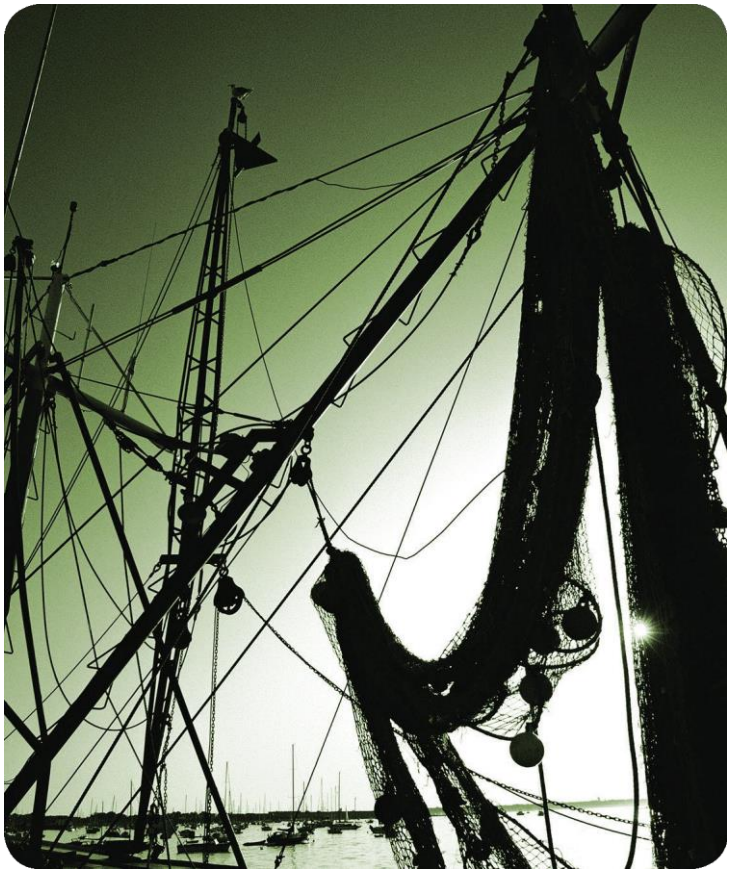

# Rhode Island Laborers' Health & Welfare Fund

## Wrap Plan Document and Summary Plan Description

### Describing benefits for the:

**Construction Plan**

**Non-Construction Plan**

**Twin River Casino Dealers Plan**

**Sodexo Providence Schools Plan**

January 1, 2025

# Rhode Island Laborers' Health & Welfare Fund

410 South Main Street
Providence, RI 02903
Telephone: 401-942-8690

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This Booklet and its Attachments summarize the benefits for participants under The Rhode Island Laborers' Health & Welfare Fund (also referred to as the "Fund"). The Attachments include the Trust Agreement, Benefit Booklets, Summaries of Benefits and Coverage, Collective Bargaining Agreements, and Insurance Contracts, which contain the information on which this Booklet is based. If there is any discrepancy between the information in this Booklet and the information in the Attachments, the Attachment will govern the rights to benefits in all cases. You can access the Benefit Booklets on the Fund's website at https://rilbf.com/en/health/. You can request paper copies of this Booklet and the Attachments from the Fund Office free of charge. In addition, this Booklet and the Attachments are available for inspection or copying at the office of the Fund Administrator.

# Spanish Language Assistance

Si usted no entiende la información en este documento, por favor de ponerse en contacto con personal del departamento de Beneficios en Fund Administrator at 401-942-8690.

# Introduction

The Board of Trustees of the Rhode Island Laborers' Health & Welfare Fund (the "Fund") is pleased to issue this Plan Document and Summary Plan Description (SPD) effective January 1, 2025. As your Board of Trustees, we continually evaluate the benefits we offer and look for opportunities to enhance those benefits while maintaining a financially sound Fund. We want you to depend on us to provide benefits that are easy to use and meet your needs. This Booklet describes benefits for members under the following Plans maintained by the Fund and supersedes prior Plan communications:

- Construction Plan
- Non-Construction Plan
- Twin River Casino Dealers Plan
- Sodexo Providence Schools Plan

Generally, the information provided in this Booklet applies to all four Plans. Therefore, the use of the word "Plan" refers to all four Plans. This Booklet will indicate when a provision applies only to certain Plans.

