees whose employment is the subject of a Collective Bargaining Agreement by and between the Employers and the Union and who work 255 hours or more in a three month or less time period are eligible.

INITIAL ELIGIBILITY

The effective date of your coverage is on the first day of the second month following the end of the prescribed time period for which 255 hours of contributions have been paid into the Fund. You will not be eligible for benefits during the first month following the period for which contributions were made for the required hours. This is called the lag month. You must be Actively at Work for any coverage to become effective. You must be Actively at Work for any coverage to be effective. Absences due to sick leave or any health condition will be considered Actively at Work.

DEPENDENT CHILD COVERAGE

Eligible Employees may enroll their Dependent Children when first eligible for coverage under the Plan. Thereafter, should the Eligible Employee not enroll their Dependent Child(ren) when the Eligible Employee is first eligible for coverage under the Plan, the Eligible Employee may only thereafter enroll their Dependent Children should they be legally entitled to do so under the HIPAA Special Enrollment requirements. The cost for Dependent child coverage will be the responsibility of the Eligible Employee.

When you add a Dependent Child to coverage under the Plan, in addition to a completed enrollment form, you will need to provide the Plan Administrator with the following information:

- The birth date, effective date of adoption or placement for adoption, or the date of your marriage (for stepchildren).
- A copy of the birth certificate or adoption papers, court order, or marriage certificate (for stepchildren).

CONTINUED ELIGIBILITY

You will remain eligible for coverage as long as contributions are received on your behalf that total 255 hours per **Qualifying Period.**

If you fail to acquire the prescribed number of hours to continue eligibility, but have worked in covered employment during the **Qualifying Period**, you will be allowed to self-pay for the difference between the hours worked and hours required. You will be allowed to pay a maximum of six (6) monthly self-payments to regain eligibility under the Plan. If you fail to work enough hours after paying the six (6) monthly self-payments, then you will have experienced a COBRA Qualifying Event. Under that scenario, the following section covering **Termination of Eligibility** shall apply.

Self-payment will be allowed only for Covered Employees working or available for work under covered employment.

DISABILITY CREDITS

If, after becoming eligible for coverage, you are unable to work due to an injury or a sickness that is not employment-related and deemed as **Totally Disabled**, then you will be credited with 22 hours for each full week of disability for the purpose of maintaining coverage under the Plan. During partial weeks of disability, you will be credited with daily hours of one-seventh (1/7) of the weekly hours.

Totally Disabled employees are those persons who are drawing **Weekly Accident and Sickness** benefits from this Fund, and who are subject to the same requirements, exclusions, and limitations as described under the **Weekly Accident and Sickness Benefit** section of this document.

TERMINATION OF ELIGIBILITY

Coverage will terminate when you no longer maintain eligibility as described in the Initial Eligibility and Continuing Eligibility sections or when your Contributing Employer no longer contributes to the Fund. If your Contributing Employer stops contributing to the Fund, then your coverage will continue only as long as the contributions are credited.

You may be able to continue coverage under the Fund's special continuation rule for self-pay active employees or COBRA Continuation Coverage, whichever is applicable.

Your eligibility will terminate upon any of the following reasons:

- The Board of Trustees may at its discretion change or eliminate benefits under the Plan or may terminate the Plan or any portion of it.
- Non-payment of contributions to the Plan, or if you fail to pay the self-payment amounts due.
- You leave active employment with your Employer;
- You fail to meet the eligibility requirements during a calendar month and elect not to make a self-payment for that month.

CERTIFICATE OF COVERAGE

You will be provided with certification of coverage upon termination from this Plan.

MILITARY CONTINUATION COVERAGE

You must inform the Plan Administrator in writing as soon as you know that you are entering military service.

- For Dependents Entering into Military Service

  Coverage for a Dependent shall cease on the date that Dependent enters military service.

- For Employees Entering into Military Service

  Employees entering into military service (and their dependents) may elect to have their coverage frozen during military service (see "Freezing Coverage," below) or may elect to continue coverage during that period (see "Military Continuation Coverage," below).

Freezing Coverage

Unless you or your dependents choose to continue coverage as described below, coverage for you (the Employee) and your Dependents will discontinue on the date you enter military service. Your eligibility status will be "frozen" when you enter military service and will be fully restored when you are honorably discharged and return to work with a contributing Employer. Please refer to the subsection entitled "Coverage Following Military Service" for information about the time limits for returning to work.

Military Continuation Coverage

Once the Plan Administrator has been notified that you are entering military service, you and your dependents will be allowed to purchase Military Continuation Coverage. That coverage will be provided as follows:

- The election procedures and coverage options will be the same as those that are available under COBRA Continuation coverage.
- You may elect to freeze your eligibility status as indicated previously. However, if you choose not to freeze your status and wish to continue your coverage while on military leave you have two options: (1) You may use any available Continuation Credits you have available, which once exhausted, could be followed by electing and paying for coverage as provided and available under COBRA Continuation Coverage; or, (2) If you do not have any Continuation Credits available or if you wish to save your Continuation Credits, you may elect to self-pay for Military Continuation Coverage.

  Under either above-noted option, you may continue your coverage for up to twenty-four (24) months.
- If you choose the first option (using Continuation Credits followed by self-pay) your eligibility status will not be frozen. Following discharge, you will need to satisfy the initial eligibility requirements of the Plan before you and your dependents will be covered again or make self-payments until the initial eligibility requirements have been satisfied.

- You must submit payment of the self-pay contribution to the Plan Administrator by the first day of each month. If a payment is not received within thirty (30) days of that due date, coverage will be retroactively terminated to the due date.

Military Continuation Coverage will terminate on the earlier of:

- The first day of the month for which a required and on-time self-payment is not received,
- The end of the available period (18 or 24 months) of self-paid Military Continuation Coverage, or
- The day after the last date on which you are required to apply for or return to a position of employment with a Contributing Employer (see the chart titled "Time limits to return to work", below).

Coverage Following Military Service

If you elect no Military Continuation Coverage, your eligibility status is frozen when you enter military service provided you have notified the Plan Administrator of that service. If you and your dependents were eligible for coverage when you entered active duty, you again will be covered when you are honorably discharged and return to work for a contributing Employer within the time limits provided below. These time limits may be extended if you have suffered a service-connected injury or illness. You should contact the Plan Administrator if that has occurred. You must be honorably discharged to be eligible to have frozen eligibility status restored.

If you do not return to work with the same contributing employer, you should notify your Union Local that you are available for work with a contributing employer. Also, you must submit your discharge papers within 14 days of the date you return to work for a contributing employer.

In the event an employee is inducted into the Armed Forces of the United States, or enlists in Military Service, their eligibility and the eligibility of their Dependents (if any) will cease immediately. Upon their discharge from the Armed Forces, their eligibility will be reinstated on the day they return to work with a contributing employer, provided such return to work is within 90 days from the date of their discharge.

If the employee does not return to work with a contributing employer within 90 days from the date of discharge, they will be considered a new employee and required to comply with the requirements of the Section 9 of this Article.

Time limits to return to work	
If you were in military service	You must
1 to 30 days	Report to your employer (or another contributing Employer) by the beginning of the first regularly scheduled work day more than eight hours after you return home.
31 to 180 days	Submit an application for re-employment to your employer (or another contributing Employer) within 14 days after the completion of your service.
More than 180 days	Submit an application for re-employment to your employer (or another contributing Employer) within 90 days after the completion of your service.

REINSTATEMENT OF ELIGIBILITY

If you were previously covered and terminated, you must again meet the **Initial Eligibility** rules outlined previously under **Rules of Eligibility**.

FAMILY AND MEDICAL LEAVE ACT

The Family and Medical Leave Act of 1993 (FMLA) creates a federal right for Covered Employees who qualify to take up to twelve weeks of unpaid leave if they are seriously ill, after the birth or adoption of a child or to care for their seriously ill spouse, parent or child. You must notify the Fund if you qualify to take a family or medical leave. Your Contributing Employer must give the Fund the necessary information to verify that the leave qualifies under the FMLA. Your Contributing Employer must also certify eligibility and pay the required premium for the extension of coverage.

Covered Employees who are receiving Workers' Compensation Benefits from a Contributing Employer during a **Qualifying Period** may self-pay.

CONTINUING ELIGIBILITY THROUGH SELF-CONTRIBUTIONS (CONTINUATION COVERAGE UNDER COBRA)

If you lose your job or do not work enough hours to maintain eligibility, you can make self-contributions to continue your coverage. Your dependents can also make self-contributions if they are going to lose coverage for certain reasons as explained below.

A federal law, (known as COBRA) gives you and your dependents the right to make self-contributions for continued health care coverage if coverage is lost for certain reasons. This continued coverage is called "COBRA Continuation Coverage." The following is an outline of the rules governing COBRA Continuation Coverage. If you have any questions about this coverage, call the Plan Administrator's office.

Additionally, you can, in lieu of COBRA buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away and you see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan which you are eligible (such as spouse's plan), even if the plan generally does not accept late enrollers, if you request enrollment within 30 days.

COBRA Qualifying Events

1. You are entitled to elect COBRA Continuation Coverage and to make self-contributions for coverage for up to 18 months if coverage terminates due to one of the following events (called "qualifying events"):
   a. A reduction in your hours; or
   b. Your loss of employment (which includes retirement), except for termination of employment due to gross misconduct.
   c. For military leaves occurring on or after December 10, 2004, coverage may last up to 24 months if the reduction of hours is the result of military leave (see "Eligibility During Periods of Military Service" on Page 26 for more details).
2. In addition, your dependents are entitled to elect COBRA Continuation Coverage and to make self-contributions for the coverage for up to 36 months after coverage terminates if their coverage terminates due to one of the following events (called "qualifying events"):
   a. Your divorce or legal separation from your spouse;
   b. A child's failure to meet the Plan's definition of a dependent;
   c. Your death; or
   d. You become enrolled in Medicare (Part A, Part B, or both).

COBRA Notification Responsibilities

1. You, your spouse or your dependent child must notify the Plan Administrator if you get **divorced** or **legally separated** or if a **child loses dependent status** or any **change in address**. The Plan Administrator must be notified within sixty (60) days of the date of any of these qualifying events or within sixty (60) days of the date coverage for the affected person(s) would terminate, whichever date is later. In providing notice, you must provide documentation to the Plan Administrator to support the qualifying event. In case of a divorce, a copy of the divorce decree or similar document evidencing the date of the divorce will be required. In case of a dependent losing dependent status, documentation indicating the date dependent status ended will be required.
2. It is your employer's responsibility to notify the Plan Administrator's office of any other qualifying events that could cause loss of coverage. However, to make sure that you are

sent notification of your election rights as soon as possible, you or a dependent should also notify the Plan Administrator any time any type of qualifying event occurs.

3. You must notify the Plan Administrator within sixty (60) days of the date of a disability determination from the Social Security Administration and within the first 18 months of COBRA coverage in order for you, your spouse or your dependent child, who is or becomes disabled to become eligible for an additional eleven (11) months of coverage (a total of twenty-nine (29) months) which is available to disabled individuals (as explained below). In providing notice, you must provide documentation to support the qualifying event to the Plan Administrator. In the case of a disability extension, you must provide a copy of the Social Security Administration determination of disability status.

COBRA Maximum Coverage Period

Eighteen (18) months is the maximum period of time that you (the Employee), your spouse and dependents can have COBRA Continuation Coverage if the COBRA Continuation Coverage is the result of your termination or reduction in hours of employment. For you, this maximum period can only be extended in a disability situation, as described below. For your spouse and dependents, the maximum period can be extended for up to a maximum of twenty-nine (29) months in a disability situation or to a maximum of thirty-six (36) months if one or more new qualifying events occurs while covered under COBRA Continuation Coverage. "Disabled" means becoming entitled to disability benefits under the Social Security Act.

Thirty-six (36) months is the maximum period of time that your spouse and dependents can have COBRA Continuation Coverage if a qualifying event occurs other than a termination or reduction in hours of employment. Thirty-six (36) months is also the maximum period of time that your spouse and dependents can have COBRA Continuation Coverage even if one or more new qualifying events occur to the person while covered under COBRA Continuation Coverage.

For example, suppose that your death occurs while you are making self-contributions for COBRA Continuation Coverage because of reduced hours. You and your family had been covered under COBRA Continuation Coverage for six (6) months before your death. Since your death is a qualifying event for your dependents, your spouse elects to continue coverage by making self-contributions for himself or herself and your dependent children. Your spouse is entitled to continue coverage for himself/herself and the children for an additional thirty (30) months (the

maximum coverage period of thirty-six (36) months minus the number of self-contributions you had already made (36 – 6 = 30).

Then, after your spouse has continued coverage for fifteen (15) of the remaining thirty (30) months for himself or herself and the children, one of the dependent children who was a student graduates from college and loses dependent status. This is a qualifying event for the child entitling him or her to make self-contributions for COBRA Continuation Coverage for himself or herself. However, the thirty-six (36)-month maximum coverage period is reduced by the twenty-one (21) months of COBRA Continuation Coverage already received (six (6) months from your self-contributions before your death plus fifteen (15) months from your spouse's self-contributions). The graduate is, therefore, entitled to make self-contributions for COBRA Continuation Coverage for up to fifteen (15) months (36 - 21 = 15).

Another example of this extension rule would involve a situation when the qualifying event is the end of your employment, and you became entitled to Medicare benefits less than eighteen (18) months before your employment termination (qualifying event). COBRA Continuation Coverage for qualified beneficiaries other than you, last until thirty-six (36) months after the date of your Medicare entitlement. For example, if you become entitled to Medicare 8 months before you terminate your employment, COBRA Continuation Coverage for your spouse and children can last up to thirty-six (36) months after the date of your Medicare entitlement, which is equal to twenty-eight (28) months after the date of your employment termination (thirty-six (36) months minus 8 months).

If you, your spouse or a dependent are disabled when you elect this coverage, or become disabled within the first sixty (60) days after you elect to continue coverage under COBRA, it may be extended for a period of up to twenty-nine (29) months.

To take advantage of the rules allowing for extended COBRA Coverage, evidence supporting the occurrence of the second qualifying event must be provided to the Plan Administrator to receive the extended COBRA Coverage. As mentioned previously, in case of a divorce, a copy of the divorce decree or similar documentation must be provided; in the case of a dependent losing dependent status, documentation indicating the date dependent status ended; or in the case of a disability determination, a copy of the Social Security disability determination.

COBRA Self-Contribution Procedures and Rules

1. When the Plan Administrator's office is notified of a qualifying event, an Election Notice will be sent to you and/or your dependent(s) who would lose coverage due to the event. The Election Notice tells you about your right to elect COBRA Continuation Coverage, the due dates for payments, the benefit options that can be elected, the amount of the monthly self-contribution for each option, and other important information.
2. An Election Form will be sent along with the Election Notice. This is the form you or a dependent must complete and send back to the Plan Administrator in order to elect COBRA Continuation Coverage.
3. The person electing COBRA Continuation Coverage has sixty (60) days after he or she has been sent the Election Notice or sixty (60) days after the coverage would terminate, whichever is later, to send back the completed Election Form. However, it is strongly recommended that the form be sent back as soon as possible. An election of COBRA Continuation Coverage is considered to be made on the date the Election Form is postmarked.
4. If the Plan Administrator is not notified of the COBRA Continuation Coverage Election within the allowable period, you and/or your dependents will be considered to have waived your right to COBRA Continuation Coverage.
5. A person electing COBRA Continuation Coverage has forty-five (45) days after the signed Election Form is returned to make his or her initial payment. (However, it is strongly recommended that the payment be made as soon as possible so that a number of months won't have to be paid for all at once.) The initial payment must be sufficient to pay all current and past due contributions.
6. COBRA Continuation Coverage self-contributions must be made monthly. After the initial self-contribution, each subsequent monthly self-contribution is due by the first day of the benefit month for which the self-contribution is being made (the "due date"). A self-contribution will be considered on time if it is received by the Plan Administrator within thirty (30) days of the due date.
7. If a self-contribution is not made in the correct amount within the time allowed, COBRA Continuation Coverage for all affected family members will terminate. The self-

contribution may not be made up nor may coverage be reinstated by making future self-contributions.

8. Each member of your family who would lose coverage because of a qualifying event is entitled to make a separate election of COBRA Continuation Coverage.
9. If you elect COBRA Continuation Coverage for yourself and your dependents, your election is binding on your dependents unless they make a separate election.
10. An election on behalf of your minor child can be made by you or another parent or legal guardian.
11. The amount of the monthly self-contributions is determined by the Trustees based on Federal regulations. The contribution amount is subject to change, but usually not more often than once a year unless substantial changes are made in the benefits provided to participants and beneficiaries.

Termination of COBRA Continuation Coverage

COBRA Continuation Coverage for a person will be terminated before the end of the maximum coverage period when the first of the following events occurs:

1. A correct and on-time self-contribution is not made to the Plan;
2. The Plan no longer provides group health coverage to any employees;
3. After the COBRA election, the person first becomes covered under another group health insurance plan with no pre-existing condition limitation or a limitation provision that does not apply to the person or which the person in question satisfies; or
4. After the COBRA Election, the person becomes covered by Medicare.

MEDICAL EXAMINATION REQUIREMENTS

No medical examination is required of you in order to become covered under the Plan. You have the sole right to select your own Physician or Hospital.

DEPENDENT CARE REIMBURSEMENT

For eligible employees who do not enroll their Dependent Children in coverage under the Fund, the Fund will reimburse an eligible employee up to Two-Hundred Twenty-Five Dollars ($225.00) per month for the cost of obtaining dependent medical care insurance (does not include such items as dental, vision, life insurance or other ancillary health related benefits). Proof of payment, along with a claim form must be submitted to the Fund for each reimbursement.

DEPENDENT: Any of the following persons are eligible as a Dependent under the Dependent Care Reimbursement Benefit:

1. Your spouse from whom you are not divorced or legally separated;
2. Each unmarried child who has not yet reached age 19 (or age 23, if the child is a full-time student), is dependent on you for more than one-half of the child's support during the calendar year and maintains a principal place of residence with the Employee during the calendar year, including:
    a. A natural child, a lawfully adopted child, or a child placed for adoption (unless placement is disrupted prior to legal adoption and the child is removed from placement). Health evidence for the adopted child is not required.
    b. Any of the following who live with you in a regular parent-child relationship:
        i. A stepchild only for the duration of your marriage with the stepchild's parent,
        ii. Each unmarried child over age 19 attending an accredited school or college as a full-time student until the child reaches age 23. Students who are living away at school are considered to maintain a residence with you if they use your residence as their permanent residence for mail purposes and reside with you during non-school time. Documentation of school attendance, such as a fee-statement, must be submitted to verify that a Dependent is a full-time student.
    c. If a dependent child is unable to carry 100% of the full-time course load due to illness injury or physical or mental disability documented by a physician, then your dependent child will remain eligible if the dependent child carries at least 60% of the full-time course load.
    d. A full-time student dependent who experiences a catastrophic illness, which requires the full-time student dependent to take a medical leave of absence based upon a physician's written statement, is allowed extended eligibility for up to twelve (12) months or until the coverage would otherwise terminated pursuant to the Plan's terms and conditions, whichever occurs first. Full-time student status is determined by the educational institution.

3. Domestic Partner Any person who has a currently registered domestic partnership with a governmental body pursuant to state, local, or other law authorizing the registration; provided the persons sharing a domestic partner relationship are two (2) adults who:

   a. Are not related by blood closer than permitted under the marriage laws of the State of Minnesota;
   b. Are not married or related by marriage;
   c. Are competent to enter into a contract;
   d. Have no other domestic partner with whom the household is shared, or with whom the adult person has another domestic partner;
   e. Are jointly responsible for the necessities of life; and
   f. Are committed to one another to the same extent as married persons are to each other, except for the traditional marital status and solemnities.

DENTAL BENEFIT

SUMMARY OF DENTAL BENEFITS

After you have satisfied the deductible, if any, the Fund pays the following percentages of the treatment cost, up to a maximum fee per procedure. The maximum fee allowed by Delta is different for DeltaPreferred Option dentists, participating dentists and nonparticipating dentists. If you see a nonparticipating dentist, your out-of-pocket expenses may increase. If a DeltaPreferred Option dentist provides dental services, the payment percentages may increase, resulting in lower out-of-pocket costs.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT PARTICIPATION STATUS WITH DELTA AND DELTAPREFERRED OPTION PRIOR TO RECEIVING DENTAL CARE.

Schedule of Dental Benefits

	Delta Premier	Delta Preferred Option
COVERAGE A- Diagnostic and Preventive Service	100%	100%
COVERAGE B1a- Basic Services	80%	100%
COVERAGE B1b- Endodontics	80%	80%
COVERAGE B1c- Periodontics	80%	80%
COVERAGE B1d- Oral Surgery	80%	80%
COVERAGE B2- Major Restorative Services	50%	60%
COVERAGE C1- Prosthetic Repairs and Adjustments	50%	50%
COVERAGE C2- Prosthetics	50%	50%

Benefit Maximums:

The Fund pays up to a maximum of $2,000.00 for you per Coverage Year for Coverages A, B1, B2, C1 and C2.

Deductible:

There is a $50.00 deductible for you each Coverage Year for Coverages B1, B2, C1, and C2. The deductible does not apply to Coverage A.

The Fund does not cover the dental insurance for your dependents age 19 and older. The Plan does provide dental coverage for Dependents under age 19 if enrolled by the Covered Employee.

The amount of benefits payable is subject to all exclusions, limitations and eligibility requirements as defined in this Summary Plan Description and the Network Agreement between Delta and the Plan.

Description of Covered Procedures:

The Fund covers the following dental procedures when they are performed by a licensed dentist and when necessary and customary as determined by the standards of generally accepted dental practice. The Plan's benefits shall be provided whether the dental procedures are performed by a duly licensed physician or a duly licensed dentist, if otherwise covered under the Fund, provided that such dental procedures can be lawfully performed within the scope of a duly licensed dentist.

As a condition precedent to the approval of claim payments, the Plan shall be entitled to request and receive, to such extent as may be lawful, from any attending or examining dentist, or from hospitals in which a dentist's care is provided, such information and records relating to you as may be required to pay claims. Also, the Plan may require that you be examined by a dental consultant retained by the Plan in or near your place of residence. The Plan shall hold such information and records confidential and in compliance with all federal and state laws.

COVERAGE A Diagnostic & Preventive Services.

Two (2) oral examinations (including emergency exams and specialist exams), including bitewing, x-rays every twelve (12) months. Full mouth x-rays or panorex once in any three (3) year interval. Two (2) dental or periodontal prophylaxis (cleaning of the teeth) as prescribed by a dentist every twelve (12) months. Oral hygiene instruction as prescribed by a dentist, but not more than once per lifetime for you.

COVERAGE B1a Basic Services.

Emergency treatment for relief of pain (minor procedures). Restoration of lost tooth structure as a result of tooth decay or fracture, when restored with amalgams (silver fillings) or resin (white fillings) restorations on anterior teeth. Intravenous Conscious Sedation and IV Sedation when performed in conjunction with a covered complex surgical service. LIMITATION:

Intravenous conscious sedation and IV sedation will not be covered when performed with non-surgical dental care.

COVERAGE B1b Endodontics.

Includes root canal therapy on permanent teeth. No coverage is provided for retreatment.