Benefits provided by the Fund include:

**Fund Benefits**

- Medical
- Prescription Drugs
- Dental
- Vision
- Hearing
- Life Insurance
- Accidental Death & Dismemberment Insurance
- Maternity Continuation Coverage
- Member Assistance Program
- Sick/Safe Leave
- Accident & Sickness (Employees of Catholic Cemeteries only)
- Vacation
- Fit for Duty

This Booklet is a "wrap" document. That means the information found herein wraps around other plan information you receive from other written materials, referred to herein as the Attachments, which are incorporated herein by reference. This Booklet together with the Attachments comprise your entire summary plan description (SPD) as required by the Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA.

The Trustees reserve the right to amend the Plans established under the Fund from time to time and to terminate the Plans. Note that your eligibility or right to benefits under the Fund should not be interpreted as a guarantee of employment. In addition, no participant, dependent, or beneficiary shall have accrued or vested rights to benefits under the Fund.

This Booklet is designed to be easy to use and understand. We encourage you and your family to read the SPD carefully to make the best use of the benefits offered by the Fund. If you have any questions concerning the benefits or your eligibility, please contact the Fund Office at 401-942-8690.

Sincerely,

**The Board of Trustees**

# Table of Contents

# Eligibility

**If you are an employee of the Twin River Casino Dealers or the Sodexo Providence Schools, your eligibility is reported to the Fund by your respective employer. If you have any questions concerning your eligibility, please contact your employer.**

Eligibility requirements for the Construction Plan and the Non-Construction Plan are described below.

Once you meet certain work requirements, you and your eligible family members are covered automatically for health benefits through the Rhode Island Laborers' Health & Welfare Fund. To be eligible, you must work for a contributing employer under the terms of a collective bargaining agreement between local unions affiliated with the RI Laborers' District Council, AFL-CIO, and the Rhode Island Chapter of the Associated General Contractors of America, Inc., or the Construction Industries of Rhode Island.

## Requirements

To become eligible for benefits, you must work at least 800 hours during 12 consecutive months. After that, you must wait one full month before your eligible medical expenses will be covered, as shown in the chart below.

| If You Work at Least 800 Hours in a Twelve-Month Eligibility Period | Plus One Full Month | You're Eligible the Following |
|---|---|---|
| January through December | January | February |
| February through January | February | March |
| March through February | March | April |
| April through March | April | May |
| May through April | May | June |
| June through May | June | July |
| July through June | July | August |
| August through July | August | September |
| September through August | September | October |
| October through September | October | November |
| November through October | November | December |
| December through November | December | January |

## Maintaining Your Coverage

You must continue to work at least 800 hours in a 12-month period to maintain your coverage.

## Eligibility for Dependents

Your eligible dependents are covered for benefits through the Rhode Island Laborers' Health & Welfare Fund. The Plan defines "eligible dependents" as:

- Your legal spouse;
- Your biological child;

- An eligible foster child;
- Your legally adopted child or child placed with you for adoption;
- Your stepchild, who is any child of your current spouse who was born to such spouse, or who was legally adopted by such spouse, prior to your marriage to that spouse;
- Your child who is permanently and totally disabled;
- Your child for whom you have been appointed the legal guardian; and
- Your child who is recognized as an alternate recipient under the terms of a Qualified Medical Child Support Order (QMCSO) approved pursuant to the procedures under the Plan.

**A dependent child:** Your dependent child will be eligible for coverage until the last day of the month in which the child reaches age 26 provided that all other eligibility requirements are met, or beyond age 26 if the child is permanently and totally disabled.