COVERAGE B1c Periodontics.

Nonsurgical periodontics: procedures necessary for the treatment of diseases of the gingiva (gums).

LIMITATION: Benefit for the repeat of any nonsurgical periodontal treatment will be provided only after a two (2) year period has elapsed.

Surgical periodontics: the surgical procedures necessary for the treatment of diseases of the gingiva (gums) and bone supporting the teeth.

LIMITATION: Benefit for the repeat of any surgical periodontal treatment will be provided only after a three (3) year period has elapsed.

EXCLUSION: Crown lengthening is not a covered benefit.

COVERAGE B1d Oral Surgery.

Routine oral surgery, provides for tooth removal (including alveolectomy, where indicated), including pre- and post-operative care. All other oral surgery such as alveoloplasty, vestibuloplasty, removal of cysts, tumors, growths, neoplasms, and treatment of compound and simple fractures. Surgical and nonsurgical treatment of temporomandibular joint disorder (TMD) and craniomandibular disorder, subject to the provisions of Coordination of Benefits. IMPORTANT: Refer to Pre-statement of Costs.

COVERAGE B2 Major Restorative Services.

Special restorative procedures to restore lost tooth structure as a result of tooth decay or fracture. Crowns, inlays or onlays when the amount of lost tooth structure does not enable the placement of a filling material. If inlays are placed, benefits shall be limited to the same number of surfaces and allowances for amalgam (silver filling).

LIMITATION: Benefit for the replacement of a crown, inlay or onlay will be provided only after a five (5) year period measured from the date on which the procedure was last benefited.

EXCLUSION: Crown lengthening is not a covered benefit.

Resin (white filling) restorations for posterior teeth.

LIMITATIONS: (a) Posterior teeth shall have a resin restoration maximum of three (3) surfaces; (b) Coverage for replacement of a resin restoration or further restoration by any other procedure, will be provided only after a two (2) year period has elapsed.

COVERAGE C1

Prosthetic Repairs and Adjustments Prosthetics: provides for repairs and adjustments to prosthetic appliances when they are serving as the permanent prosthetic appliance.

COVERAGE C2

Prosthetics: Removable and Fixed Prosthetics: provides bridges, standard partial dentures and full dentures for the replacement of fully extracted permanent teeth. Benefits are limited to the commonly performed method of tooth replacement.

EXCLUSION: Coverage is NOT provided for the replacement of teeth congenitally missing.

IMPORTANT: Refer to Pre-statement of Costs.

Replacement benefits for a given prosthetic appliance for the purpose of replacing an existing appliance will be provided only after five (5) years have elapsed from when last benefited and then only in the event that the existing appliance is not, and cannot be, made satisfactory.

EXCLUSION: Coverage is NOT provided for the replacement of misplaced, lost or stolen dental prosthetic appliances.

Replacement Benefits for Fixed Prosthetics: None of the individual units of the bridge may have been benefited previously as a crown or cast restoration during the last (5) year period. The fabrication of the bridge due to the loss of an existing permanent tooth does not set aside the five-year exclusion on cast restorations. Services which are necessary to make an appliance satisfactory will be provided.

Exclusions and Limitations

Exclusions - Coverage is NOT provided for:

1. Dental services which you would be entitled to receive for a nominal charge or without charge under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if you receive a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits will not be reduced or denied because dental services are rendered to you while

you are eligible for or receiving Medical Assistance pursuant to Minnesota Statute Section 62A.045.

2. Dental procedures performed for purely cosmetic purposes.
3. Charges for dental procedures which were completed prior to the date you became eligible.
4. Services of anesthesiologists.
5. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration.
6. Charges for any dental procedures or health care services not specifically covered under the Group Dental Plan Contract (including any hospital charges or prescription drug charges). New or experimental dental techniques or procedures may be denied until there is, to the satisfaction of the Plan, an established scientific basis for recommendation.
7. Dental procedures performed other than by a licensed dentist and his or her employees or agents.
8. Dental procedures, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: Increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition (wear), realignment of teeth, periodontal splinting and gnathologic recordings.
9. Direct diagnostic, surgical or nonsurgical treatment procedures applied to body joints or muscles; except as provided under orthodontics or oral surgery.
10. Any artificial material implanted into or onto bone or soft tissue including implant procedures and associated fixtures, or surgical removal of implants.
11. Veneers (bonding of coverings to the teeth).
12. Orthodontic treatment procedures, unless specified in this brochure as a covered dental benefit.
13. Consultations and office visits.
14. Temporary procedures.
15. Correction of congenital conditions.
16. Athletic mouth guards.
17. Coverage is not provided for re-treatment or additional treatment necessary to correct or relieve the results of previous treatment.

18. Removable unilateral dentures.

19. Sealants.

20. Crown lengthening.

Limitations

1. Alternative Treatment Plans: in all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of you and the dentist; however, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining your payment responsibility.

2. Reconstructive Surgery: benefits shall be provided for reconstructive surgery when such dental procedure is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, provided, however, that such procedures are dental reconstructive surgical procedures.

PLAN PAYMENTS

Covered Fees

YOU ARE FREE TO GO TO THE DENTIST OF YOUR CHOICE. There may, however, be a difference in the payment amount if your dentist is not a participating dentist of the Plan. This payment difference could result in some financial liability to you beyond the usual indemnity features of the Program. The amount is dependent on the nonparticipating dentist's usual fees in relation to the Table of Allowances determined by the Plan.

Claim Payments

DeltaPreferred Option Dentists: Claim payments are based on the DeltaPreferred Option maximum allowable fee or the actual charge, whichever is less. The payment percentages may be increased as shown in the Summary of Dental Benefits. Claim payments are sent directly to the DeltaPreferred Option dentist. If a claim is submitted for dental services rendered by a DeltaPreferred Option dentist, the "Allowable Charges" are the lesser of:

- The DeltaPreferred Option maximum allowable fees as determined by Delta Dental
- The actual charge

- The amount actually accepted as payment in full by the dentist, irrespective of the amount charged.

Participating Dentists: Claim payments are based on the dentist's usual pre-filed fees, the actual charge, the amount accepted by the dentist as payment in full or Delta's maximum customary fee, whichever is less. Claim payments are sent directly to the participating dentist.

Nonparticipating Dentists: Claim payments are based on the treating dentist's usual fees or the Table of Allowances established solely by Delta Dental, whichever is less. Claim payments are sent directly to the Covered Person.

YOU ARE RESPONSIBLE FOR ALL TREATMENT CHARGES MADE BY THE NONPARTICIPATING DENTIST.

Claim payments for participating and nonparticipating dentists are based on the "Allowable Charges" which are the lesser of:

- The usual, customary and reasonable fees of participating dentists
- The Table of Allowances as determined by Delta as to nonparticipating dentists

or, for DeltaPreferred Option, participating and nonparticipating dentists,

- The fees actually charged to you.
- The fees regularly offered to patients.
- The amount actually accepted as payment in full by the dentist irrespective of the amount charged. Payments are made by the Fund only when the covered dental procedures have been completed.

During your first dental appointment, it is very important to advise your dentist of the following information:

- YOUR GROUP NUMBER
- YOUR SOCIAL SECURITY NUMBER
- YOUR DATE OF BIRTH

LIFE INSURANCE BENEFIT

The **Life Insurance Benefit** is payable to your beneficiary if you die from any cause while you are eligible for benefits under the Plan. The amount of the **Life Insurance Benefit** is $6,000.00, and it is paid in a lump sum after a death certificate or a certified copy of a death certificate is submitted to the Plan. An additional $6,000 benefit is payable if your death was caused by accident. For all death claims, proof of death must be provided within one year after death or the Plan will not be liable for payment of the benefit.

BENEFICIARY

Your beneficiary is any person or persons named on a designated form kept on record with the Fund. You may change your beneficiary at any time by submitting a new beneficiary form to the Fund. You do not need the consent of your current beneficiary to change your beneficiary. A change of beneficiary will become effective when you send the new beneficiary form to the Plan.

If you have not named a beneficiary, or if your beneficiary dies before you do, then payment will be made equally to all of the members of the first of the following groups that applies:

- Surviving spouse, if any; otherwise
- Child and/or children, if any; otherwise
- Parents, if living; otherwise
- Estate.

WEEKLY ACCIDENT AND SICKNESS BENEFIT (LOSS OF TIME)

The **Weekly Accident and Sickness Benefit** is payable if you are **Totally Disabled** due to an Injury or a Sickness that is not employment-related. You must be unable to perform the duties of your occupation and you must not be engaged in any other occupation for wage or profit. In addition, you must have been working for a Contributing Employer at the time that you became disabled.

The amount of the **Weekly Rate** is $250.00 and the **Maximum Number of Weeks Payable** is 13 weeks. The **Weekly Accident and Sickness Benefit** will begin on the first day of a disability due to an Injury and on the eighth day of a disability due to a Sickness. Sickness includes physical illness, including pregnancy, and mental or nervous disorders.

SUCCESSIVE PERIODS OF DISABILITY

Two or more periods of disability are considered one period of disability unless you return to active full-time work for at least two weeks between disability periods. Subsequent disabilities due to entirely unrelated causes are considered separate periods of disability as long as you return to active full-time work for at least one day between disability periods.

During partial weeks of disability, you will be paid at the daily rate of one-seventh (1/7) of the **Weekly Rate**.

EXCLUSIONS AND LIMITATIONS

No benefits are payable under this **Weekly Accident and Sickness Benefit** for any:

- Disability resulting from Sickness or accidental Injury for which you are not under the care of a legally qualified Physician;
- Disability covered by Workers' Compensation or any occupational sickness law; or
- Disability due to an occupational Injury that occurred while working for pay or profit.

NOTE: The Tax Reform Act of 1986 provides that any benefit that you receive as **Weekly Accident and Sickness Benefits** (such as under the provisions of this benefit program) are no longer tax exempt and must be included as part of your annual gross income.

HOME HEALTH CARE BENEFIT

HOME HEALTH SERVICES. The Plan covers skilled nursing services, physical therapy, occupational therapy, speech therapy, respiratory therapy, total parenteral nutrition/intravenous ("TPN/IV") therapy and other therapeutic services, prenatal and postnatal services, child health supervision services, phototherapy services, home health aide services, laboratory services, and other eligible home health services when provided in the Plan Participant's home, if the Plan Participant is homebound (i.e., unable to leave home without considerable effort due to a medical condition. Lack of transportation does not constitute homebound status). Home health services are eligible and covered only when they are:

- Medically necessary; and
- Provided as rehabilitative or terminal care (and not as non-rehabilitative, custodial or respite care); and
- Ordered by a physician, and included in the written home care plan.

For IV therapy and phototherapy related to prenatal and postnatal maternal services, and preterm high-risk pregnancy services, equipment, supplies and drugs for these services, as appropriate, are included in the coverage.

If more than one home health visit occurs in a day, a separate copayment applies to each. For example, if a nurse and a physical therapist visit a Plan Participant in the same day, a separate copayment will be charged for each visit.

Home health services are not provided as a substitute for a primary caregiver in the home or as relief (respite) for a primary caregiver in the home. The Plan will not reimburse family members or residents in the Plan Participant's home for the above services.

A service shall not be considered a skilled nursing service merely because it is performed by, or under the direct supervision of, a licensed nurse. Where a service (such as tracheotomy suctioning or ventilator monitoring) or like services, can be safely and effectively performed by a non-medical person (or self-administered), without the direct supervision of a licensed nurse, the service shall not be regarded as a skilled nursing service, whether or not a skilled nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it a skilled service when a skilled nurse provides it. Only the skilled nursing component of so-called "blended" services (i.e., services which include skilled and non-skilled components) are covered under this Plan.

COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFIT

The **Comprehensive Major Medical Expense Benefit** is payable if you incur covered Expenses as the result of an Injury or Sickness that is covered by this Plan. This Plan will pay the **Comprehensive Major Medical Expense Benefit** as outlined in the **Schedule of Benefits**.

BENEFITS

Benefits are payable at the percentage shown in the **Schedule of Benefits** for Expenses incurred in excess of the deductible amount.

If you incur covered Expenses during any calendar year in excess of the out-of-pocket maximum shown in the **Schedule of Benefits**, benefits are payable at 100% for the remainder of the calendar year.

DEDUCTIBLE AMOUNT

The deductible amount is the amount of covered expenses which you must pay each calendar year before the **Comprehensive Major Medical Expense Benefit** will be paid. The deductible amount consists of the **Calendar Year Deductible Amount** shown in the **Schedule of Benefits**.

COVERED CHARGES

Covered Charges are the Fair and Reasonable Charges incurred for the following Medically Necessary services and supplies recommended by the attending Physician for the treatment of an Injury or Sickness:

1. **Inpatient and Outpatient Hospital Expenses** - including:
   a. Hospital Room and Board, up to the average semi-private room rate charged by the Hospital for In-Network Benefits only (there is no coverage for out-of-network inpatient Hospital Room and Board). If the Hospital has no semi-private accommodations, 90% of the Hospital's minimum daily private room and board rate will be the Covered Charge.

   b. Operating room, medicines, drugs, blood and blood plasma (including administration thereof), anesthetic (including administration when billed as part of Hospital charges), X-ray examinations, radiation treatments, physiotherapy, laboratory tests, surgical dressings and medical supplies.
2. **Surgical Expenses** - Cutting, suturing, correction of a fracture, reduction of dislocation, electrocauterization, tapping (paracentesis), administration of artificial pneumothorax, removal of stone or foreign body by endoscopic means or injection of sclerosing solution, including pre-and post-operative care. The Plan also pays up to 20% of the surgical reimbursement for anesthesia expenses when not billed as part of the Hospital charges.
   a. Multiple Operations - A separate payment is made for each operation performed. However, when two or more surgical procedures are performed through the same abdominal incision, the total benefit will be the amount payable for the operation with the highest allowance. If two or more surgical procedures are performed at the same time through separate incisions, the total benefit for all such operations will not exceed one and one-half (1½) times the amount payable for the operation with the highest allowance.

b. Successive operations - are considered performed during one continuous period of disability unless:

i. They are due to entirely unrelated causes;

ii. You have fully recovered from the Injury or Sickness which made the previous surgery necessary; or

iii. You have returned to active employment for at least one full working day between surgeries.

3. Inpatient **Treatment for Alcoholism, Chemical Dependency, Drug Addiction, and Mental or Nervous Disorders** for confinement in a licensed In-Network Hospital or residential primary treatment program for the treatment of alcoholism, chemical dependency, drug addiction or a mental or nervous disorder after diagnosis or upon recommendation of a Physician and such confinement begins while the person is covered, the Plan will pay up to the applicable amounts stated in the **Schedule of Benefits**. There is no out-of-network coverage for this benefit. Physician visits include visits by licensed psychologists and licensed consulting psychologists.

See Employee Assistance Program following this section for a description of services provided by TEAM.

4. **Outpatient Treatment for Alcoholism, Chemical Dependency, Drug Addiction and Mental or Nervous Disorders** - Outpatient treatment for alcoholism, chemical dependency and drug addiction in a non-residential treatment program approved by an authorized state agency.

See Employee Assistance Program following this section for a description of services provided by TEAM.

5. Outpatient treatment for mental or nervous disorders includes consultation, diagnosis and treatment which is provided by any of the following:

a. A licensed psychiatrist, a licensed consulting psychologist or a licensed psychologist practicing under state law;

b. A licensed or accredited Hospital; or

c. A community mental health center or a mental health clinic approved or licensed by the Commissioner of Public Welfare or any other authorized State agency.

6. Benefits for alcoholism, chemical dependency or drug addiction will not exceed the **Lifetime Maximum** amount stated in the **Schedule of Benefits** for all such services or treatments.
7. Medical and surgical expenses for mastectomies as required by the Women's Health and Cancer Rights Act of 1998, including:
   a. Reconstruction of the breast on which the mastectomy has been performed;
   b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
   c. Prostheses and physical complications of all stages of the mastectomy, including lymphedemas.
8. **Maternity Expenses** resulting from a pregnancy are covered immediately for Expenses incurred on or after the effective date of your coverage under the Plan. Under federal law, the Plan may not restrict the hospital stay for childbirth to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section delivery. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours as applicable). The Plan may not require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).
9. **Nursery care** for each newborn dependent child will be covered for Hospital room and board and miscellaneous charges during the period the mother is confined in the Hospital as the result of giving birth. Such benefits will be payable only if the mother was eligible for maternity benefits at the time the child was born. In no event will Hospital room and board and miscellaneous benefits continue after the mother is released from the Hospital.
10. **Diagnostic Laboratory and X-Ray** charges for laboratory tests or X-rays made or recommended by a Physician while not Hospital confined.

    The following services are not covered:
    a. Examinations made for routine check-up purposes;
    b Dental care or treatment;
    c. Eye refractions; or
    d. Therapeutic X-rays.

11. **Deep X-ray or radiation therapy treatment** recommended or approved by a legally qualified Physician or Surgeon and rendered in either the Physician's office or the out-patient department of the Hospital making the charge.

    The following services are not covered:

    a. X-rays;
    b. Rental or purchase of radioactive substances; or
    c. Diagnostic tests.

12. **Skilled Nursing Care Facility** charges for a Skilled Nursing Care Confinement as the result of an Injury or Sickness. Benefits will be payable for the Fair and Reasonable Charges incurred for the period of confinement in a Skilled Nursing Care Facility.

13. **Body Organ Transplants** - Expenses for transplant surgery will be paid under this Plan for the following:

    Transplant Services

    a. **Autologous.** This is when the source of cells is from the individual's own marrow or stem cells.
    b. **Allogeneic.** This is when the source of cells is from a related or unrelated donor's marrow or stem cells.
    c. **Autologous Bone Marrow Transplant.** This is when the bone marrow is harvested from the individual and stored. The patient undergoes treatment, which includes tumor ablation with high-dose chemotherapy and/or radiation. The bone marrow is refused (transplanted).
    d. **Allogeneic Bone Marrow Transplant.** This is when the bone marrow is harvested from the related or unrelated donor and stored. The patient undergoes treatment, which includes tumor ablation with high-dose chemotherapy and/or radiation. The bone marrow is refused (transplanted).
    e. **Autologous/Allogeneic Stem Cell Support.** This is a treatment process that includes stem cell harvest from either bone marrow or peripheral blood, tumor ablation with high-dose chemotherapy and/or radiation, stem cell reinfusion, and supportive care. Autologous/allogeneic bone marrow transplantation and high dose chemotherapy with peripheral stem cell rescue/support are considered to be autologous/allogeneic stem cell support.

f. **Designated Center of Excellence for Transplants.** This is any health care provider, group or association of health care providers designated by us to provide services, supplies or drugs for specified transplants for our members.

g. **Transplant Services.** This is transplantation (including re-transplants) of the human organs or tissue listed below, including all related post-surgical treatment and drugs and multiple transplants for a related cause. Transplant services do not include other organ or tissue transplants or surgical implantation of mechanical devices functioning as a human organ, except surgical implantation of FDA approved Ventricular Assist Devices (VAD), functioning as a temporary bridge to heart transplantation.

What is covered. The Plan covers eligible transplant services (as defined above) while you are a Plan Participant. Transplants that will be considered for coverage are limited to the following:

a. Kidney transplants for end-stage disease.

b. Cornea transplants for end-stage disease.

c. Heart transplants for end-stage disease.

d. Lung transplants or heart/lung transplants for: (1) primary pulmonary hypertension; (2) Eisenmenger's syndrome; (3) end-stage pulmonary fibrosis; (4) alpha 1 antitrypsin disease; (5) cystic fibrosis; and (6) emphysema.

e. Liver transplants for: (1) biliary atresia in children; (2) primary biliary cirrhosis; (3) post-acute viral infection (including hepatitis A, hepatitis B antigen e negative and hepatitis C) causing acute atrophy or post-necrotic cirrhosis; (4) primary sclerosing cholangitis; and (5) alcoholic cirrhosis.

f. Allogenic bone marrow transplants or peripheral stem cell support associated with high dose chemotherapy for: (1) acute myelogenous leukemia; (2) acute lymphocytic leukemia; (3) chronic myelogenous leukemia; (4) severe combined immunodeficiency disease; (5) Wiskott-Aldrich syndrome; and (6) aplastic anemia.

g. Autologous bone marrow transplants or peripheral stem cell support associated with high-dose chemotherapy for: (1) acute leukemias for Plan Participants in second or subsequent remission, except for selective AML patients in first remission; (2) chemotherapy-sensitive, relapsed non-Hodgkin's lymphoma; (3)

Hodgkin's disease; (4) Burkitt's lymphoma for adolescents and young adults; and (5) breast cancer stages II, III and IV.

h. Pancreas transplants for simultaneous pancreas-kidney transplants for type I uncontrolled diabetes.

Charges for transplant services must be incurred at a designated center of excellence for transplants. The transplant-related treatment provided shall be subject to and in accordance with the provisions, limitations and other terms of this Plan.

Medical and hospital expenses of the donor are covered only when the recipient is a Plan Participant and the transplant has been approved for coverage. Treatment of medical complications that may occur to the donor are not covered.

Additionally, the following applies:

i. For a recipient:

- The use of temporary mechanical equipment, pending the acquisition of "matched" human organ(s);
- Multiple transplant(s) during one operative session;
- Replacement(s) or subsequent transplant(s); and
- Follow-up Expenses for covered services (including immuno-suppressant therapy) up to the Follow-up Expense Maximum.

ii. For a donor:

- Testing to identify suitable donor(s);
- The Expense for the acquisition of organ(s) from a donor;
- The Expense of life support of a donor pending the removal of a usable organ(s);
- Transportation for a living donor;
- Transportation of organ(s) or a donor on life support.

iii. Definitions

Transplant Surgery: Transfer of a body organ(s) from the donor to the recipient.

Donor: A person who undergoes a surgical operation for the purpose of donating a body organ(s) for transplant surgery.

Body Organ: Any of the following - kidney, heart, heart/lung, liver, pancreas (when condition not treatable by use of insulin therapy), bone marrow (for leukemia), bone, and cornea.

Recipient: An eligible person who undergoes a surgical operation to receive a body organ transplant.

iv. Benefits will not be paid for:

- Organ transplants unless there is medical documentation that conventional treatment could be unsatisfactory, unavailable and/or more hazardous than a transplant;
- Any animal organ or mechanical equipment, device or organs except as provided under the benefits for a recipient;
- Any financial consideration to the donor other than for a Covered Expense which is incurred in the performance of or in relation to transplant surgery;
- Organ transplants that you may not be legally required to pay for;
- Anything excluded under the General Exclusions and Limitations, and
- Body organ transplant Expenses which are in excess of the Lifetime Maximum Benefit as stated earlier.

14. **Other Expenses** - including:

a. Treatment by a legally qualified Physician.

b. Treatment by a physiotherapist (other than a member of your immediate family).

c. Dental treatment by a Physician, dentist or dental Surgeon for a fractured jaw or for an Injury to natural teeth including replacement of such teeth within twelve (12) months after the date of the accident.

d. X-ray or radium treatment.

e. X-ray and laboratory examinations, excluding dental X-rays unless rendered for dental treatment of a fractured jaw or for an Injury to natural teeth within twelve (12) months after the date of the accident.

f. Professional ambulance service for Medically Necessary transportation to and from a Hospital, except service by railroad, ship, bus, airplane or other common carrier.

g. Human growth hormone injections.

h. The following Medical Supplies:

i. Drugs and medicines legally obtained from a licensed pharmacist only upon prescription of a currently licensed Physician, but specifically excluding those drugs or any other form of medication which may be obtained without such a prescription, even though they may be so prescribed.

ii. Blood and blood plasma;

iii. Artificial limbs and eyes;

iv. Surgical dressings;

v. Casts;

vi. Splints;

vii. Trusses;

viii. Braces;

ix. Crutches;

x. Rental of wheel chairs or Hospital beds; and

xi. Oxygen and the rental of equipment for its administration.

i. Medical injectables to be administered by a medical professional.

EMPLOYEE ASSISTANCE PROGRAM

The Fund has contracted with T.E.A.M. to provide employee assistance services. T.E.A.M. offers real life solutions to a broad spectrum of issues including:

- Stress
- Legal Issues
- Relationships
- Workplace
- Chemical Abuse
- Depression
- Anger Management
- Financial
- Parenting Issues

T.E.A.M. provides Employee Assistance Placement (EAP) assessment and short-term counseling (1-3 sessions). When you contact T.E.A.M. with an issue, they may be able to help you or they will refer you to the appropriate professional in their network. All services with T.E.A.M. are confidential and at no costs to you. All services will be covered by insurance benefits on the same basis as any other medical condition.

Confidential assistance is available 24 hours a day by calling:
651-642-0182 or 1-800-634-7710
www.team-mn.com

Treatment will be limited to services provided by:

- For mental health counseling: LPSS, LPC, LICSW, LMFT, LP, or summarily qualified provider.
- For medication management: MD/DO, CNS/NP.
- For substance abuse treatment: LADC or licensed therapist who can show competence in substance abuse.

The following services are covered under the T.E.A.M. Program with the T.E.A.M. Program

- Behavioral issues;
- Conduct disorder;
- Oppositional defiant disorder;
- Developmental disorders;
- Impulse control disorders;
- V codes;
- Sexual disorders.

COORDINATION OF BENEFITS

The purpose of this Plan is to help you meet the cost of needed medical care or treatment. No Covered Employee should receive benefits greater than actual Expenses incurred. In no event will payment under this Plan exceed the amount which would have been allowed if no other plan were involved. All medical benefits provided under this Plan are subject to these rules.

DEFINITIONS

Plan means any plan providing benefits or services for or reason of medical, dental, or vision care or treatment under:

- Group insurance;
- Group practice, group UnitedHealthcare, individual practice offered on a group basis, or other group prepayment coverage;
- Labor-management trustee plans, or employee benefit organization plans;
- Governmental programs, or coverage required or provided by any statute, including a Special Needs Trust or Supplemental Needs Trust;

- Group arrangements for members of associations of individuals;
- Group or individual automobile No-Fault coverage; and
- The net recovery amount awarded by jury verdict, court order or settlement attributable to the accident injury or illness.

The term **Plan** is construed separately as to each policy, contract, or other arrangement for benefits or services, and separately as to any part of a Plan which may consider benefits or services of other Plans in determining its benefits and any part which does not.

A **Charge** means any necessary, reasonable, and customary item of expense, at least a part of which is covered under one of the Plans covering the person for whom claim is made.

If a Plan provides benefits in the form of services and supplies instead of cash, the reasonable cash value of the service provided and supplies furnished (if otherwise a **Charge**) will be deemed both a **Charge** and a benefit paid.

EFFECT ON BENEFITS

If you are covered by another plan or plans, the benefits under this Plan and the other plans will be coordinated. This means one plan pays its full benefits first, and then the other plan pays.

- The primary plan (the plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this rule.
- The secondary plan (is the plan that pays benefits after the primary plan) will limit the benefits it pays so that the sum of its benefit and all other benefits paid by the primary plan will not exceed the greater of:
    - 100% of total **Charges**; or
    - The amount of benefits it would have paid had it been the primary plan.

When you are eligible under another plan, these are the rules which determine the order in which benefits are paid:

- When the other plan does not have Coordination of Benefits rules (COB rules), then that plan is primary and it must determine benefits first.
- When another plan does have COB rules, the first of the following rules to apply governs:

- If one of the plans covers the claimant as an employee, then that plan will be primary and determines benefits before a plan that covers the claimant as other than an employee.
- Where part of the plan coordinates benefits and a part does not, each part will be treated like a separate plan.

COORDINATION OF BENEFITS UNDER NO-FAULT AUTO LAW

The State of Minnesota statutes enable Health and Welfare Plans to coordinate benefit payments under the No-Fault Auto Law. If you are involved in an accident involving a motor vehicle and medical payments are received from a policy (or self-insured program) for the motor vehicles involved, Plan benefits will be coordinated with such payments. If you fail to purchase No-Fault Auto Insurance, then the Plan will coordinate benefits as if you were covered by No-Fault Auto Insurance. The Plan will not pay benefits until the statutory No-Fault minimum amounts have been paid.

INFORMATION ABOUT MEDICARE

Medicare is a multi-part program:

- **Medicare Part A:** Officially called "Hospital Insurance Benefits for the Aged and Disabled primarily covers hospital benefits, although it also provides other benefits.

- **Medicare Part B:** Officially called "Supplementary Medical Insurance Benefits for the Aged and Disabled" primarily covers Physician's services, although it, too, covers a number of other items and services.

- **Medicare Part C:** Called "MedicareAdvantage" is Medicare's managed care offering. If you are covered by a managed care program, the Plan will presume that you have complied with the program's rules necessary for your expenses to be covered by the program.

- **Medicare Part D:** Called "Medicare Prescription Drug Coverage" is Medicare's prescription drug coverage that is offered through private companies to all Medicare-eligible individuals.

Typically, you become eligible for Medicare when you reach age 65. Under certain circumstances, you may become eligible for Medicare before age 65 if you are a disabled worker or have chronic End-Stage Renal Disease (ESRD). Special rules may apply if you are eligible for Medicare based solely on ESRD. Contact the Fund Office for more information.

COORDINATION OF BENEFITS WITH MEDICARE

When Medicare is the primary coverage (as outlined below), the Plan will not duplicate Medicare Part A and Part B Benefits. Benefits will be reduced by the amount Medicare would have paid even if you had not enrolled for Part A and/or Part B coverage or had filed a claim. Therefore, it is very important that you enroll in Medicare when you retire or become disabled.

This Plan will be primary over Medicare for your claims if you maintain your eligibility under this Plan and if you:

- Medicare will be primary over Are at least age 65, eligible for Medicare because of age and actively employed by an ADEA employer who pays all or part of the required contributions for eligibility;
- Are considered disabled by Social Security but are still considered active by an ADEA employer; or
- Have end stage renal disease (ESRD) but have not completed the required waiting period prior to Medicare becoming primary.

Medicare will be primary over the Plan if you:

- Are over age 65 and not actively employed by an ADEA employer who pays all or part of the required premium;
- Are at least age 65 and retired. (However, if you become entitled to Medicare due to ESRD prior to becoming eligible for Medicare due to age or another disability, this Plan will be primary for the required waiting period.); or
- Are disabled, have completed the 24-month waiting period and are not actively employed by an ADEA employer who pays all or part of the required premium.

The Coordination of Benefits rules outlined in the **Coordination of Benefits** section of this booklet still apply in determining primary coverage for your Dependents.

The following definitions have specific meanings for this section:

Medicare Benefits means benefits for services and supplies which you receive or are entitled to receive under Medicare Part A and B.

Age 65 means the age attained at 12:01 a.m. on the first day of the month in which your 65th birthday occurs.

ADEA Employer means an Employer who:

- Is subject to the U.S. Age Discrimination in Employment Act (ADEA); and
- Has 20 or more employees each working day in 20 or more calendar weeks during the current or preceding calendar year.

GENERAL INFORMATION
FACILITY OF PAYMENT

If payments which should have been made under this Plan as stated in this provision have been made under any other plan or plans, then this Plan may, at its sole discretion, pay any organizations making such other payments the amount which it determines will satisfy the intent of this provision. Amounts so paid are considered benefits paid under this Plan and, to the extent of such payments, the Fund will be fully discharged from liability under this Plan.

NO SURPRISES ACT

Under the No Surprises Act, you will not be subject to surprise or balance billing when you receive the following types of care:

- Emergency care; or
- Treatment by an out-of-network provider at an in-network hospital or ambulatory surgical center.

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 the Plan's UnitedHealthcare network.

"Out-of-network" describes providers and facilities that haven't signed a provider agreement with UnitedHealthcare. Out-of-network providers may be permitted to bill you for the

difference between what the 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.

"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.

<u>You are protected from balance billing for:</u>

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 the 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 the 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 <u>never</u> required to give up your protections from balance billing. You also aren't required to get care out-of-network and the Plan would strongly encourage you to seek care from providers in the UnitedHealthcare Network.

<u>When balance billing isn't allowed, you also have the following protections:</u>

- 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). The Plan will pay out-of-network providers and facilities directly.
- The Plan will:

- 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 the Plan 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 under the Plan.

<u>No Surprises Act Claims – Appeal Rights</u>: Should you have a claim be denied for coverage or payment in the manner described above for emergency services or non-emergency services performed at an in-network facility by an out-of-network provider, you may appeal the matter to the Board of Trustees. Further, should the Board of Trustees deny the appeal the above noted claims are subject to an External Third-Party Review as further provided below.

External Claim Appeals for No Surprises Act Claims Only

If the Board of Trustees denies your claim appeal involving a claim covered by the No Surprises Act, you may elect to have that adverse appeal determination reviewed by an External Third-Party Review.

Standard External Review for Non-Urgent Claim

You may file a request for an external review within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination.

- Within five (5) business days following the date of receipt of the external review request, the Plan Administrator will complete a preliminary review of the request to determine whether:
  - You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
  - The adverse benefit determination or the final adverse benefit determination is not based on the fact that you were not eligible under the Plan;
  - You have exhausted the Plan's internal appeal process (unless exhaustion is not required); and
  - You have provided all the information and forms required to process an external

review.

- Within 1 business day after completion of the preliminary review, the Plan Administrator will notify you in writing regarding whether your claim is eligible for external review. To be eligible for external review, the adverse appeal decision must be based upon a medical judgment, or it must involve a rescission of coverage. If your request was not complete, the notice will describe information or materials needed to complete request. You will have until the end of the 4-month period you had to file a request for an external review or 48 hours (whichever is later) to complete your request. If your request is complete but not eligible for external review, the notice will include the reasons your request was ineligible and contact information for the Employee Benefits Security Administration.
- If the request is complete and eligible for external review, the Plan Administrator will assign an accredited independent review organization (IRO) to conduct the external review.
    - The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan and will notify you in writing of the request's eligibility and acceptance for external review. You may submit additional information in writing to the IRO within 10 business days that the IRO must consider when conducting the external review.
    - The Plan Administrator will provide documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO.
    - The IRO will review all the information and documents timely received and is not bound by the Plan Administrator's prior determination. The IRO may consider the following in reaching a decision:
        - Your medical records;
        - The attending health care professional's recommendation;
        - Reports from appropriate health care professionals and other documents submitted by the Plan Administrator, you, or your treating provider;
        - The terms of the Plan;
        - Evidence-based practice guidelines;

        - Any applicable clinical review criteria developed and used by the Plan Administrator; and
        - The opinion of the IRO's clinical reviewer or reviewers after considering information noted above as appropriate.
    - The IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision.

Expedited External Review

- You may request an expedited external review when you receive:
    - An adverse benefit determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
    - A final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.
- Immediately upon receipt of the request for expedited external review, the Plan Administrator will determine whether the request meets the reviewability requirements noted above for standard external review and will notify you of its eligibility determination.
- When the Plan Administrator determines that your request is eligible for external review an IRO will be assigned. The Plan Administrator will provide all necessary documents and information considered in making the adverse benefit determination or

final internal adverse benefit determination to the IRO by any available expeditious method.