Your dependent child who is permanently and totally disabled: Your dependent child will be eligible for coverage if:

- The child is not married;
- The child is unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that can be expected to result in death or that has lasted, and can be expected to last, for a continuous period of not less than 12 months;
- The child depends on you for more than one-half of his or her financial support during the calendar year, and resides with you for more than one-half of the calendar year;
- You give proof of your child's disability no later than 30 days before your child reaches age 26; and

You give continuing proof of the child's permanent and total disability when later required. Proof may be required at least once a year.

**Your dependent child who is under your legal guardianship or your stepchild:** Your child will be eligible for coverage if:

- The child is not married;
- The child depends on you for more than one-half of his or her financial support during the calendar year and resides with you for more than one-half of the calendar year; and
- You provide proof of your legal guardianship or your relationship to the stepchild.

To confirm financial dependency, the Plan may ask for a copy of your official federal income tax return that shows the dependent listed as a tax dependent. In addition, to confirm residency, the Plan may ask for supporting documentation showing the dependent's address.

## Dependents' Eligibility

If you have coverage for yourself, you may also enroll your eligible dependents in medical, dental, vision, and MAP coverage on the later of the day you become eligible for your own medical coverage or the day you acquire an eligible dependent, either by marriage, birth, adoption or placement for adoption. You may obtain an enrollment form from the Fund Administrator. You will be required to provide proof of dependent status **and** pay any required contribution for coverage of the dependent(s).

**Keep in mind that a dependent may not be enrolled for coverage unless you are also enrolled.**

## Proof of Dependent Status

Specific documentation to substantiate dependent status will be required by the Plan, including a birth certificate, marriage certificate, dependent's Social Security Number, and proof of the dependent's age.

**Note that failure to provide timely proof of dependent status means that claims submitted to the Plan for the dependents will not be able to be considered for payment until such proof is provided.**

- **Marriage**: the certified marriage certificate.
- **Birth**: the certified birth certificate showing biological child of employee.
- **Stepchild**: the certified birth certificate, divorce decree and marriage certificate.
- **Adoption or placement for adoption**: court order paper signed by the judge showing that employee has adopted or intends to adopt the child, birth certificate.
- **Legal Guardianship**: the court-appointed legal guardianship documents and certified birth certificate.
- **Disabled Dependent Child**: Current written statement from the child's physician indicating the child's diagnoses that are the basis for the physician's assessment that the child is currently mentally or physically disabled (as that term disabled is defined in this document) and that disability existed before the attainment of the Plan's age limit and is incapable of self-sustaining employment as a result of that disability; and dependent chiefly relies on you and/or your Spouse for support and maintenance. The plan may require that you show proof of initial and ongoing disability, and that the child meets the Plan's definition of dependent child including proof that the child is claimed as a dependent for federal income tax purposes.
- **Qualified Medical Child Support Order (QMCSO)**: Valid QMCSO document signed by a judge or a National Medical Support Notice.

An employee or retiree must **reimburse the Plan** for any benefits that were paid by the Plan for a dependent at a time **when that dependent did not satisfy the definition of a dependent** or was not otherwise eligible for benefits under this Plan.

### Dependent Social Security Numbers Needed

To comply with federal Medicare coordination of benefit regulations and certain IRS reporting rules, you must promptly furnish to the Plan Administrator, or its designee, the Social Security Number (SSN) of your eligible dependents for whom you have elected, or are electing, Plan coverage, and information on whether you or any of such dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.

If your dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN:
https://www.ssa.gov/number-card/request-number-first-time.
Applying for a social security number is **free**.

Failure to provide the SSN means that claims for your eligible dependent may not be paid.

# Payment for Your Coverage

If your employer requires you to make a contribution for benefit coverage, your employer will notify you and collect any required contributions.

# Coverage During Disability

If you are eligible for benefits and you become temporarily disabled, your coverage under this Plan will be extended for up to one year beyond the date it would normally end (because you fail to meet the hours requirement). This rule applies to occupational disability (for example, Workers' Compensation). You do not have to pay for this coverage.

### Permanent Disability

If you become totally and permanently disabled due to an illness or injury while you're an eligible member before you reach age 65, you will be eligible to continue your coverage under this Plan if you apply for and qualify for Social Security Disability benefits. You do not have to pay for this coverage. You will remain eligible for benefits until you are covered by Medicare or up to a maximum of 24 months, whichever comes first.