- The IRO must consider the information or documents provided and is not bound by the Plan Administrator's prior determination. The IRO will provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the IRO's notice is not in writing, the IRO must provide written confirmation of the decision within 48 hours to the claimant and the Plan.

SUBROGATION/REIMBURSEMENT

The Plan has a first priority subrogation and reimbursement right if it provides benefits resulting from or related to an injury, occurrence or condition for which the Subrogee has a right of redress against any third-party. For purposes of this Subrogation and Reimbursement section, Subrogee means the participant, employee, dependent, beneficiary, representative (including a trustee in a wrongful death action), an administrator of an estate or any other person asserting a claim related to the injury, claim, action or occurrence under this section.

What does first priority right of subrogation and reimbursement mean? It means that if the Plan pays benefits which are, in any way, compensated by a third-party, such as an insurance company, the Subrogee agrees that when a recovery is made from that third-party, the Plan is fully reimbursed out of that recovery for the benefits the Plan previously paid. If the Subrogee does not agree to the Plan's subrogation and reimbursement rules, benefits will not be paid.

For example, the subrogation and reimbursement right may apply if a Subrogee is injured at work, in an automobile accident, at a home or business, in an assault or in any other way for which a third-party has or may have responsibility. If a recovery is obtained from a third-party, such as an insurance company, the Plan will be paid first and to the full extent of the benefits it paid. The Subrogee receives payment only after the Plan is fully reimbursed.

The rights of subrogation and reimbursement are incorporated into this Plan for the benefit of each Subrogee in recognition of the fact that the value of benefits provided to each employee or dependent will be maintained and enhanced by enforcement of these rights.

Rules for the Plan

The following rules apply to the Plan's right of subrogation and reimbursement:

- Subrogation and Reimbursement Rights in Return for Benefits: In return for the receipt of benefits from the Plan, the Subrogee agrees that the Plan has the subrogation and reimbursement rights as described in this Subrogation and Reimbursement section. Further, the Subrogee and their attorney will sign a Subrogation Agreement with the Plan acknowledging the Plan's subrogation and reimbursement rights prior to payment, or further payment, of benefits. Benefits will not be paid if the Subrogee and/or their attorney refuses to sign the Subrogation Agreement. The Plan's subrogation and reimbursement rights to benefits paid prior to Plan notice of a subrogation and reimbursement right are not impacted if the Subrogee and (if represented) their attorney refuses to sign the Subrogation Agreement. Should the Subrogee and/or their attorney fail to sign the required Subrogation Agreement, the Plan will take any and all action necessary to protect its subrogation and reimbursement rights including denying the payment of benefits, offsetting any future benefits payable under the Plan, recouping any benefits previously paid, suspending and/or terminating coverage under the Plan.
- Plan Granted Constructive Trust or Equitable Lien: The Plan's subrogation and reimbursement rights grant the Plan an equitable lien on the proceeds of any recovery obtained by the Subrogee from a third-party, whether by settlement, judgment or otherwise and in consideration for the payment of benefits, the aforementioned individual(s) agree to the same. When a recovery is obtained, the recovery proceeds are held in trust for the Plan. The Plan then imposes a constructive trust or equitable lien on the recovery proceeds and is paid to the full extent of its equitable subrogation and reimbursement rights. If the Subrogee fails to hold the recovery proceeds in trust or in any other way prejudices or adversely impacts the Plan's subrogation and reimbursement rights, the Plan reserves the right to, among other things, and at the discretion of the Trustees, pursue all available equitable remedies, pursue all available legal remedies, offset any benefits payable under the Plan, recoup any benefits previously paid, suspend all benefits available under the Plan, deny all claims related to the incident in which a recovery was received in addition to non-related claims submitted by the Subrogee, or terminate coverage of the Subrogee or Subrogees.

- <u>Subrogee Constructive Trust and/or Equitable Lien Duties</u>: The Subrogee is required to use his or her best efforts to preserve the Plan's right of subrogation and reimbursement. This will include, but not be limited to, the Subrogee's causing of the Plan's subrogation or reimbursement interest to be paid to the Plan, advising their legal counsel to segregate the Plan's subrogation or reimbursement interest to be held in such legal counsel's trust account until the Plan's interest is agreed to or completely adjudicated, and not allowing any other disbursement from any settlement or judgment proceeds to Subrogee, Subrogee's attorney, or any other third-party, prior to complete disbursement to the Plan. Should Subrogee fail to use their best efforts to preserve the Plan's right of subrogation and reimbursement, including but not limited to, the actions set-forth in paragraph (b) above as well as the entirety of these subrogation provisions and the terms of the Plan as a whole, Subrogee's coverage under the Plan will terminate until such time as the Plan is made whole, including the reimbursement of all interest, attorney's fees and costs reasonably incurred. Only upon the Plan's being made whole may the Subrogee make application to the Board of Trustees of the Plan for reinstatement of their coverage.
- <u>Plan Paid First</u>: Amounts recovered or recoverable by or on the Subrogee's behalf are paid to the Plan first, to the full extent of its subrogation and reimbursement rights, and the remaining balance, if any, to the Subrogee. The Plan's subrogation and reimbursement right comes first even if the Subrogee is not paid for all of their claims for damages. If the Plan's subrogation and reimbursement rights are not fully satisfied directly by a third-party, the Plan's right to reimbursement may be enforced to the full extent of any recovery that the Subrogee may have received or may be entitled to receive from the third-party.
- <u>Right to Take Action</u>: The Plan's right of subrogation and reimbursement is an equitable one and applies to all categories of benefits paid by the Plan. The Plan can bring an action (including in the Subrogee's name) for, breach of contract, specific performance, injunction or any other equitable action necessary to protect its rights in the cause of action, right of recovery or recovery by a Subrogee. The Plan will commence any action it deems appropriate against a Subrogee, an attorney

or any third-party to protect its subrogation and reimbursement rights. The subrogation and reimbursement right applies to claims of eligible dependents covered by the Plan regardless of whether such dependent is legally obligated for expenses of treatment.

- Applies to All Rights of Recovery or Causes of Action: The Plan's subrogation and reimbursement rights apply to any and all rights of recovery or causes of action the Subrogee, regardless of whether such person or entity has the right, legal or otherwise, to recover the medical expenses paid by the Plan, has or may have against any third-party.
- No Assignment: The Subrogee cannot assign any rights or causes of action they may have against a third-party to recover medical expenses without the express written consent of the Plan.
- Full Cooperation: The Subrogee will cooperate fully with the Plan and do nothing to prejudice or adversely affect the Plan's subrogation and reimbursement rights. Benefits will be denied if the Subrogee does not cooperate with the Plan. This includes, but is not limited to, responding to any Plan request for information and updates.
- Notification to the Plan: The Subrogee must promptly advise the Plan Administrator, in writing, of any claim being made against any person or entity to pay the Subrogee for their injuries, sickness, or death. Further, the Subrogee must periodically update the Plan regarding the claim and notify the Plan of a settlement prior to reaching a compromise of their claims. The Subrogee must promptly notify the Plan Administrator, in writing, with the name, address and telephone number of their attorney in the event a claim is pursued.
- Third-Party: Third-party includes, but is not limited to, all individuals, entities, federal, state or local governments, and insurers (including, but not limited to, liability, medical expense, wage loss, workers' compensation, premises liability, no-fault, uninsured or underinsured motorist insurers), who reimburse, compensate or pay for a Subrogee's losses, damages, injuries or claims relating in any way to the injury, occurrence, conditions or circumstances leading to the Plan's payment

of benefits. This right of subrogation and reimbursement exists regardless of whether the policy of insurance is owned by the Subrogee.

- Apportionment, Comparative Fault, Contributory Negligence, Make-Whole and Common-Fund Doctrines Do Not Apply: The Plan's subrogation and reimbursement rights include all portions of the Subrogee's claims regardless of any allocation or apportionment that purports to dispose of any portion of the claims not otherwise subject to subrogation, including, but not limited to, any apportionment for pain and suffering, wage loss, partial or total disability, or to a spouse for loss of consortium. The Plan's subrogation and reimbursement rights are not affected, reduced or eliminated by comparative fault, contributory negligence, the make-whole and common-fund doctrines or any other equitable defenses.
- Attorney's Fees: The Plan will not be responsible for any attorney's fees or costs incurred by the Subrogee in any legal proceeding or claim for recovery, unless prior to incurring such fees or costs, the Trustees agree in writing to pay all or some portion of attorney's fees or costs.
- Course and Scope of Employment: If the Plan has paid benefits for any injury which arises out of and in the course and scope of employment, the Plan's right of subrogation and reimbursement will apply to all awards or settlements received by the Subrogee regardless of how the award or settlement is characterized and regardless of whether the Plan has intervened in the action. If attorney's fees are awarded to the Subrogee's attorney from the Plan's recovery, the Subrogee will reimburse the Plan for the attorney's fees.

UNIFORM PROVISIONS ABOUT FILING A CLAIM (APPLICABLE TO ACCIDENT AND HEALTH COVERAGES)

Written notice of Injury or Sickness upon which claim may be based must be given to the Plan within ninety (90) days of the date the first loss arises or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the Plan, with sufficient information to identify the Covered Employee, will be considered notice to the Plan.

The Plan, upon receipt of notice of a claim, will furnish you any forms necessary for filing a claim. If such forms are not furnished within fifteen (15) days after the Plan receives such notice, you

will be considered to have complied with the requirements of the Plan, within the time fixed for filing claims. Proof of loss includes written documentation of the occurrence, the character and extent of the loss for which claim is made.

Failure to furnish proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

Benefits payable under the Plan for a loss other than continuing loss will be paid upon receipt of due proof. Upon receipt of proof, all claims for continuing loss will be paid each two weeks during any period for which the Plan is liable and any balance remaining unpaid immediately upon receipt of due proof.

If any benefits of the Plan will be payable to a person who is a minor or otherwise not competent to give a valid release, the Plan may pay such indemnity up to an amount not to exceed $5,000.00 to any relative by blood or marriage of the Covered Employee who is considered by the Trustees to be entitled. Any payment made by the Plan in good faith and pursuant to this section will fully discharge the Plan to the extent of such payment.

Weekly Accident and Sickness Benefit: The Plan, through its Physician, has the right and opportunity to examine the Covered Employee, whose Injury or Sickness is the basis of claim. Such examination may be required as often during pendency of the claim as may be reasonable.

No action in law or in equity may be brought to recover from the Plan prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the Plan. No action may be brought at all unless it is within three years from the expiration of the time in which proof of loss is required by the Plan.

PROCEDURE FOR FILING A MEDICAL CLAIM

In the event you go to the Hospital, you should advise the Hospital to contact the Plan at the address indicated on the Identification Card. The Plan will check your record of hours worked and, if applicable, will certify eligibility. The Plan will describe the benefits payable.

This Plan has an automatic assignment of benefits provision for all claims. All such benefits payable will be paid directly to the providers.

When you use the **Plan Benefits**, you should contact the Fund for a claim form. This form is to be completed in full by you and your Physician and must be submitted with the bills for medical

care to the Plan as soon as possible. No claims forms need to be submitted for care received through UnitedHealthcare.

BENEFIT CLAIMS AND APPEALS

This section describes the procedures for filing claims for benefits from the Fund. It also describes the procedure for you to follow if you desire to appeal a claim denial.

How to File a Claim

A "claim for benefits" is your request for the Fund to pay benefits under the Plan. The Fund does not have any "pre-service" claim requirements. Accordingly, if you contact the Fund to inquire whether the Fund will pay a claim that has yet to be incurred, then it is not a claim for benefits. The Fund will use its best efforts to address your inquiry, but you should be aware that the Fund's attempt to address your inquiry is not considered the Fund's decision on a pre-service claim for benefits.

In order to file your claim for benefits, you must submit a completed claim form. You may obtain a claim form from the Fund by calling 952-854-0795 or 1-800-535-6373. If you use the services of a network provider, the provider will file your claims for you. Also, you must contact the Fund about how to file a claim for a Death Benefit.

The following procedures apply in order for the Fund to decide your claim for benefits:

- Obtain a claim form (or a claim may be filed for you by a PPO or other network provider).
- Complete your portion of the claim form.
- Have your Physician complete the Attending Physician's Statement section of the claim form, submit a completed HCFA health insurance claim form, or submit an HIPAA-compliant electronic claims submission.
- Attach all itemized Hospital bills or doctor's statements that describe the services rendered.

To speed the processing of your claim, check the claim form to be certain that all applicable portions of the form are completed, and that you have submitted all itemized bills. Failure to provide all of the necessary information will cause delay in payment of your claim. Please mail all bills or statements for any Medical or Hospital services covered by the Fund to the Fund as soon as you receive them.

When Claims Must Be Filed

Either you or the medical service provider must file your claim for benefits within ninety (90) days following the date you receive the medical services. The Fund recognizes that it may not be possible for you to file the claim immediately after you receive the service. Accordingly, minor delay will not invalidate or reduce your claim, provided that you submit your claim for benefits within twelve (12) months from when you received the medical service. If you file your claim for benefits quickly, then the Fund can quickly make its determination on your claim for benefits.

Where Claims Must Be Filed

Your claim will be considered to have been filed on the date the Fund receives your claim. You should file all claims with the Fund at the following address:

Greater Metropolitan Hotel Employers-Employees Health & Welfare Fund
c/o Wilson-McShane Corporation
3001 Metro Drive #500
Minneapolis, Minnesota 55425

Time of Payment of Claims

The Fund will pay medical claims under the Plan as soon as reasonably possible after it receives your claim. All accrued claims for Weekly Accident and Sickness (loss of time) benefits will be paid at the expiration of each two-week period and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

Facility of Payment of Claims

Accrued claims unpaid at the Employee's death may, at the option of the Board of Trustees, be paid either to the Employee's beneficiary or to the Employee's estate.

If any claim is payable to the estate of the Employee or to a beneficiary who is a minor or otherwise not competent to give a valid release, the Trustees may pay the claim up to an amount not exceeding $5,000.00 to any relative by blood or connection by marriage of the Employee or beneficiary who is deemed by the Trustees to be equitably entitled. Any payment made by the Trustees in good faith according to this provision will fully discharge the Trustees to the extent of the payment.

Any claims for hospital, nursing, medical or surgical service may be at the option of the Board of Trustees, be paid directly to the Hospital or person rendering such services.

Physical Examinations and Autopsy

The Board of Trustees, at its own expense, has the right to examine any individual whose injury or illness is the basis of a claim for benefits. This also applies in situations where it is necessary to make an autopsy where it is not forbidden by law.

Discretionary Authority of Fund Board of Trustees

In carrying out responsibilities under the Fund, the Board of Trustees, other Fund fiduciaries and individuals to whom responsibility for Fund administration has been delegated, have discretionary authority to interpret the terms of the Plan document and this Summary Plan Description, to interpret facts relevant to the benefit claim determination, and to determine eligibility and entitlement to benefits. Any interpretation or determination made under this discretionary authority has full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Authorized Representatives

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself, and you have previously designated the individual to act on your behalf. You can obtain a form from the Fund to designate an authorized representative. The Fund may request additional information to verify that this person is authorized to act on your behalf.

Assignment of Benefits

You do not have the right to anticipate, alienate, sell, transfer, pledge, assign or otherwise encumber any interest in benefits to which you may become entitled under the Fund. The Fund's Board of Trustees may, however, honor your assignment of benefits to the provider of covered services. Neither you nor your beneficiary may transfer or assign any death benefit payments in anticipation of receiving them.

Fund Determination of Your Claim for Benefits

The Fund will notify you of its decision on your medical claim within thirty (30) days after the Fund's receipt of the claim. The Fund may extend this period one time for up to fifteen (15) days if the extension is necessary due to matters beyond the Fund's control. If an extension is necessary, then the Fund is required to notify you before the end of the initial thirty (30) day period of the circumstances requiring the extension of time and the date by which the Fund expects to make its decision.

If an extension is needed because the Fund needs additional information from you, then the extension notice will state the information needed. In that case, you will have forty-five (45) days from receipt of the extension notice to supply the additional information. If you do not provide the information within forty-five (45) days, then the Fund will deny your claim. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either forty-five (45) days or until the date you respond to the request (whichever is earlier). Upon receipt of the additional information, the Fund has fifteen (15) days to make a decision on the Medical Claim and notify you of its decision.

Weekly Accident and Sickness (Loss of Time) Claims

For Weekly Accident and Sickness (loss of time) claims, the Fund will make a decision on the claim and notify you of its decision within forty-five (45) days. If the Fund requires an extension of time due to matters beyond the control of the Fund, the Fund will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the forty-five (45) day period. A decision will be made within thirty (30) days of the time the Fund notifies you of the delay. The period for making a decision may be delayed an additional thirty (30) days, provided the Fund notifies you, prior to the expiration of the first thirty (30) day extension period, of the circumstances requiring the extension and the date as of which the Fund expects to make its decision.

If the Fund needs additional information from you, thus requiring an extension, the Fund's extension notice will specify the information needed. In that case, you will have forty-five (45) days from receipt of the extension notice to supply the requested information. If you do not provide the information within that time, then the Fund will deny your claim. During the period in which you are to supply the requested information, the normal period for the Fund to make a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either forty-five (45) days or the date you respond to the request (whichever is earlier). Once you respond to the Fund's request for additional information, the Fund will notify you of its decision on the claim within thirty (30) days.

Notice of Denial of Claim (Adverse Benefit Determination)

The Fund must provide you with a notice of its initial determination about your claim within the above-referenced timeframes after it receives your claim form. If the Fund denies your

claim for benefits, then the Fund must provide you with a determination notice stating the following information:

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

If your claim for disability benefits is denied, the Plan will provide you with a description of the review process applicable to disability claims and a discussion of the decision including an explanation, if applicable, of the basis for disagreeing with or not following:

1. The views presented by your health care and/or vocational professionals;
2. The views of medical and/or vocational experts whose advice was obtained by the Plan in connection with this adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination; and
3. Your disability determination from the Social Security Administration.

In addition, you will be provided either the specific internal rules, guidelines, protocols, standards, or other similar criteria the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

During the time an appeal of a claim denial for a disability benefits is being considered, the Plan Administrator will provide you, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the Plan, insurer or other person making the benefit determination in connection with the claim and you will be given a reasonable opportunity to respond prior to the date that the Trustees must make a decision on your appealed claim.

Your Right to Appeal the Fund's Denial of Your Claim

You have the right to a full and fair review of your denied claim for benefits on appeal. You must submit a written appeal to the Fund within 180 days after you receive notice of denial. You may submit any document you feel appropriate, and you may submit your written issues and comments as to why you believe the claim denial was incorrect.

Appeal Process

The appeal process works as follows:

You have the right to review documents relevant to your claim. A document, record or other information is relevant if:

- The Fund relied on it in making the denial;
- It was submitted, considered or generated in the course of making the denial (regardless of whether it was relied upon);
- It demonstrates compliance with the Fund's administrative processes for ensuring consistent decision-making; or
- It constitutes a statement of Fund policy regarding the denied treatment or service.

Upon your written request, the Fund will provide you with the identification of medical or vocational experts, if any, who provided advice to the Fund on your claim, regardless of whether the Fund relied on such advice in denying your claim.

A different person (or persons) will review your appeal other than the one who initially denied your claim. The reviewer will not give deference to the initial adverse benefit determination. The decision on appeal will be made on the basis of the record, including such additional documents and comments that you submit to the Fund on appeal.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was investigational or experimental), then the Fund will consult with a health care professional who has appropriate training and experience in a relevant field of medicine.

Timing of Notice of Decision on Appeal

Ordinarily, decisions on appeals involving Medical Claims, Weekly Accident and Sickness (loss of time) or Death Benefit Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your appeal is received within 30 days of the next regularly scheduled meeting, then your appeal will be considered at the following regularly scheduled meeting of the Board of Trustees. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your appeal may be necessary. The Fund will notify you in advance if any extension will be necessary. Once the Fund reaches a decision on your appeal, the Fund will notify you of the decision as soon as possible, but no later than five (5) days after the date when the Fund reaches its decision.

Notice of Decision on Review

The Fund will notify you in writing of its decision on your appeal. If the Fund denies your appeal, then the notice of a denial of a claim on review will state:

- The specific reason(s) for the determination
- Reference to the specific Fund provision(s) on which the determination is based
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If the Fund relied on an internal rule, guideline or protocol, then the Fund will send you at no charge and upon your request either a copy of the rule, guideline or protocol. If the denial was based on Medical Necessity, or because the treatment was experimental or investigational, or other similar exclusion, then the Fund will send you written explanation of the scientific or clinical judgment for the determination applying the terms of the Fund to your claim, or a statement that such information is available upon request at no charge.

If your claim for disability benefits is denied on appeal, the Plan will provide you with the basis for disagreeing with or not following:

- o The views presented by your health care and/or vocational professionals;

- The views of medical and/or vocational experts whose advice was obtained by the Plan in connection with this adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination; and

- Your disability determination from the Social Security Administration.

In addition, you will be provided either the specific internal rules, guidelines, protocols, standards or other similar criteria the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

Legal Actions

You may not start a lawsuit to obtain benefits until after you have appealed the Fund's adverse determination and the Fund has reached a final decision on that particular appeal, or until the appropriate time frame described above has elapsed since you filed an appeal and you have not received a final decision or notice that an extension will be necessary to reach a final decision. Any lawsuit brought upon appeal of the Fund's denial of your claim for benefits is governed by the applicable statute of limitations.

MEDICAL DATA PRIVACY

Introduction

Under the Health Insurance Portability and Accountability Act (HIPAA), the Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to tell you about:

- The Plan’s uses and disclosures of Protected Health Information (“PHI”);
- Your privacy rights with respect to your PHl;
- The Plan’s duties with respect to your PHI;
- Your right to file a complaint with the Plan and the Secretary of the U.S. Department of Health and Human Services; and
- The person or office to contact for further information about the Plan’s privacy practices.

The Plan’s Use and Disclosure of PHI

The Plan will use Protected Health Information (“PHI”) to the extent of and according to the uses and disclosures allowed by the Medical Data Privacy Regulations (“Privacy Regulations”) adopted under HIPAA, including for purposes related to *Health Care Treatment, Payment, and Health Care Operations.*

The Plan will enter into agreements with other entities known as “Business Associates” to perform some of these functions on behalf of the Plan. Each Business Associate will be allowed to use and disclose only the minimum amount of PHI needed to perform the Business Associate’s duties on behalf of the Plan. The Plan’s agreements with its Business Associates will also meet the other requirements of the Privacy Regulations.

Use of PHI for Treatment Purposes

Treatment includes the activities relating to providing, coordinating or managing health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. As a health plan, the Plan is generally not involved in treatment situations but may, from time-to-time, release PHI to assist providers in your treatment.

Use of PHI for Payment and Health Care Operations

Payment includes the Plan's activities to obtain premiums, contributions, self-payment, and other payments to determine or fulfill the Plans responsibility for coverage and providing benefits under the Plan. It also includes the Plan obtaining reimbursement or providing reimbursement for providing health care that has been provided. These activities include but are not limited to the following:

- Determining eligibility or coverage under the Plan;
- Adjudicating claims for benefits (including claim appeals and other benefit payment disputes);
- Subrogation;
- Coordination of Benefits;
- Establishing self-payments by persons covered under the Plan;
- Billing and collection activities;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to covered persons' inquiries about payments;
- Obtaining payment under stop-loss or similar reinsurance;
- Reviewing whether claims are payable under the Plan, including whether they are Medically Necessary, Reasonable and Customary, or otherwise payable;
- Reviewing coverage under the Plan, appropriateness of care, or justification of charges;
- Utilization review, including precertification, preauthorization, concurrent review and retrospective reviews;
- Disclosing to consumer reporting agencies certain information related to collecting contributions or reimbursement (the information that may be released is: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
- Reimbursement to the plan.

Health Care Operations can include any of the following activities. While the Plan does not currently use or release PHI for all of these activities, it may do so in the future to perform health care operations of the Plan:

- Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines as long as general knowledge is not the primary purpose of these studies; population based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;
- Reviewing the competency or qualifications of health care professionals; evaluating provider performance; accreditation, certification, licensing or credentialing activities;
- Underwriting, premium rating and other activities relating to creating, renewing or replacing a health insurance contract (or reinsurance) or health benefits under the Plan;
- Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
- Planning and development, such as conducting cost-management and planning related analyses relating to managing and operating the Plan (including formulary development and administration, development or improvement of methods of payment or coverage policies); and
- Management and general administrative activities of the Plan, including but not limited to:
- Managing activities related to implementing and complying with the Privacy Regulations;
    - Resolving claim appeals and other internal grievances;
    - Merging or consolidating the Plan with another Plan, including related due diligence; and
    - As permitted under the Privacy Regulations, creating de-identified health information or a limited data set.

Other Uses and Disclosures of PHI

The Privacy Regulations permit certain other uses and disclosures of your PHI. These include, for example, releasing PHI to personal representatives of deceased covered persons, releasing PHI for public health activities, releasing PHI for court proceedings, and releasing PHI for law enforcement and similar purposes. If the Plan releases PHI in any of these other permitted situations, it will do so according to the requirements of the Privacy Regulations.

The Privacy Regulations also permit the Plan to release PHI if it receives a valid authorization from you. If the Plan receives a valid authorization, the Plan will disclose PHI to the person or organization you authorize to receive the information. This may include, for example, releasing information to your spouse, to the pension plan, other retirement plans, vacation plan or similar plan for the purposes related to administering those plans.

Release of PHI to the Board of Trustees

The Plan will disclose PHI to the Board of Trustees, which is considered the Plan Sponsor under the Privacy Regulations. The Plan has received a certificate from the Board of Trustees that the plan documents, including this Summary Plan Description, have been amended to incorporate the following provisions.

The Board of Trustees will receive and use PHI only for the Plan administration functions that the Trustees perform for the Plan. In addition, the Trustees will:

- Not use or further disclose PHI other than as permitted or required by the Summary Plan Description or as required by law.
- Ensure that any agents (such as union business agents or the Trustees' staffs), including subcontractors, to whom the Board of Trustees provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Board of Trustees with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by the person who is the subject of the PHI;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the person who is the subject of the information;

- Report to the Plan any PHI use or disclosure that is inconsistent with the allowed uses or disclosures of which it becomes aware;
- Make PHI available to a person who is the subject of the information according to the Privacy Regulation's requirements;
- Make PHI available for amendment and incorporate any amendments to PHI according to the requirements of the Privacy Regulations;
- Make available the PHI required to provide an accounting of disclosures;
- Make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for the purposes of determining the Plan's compliance with the Privacy Regulations; and
- If feasible, return or destroy all PHI received from the Plan that the Trustees maintain in any form, and retain no copies of the PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

Trustee Access to PHI for Plan Administration Functions

As required under the Privacy Regulations, the Plan will give access to PHI only to the following persons:

1. The Board of Trustees (including alternate Trustees). The Plan will release PHI to the Trustees, and the Trustees will be able to use PHI, for purposes of hearing and determining claim appeals; making other determinations concerning claims payments; assisting covered persons with eligibility and benefit issues; Plan benefit design; amending, modifying and terminating the Plan; and Plan management issues.
2. The Trustees' agents, such as union business agents, and the Trustees' staffs, only to the extent reasonable to assist the Trustees in fulfilling their duties consistent with the above uses and disclosures of PHI.

Noncompliance Issues

If the persons described above do not comply with this Summary Plan Description, the Board of Trustees will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Plan's Privacy Officer and Contact Person

As required by the Privacy Regulations, the Plan has named a Privacy Officer to oversee the Plan's compliance with the Privacy Regulations. The Plan has also named a Contact Person to help answer your questions concerning the Privacy Regulations and your PHI. You can also call the Contact Person if you have any complaints concerning the use or disclosure of your PHI. If you have any questions or complaints concerning your PHI, please contact the Plan Administrator and ask to speak with the Plan's Contact Person.

HIPAA SECURITY

Introduction

The Plan has an obligation to maintain the security of your health information. This requirement arises from the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). These regulations work in conjunction with the Medical Data Privacy Regulations ("Privacy Regulations"), which provisions which are outlined above. While the Plan has always taken care to secure your health information, these regulations require the Plan, along with the Plan Administrator, to take some additional steps, in addition to those required by the Privacy Regulations, to maintain the electronic, physical and technical security of your protected health information. The information below outlines the additional steps the Plan has taken to secure your health information in compliance with the HIPAA Security Regulations.

Policies to Protect PHI in Electronic Form

The Plan, in conjunction with the Plan Administrator, has implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of protected health information (PHI) in electronic form (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these regulations) that they create, receive, maintain or transmit on behalf of the Plan. The Trustees will report to the Plan any security incident of which they become aware.

Business Associates

The Plan will enter into agreements with other entities known as "Business Associates" to perform functions as part of the administration of the Plan. The Plan's agreements with its Business Associates will require that the electronic, physical and technical security of your electronic PHI be maintained.

Access to PHI in Electronic Form for Plan Administrative Functions

As indicated in Article XXXI of the Summary Plan Description covering the Privacy Regulations, the Plan will give access to PHI to the Board of Trustees. Any such disclosures of your PHI in electronic form the Trustees are supported by reasonable and appropriate security measures. If

any Trustee fails to comply with these provisions, the Board of Trustees will provide a mechanism for resolving issues of noncompliance.

If You Have Any Questions

The Plan Administrator is largely responsible for maintaining the security of your PHI in electronic from. The Plan Administrator has appointed a Security Officer for purposes of Security Regulations compliance. If you have questions regarding the security of your PHI in electronic form, you may contact the Security Officer through the Plan Administrator.

IMPORTANT INFORMATION ABOUT THE WELFARE PLAN

This supplement contains information required by the Employee Retirement Income Security Act of 1974 (ERISA). This information is provided to help identify this Welfare Plan and the people who are involved in its operation as required under ERISA:

1. The Plan is known as the Greater Metropolitan Hotel Employers-Employees Health and Welfare Fund. This Summary Plan Description serves also as the official Plan Document.
2. A Board of Trustees is responsible for the operation of this Welfare Fund. The Board of Trustees has the responsibility of determining the eligibility rules for participation by Covered Employees in the benefit Plan and for determining the benefits to be offered to Covered Employees. The Board of Trustees is also responsible for seeing that information regarding the Plan is reported to the government agencies and disclosed to Plan participants and beneficiaries in accordance with the requirements of ERISA.
3. The Board of Trustees is both the Plan Sponsor and Administrator of the Health and Welfare Fund. If you wish to contact the Board of Trustees, you may use the address and telephone number below:

Greater Metropolitan Hotel Employers-Employees
Health and Welfare Fund
c/o Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, Minnesota 55425

952-854-0795
800-535-6373

As of February 1, 2024 the Trustees are:

UNION TRUSTEES

Mr. Wade Luneburg
Union Local 17
444 United Labor Centre
312 Central Avenue SE
Minneapolis, MN 55414

Ms. Christa Sarrack
Union Local 17
444 United Labor Centre
312 Central Avenue SE
Minneapolis, MN 55414

Mr. Uriel Perez Espinoza
Union Local 17
444 United Labor Centre
312 Central Avenue SE
Minneapolis, MN 55414

EMPLOYER TRUSTEES

Ms. Lisa Zollars
Graves Hospitality
1934 Hennepin Ave. S., Suite 201
Minneapolis, MN 55403

Mr. Adam Welch
Hilton Minneapolis
1001 Marquette Ave.
Minneapolis, MN 55403

Ms. Elizabeth Sobolik
Loews Minneapolis Hotel
601 1st Avenue North
Minneapolis, MN 55403

4. This Health and Welfare Fund is self-funded.
5. This booklet describes the requirements and eligibility for participation, the types of benefits available and the circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits.
6. The Board of Trustees holds all assets in trust.
7. In accordance with Collective Bargaining Agreements in effect with the Union, the Health and Welfare Fund receives money from Contributing Employers on an hourly basis for each hour paid to all persons covered by the agreement. The terms of the collective bargaining agreement also indicate the effective dates of the Collective Bargaining Agreement and specify the contribution rate required from the Contributing Employer to be paid to the Welfare Fund. Copies of the Collective Bargaining Agreement are available at the Union and the Plan.
8. The Employer Identification Number assigned to the Board of Trustees by the Internal Revenue Service is 41-0737593. The Number assigned to this Plan by the Board of Trustees pursuant to the

instructions of IRS is 501. The Department of Labor Number issued to the Board of Trustees is WP-015851.

9. The Fund's fiscal year for the purpose of maintaining records and filing various governmental records and filing various governmental reports is the annual period October 1 through September 30.

10. The Agent for Service of legal process is:

    Wilson-McShane Corporation
    3001 Metro Drive, Suite 500
    Bloomington, MN 55425

11. The Board of Trustees intends to continue the Welfare Plan indefinitely. The Board of Trustees retains the right to amend the Plan at any time. Any amendment to the Plan will be binding on all Covered Employees covered under the Plan prior to or on or after the effective date of the amendment. The Board of Trustees also retains the right to terminate the Welfare Plan and Welfare Trust Fund if all Contributing Employers are no longer obligated through written agreement to make required contributions. In this event, the monies of the Trust Fund will be applied to all existing benefit obligations in effect on the date of termination of the Welfare Plan and Trust. Termination of the Plan will be binding on all Covered Employees who were covered under the Plan prior to termination.

12. Any balance of the Welfare Trust Fund that cannot be so applied, will be applied to other uses as, in the opinion of the Board of Trustees, will best serve the intentions of the Welfare Plan. Upon the disbursement of the entire Trust, the Trust will then terminate.

STATEMENT OF RIGHTS UNDER ERISA

As a participant in the ***Greater Metropolitan Hotel Employers-Employees Health and Welfare Fund***, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls all documents governing the Plan, including insurance contracts, 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.

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 Descriptions. The administrator may make a reasonable charge for the copies.

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.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who have the responsibility 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, the Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a retirement benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a Health and Welfare Fund benefit is denied or ignored in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the

latest annual report from the Plan and do not receive them within thirty (30) days, then you may file suit in federal court. In such a case, the Court may require the Plan administrator to provide the materials and pay you up to $110.00 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 which is denied or ignored, in whole or in part, you may file suit in either 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, 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 the claim 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, you should contact the nearest area office of the Employee Benefits Security Administration (f/k/a Pension and Welfare Benefits Administration), U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PROCEDURE FOR OBTAINING ADDITIONAL PLAN DOCUMENTS

If you wish to inspect or receive copies of additional documents relating to this Plan, contact the Plan at the address or phone number at the front of this booklet. You will be charged a reasonable fee to cover the cost of any materials you wish to receive.