# When Coverage Ends

Generally, your coverage under the Fund will end:

- The date you do not meet the requirements for eligibility;
- If you fail to timely make required contributions;
- The date your employer stops participating in the Plan; or
- The date the Plan terminates.

## Continuing Your Coverage Under COBRA

When your coverage under this Plan ends, you may be eligible to continue the healthcare coverage you had under the Fund for a limited time under COBRA. Please refer to the COBRA Continuation Coverage section that follows.

# Special Enrollment Periods

## Dependents Losing Other Coverage

If your Dependent is eligible, but not enrolled, for coverage under the Plan, such Dependent may enroll in the Plan through a mid-year benefit election if each of the following conditions is met:

- The Dependent was covered under other group health coverage at the time coverage under this Plan was previously offered to the Dependent;
- The Dependent's other coverage was under a COBRA continuation provision and that COBRA coverage is exhausted, or the other coverage was maintained by an employer and the other coverage terminated as a result of loss of eligibility or because the Employer stopped contributing toward the other coverage (but not because of a failure to make a required payment or for cause).
- You enroll such Dependent for coverage under this Plan no later than 30 days after the other coverage terminates.

## New Dependents

If you acquire a Dependent through marriage, birth, adoption or placement for adoption, you may enroll the new Dependent and, in the case of birth, adoption or placement for adoption, your Dependent spouse who is not then enrolled within 30 days after the date of the marriage, birth, adoption or placement for adoption.

## Effective Dates

Coverage for Dependents added because of marriage is effective as of the date all of the necessary paperwork to enroll the Dependents is received, provided it is received within the 30 days following the marriage. Coverage for Dependents added because of birth, adoption or placement for adoption is effective retroactive to the date of the birth, adoption, or placement for adoption provided all of the necessary paperwork to enroll the Dependents is received within 30 days following the birth, adoption, or placement for adoption.

## Medicaid/CHIP

The Plan must allow a HIPAA special enrollment for employees and dependents who are eligible but not enrolled if they lose Medicaid or CHIP coverage because they are no longer eligible, or they become eligible for a state's premium assistance program. Employees have 60 days from the date of the Medicaid/CHIP event to request enrollment under the Plan. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

To request special enrollment or obtain more information, contact the Plan Administrator.

# Continuing Your Coverage under COBRA

**Fast Facts:**

- Youand your family members may continue certain medical benefits if your coverageends due to a "Qualifying Event."
- Your children are eligible to continue coverage under COBRA when they no longer satisfy the Fund's definition of eligibledependentbecause of age.
- Tokeep your coverage under COBRA, you must make monthly payments to the Fund Office on time. You are fully responsible for the payment of your benefits through COBRA.

If your coverage under the Rhode Island Laborers' Health & Welfare Fund ends due to a "Qualifying Event" (see below), you and/or your covered dependents may be eligible to continue your health care coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

By making monthly payments, you and/or your dependents may continue the medical, dental, vision and prescription drug coverage that you had before your coverage ended. Your coverage can last for up to 18, 29 or 36 months, depending on the Qualifying Event. You may not continue accident and sickness (loss of time), life insurance or accidental death and dismemberment coverage under COBRA.

## Qualifying Events

To be eligible for COBRA Continuation Coverage, you (as the employee) and/or your dependent(s) must lose coverage due to any one of the following Qualifying Events:

| Qualifying Event | Who May Purchase Continuation Coverage | Maximum Period of Coverage |
|---|---|---|
| Member loses eligibility due to termination or a reduction in hours of employment (including retirement) | Member, spouse, and/or dependent children | 18 months[1] |
| Termination or reduction in hours while you or your dependent is disabled, and entitled to Social Security Disability income benefits | Member, spouse, and/or dependent children | 29 months (18 months plus an additional 11) |
| Member becomes entitled to Medicare and voluntarily drops plan coverage | Spouse and/or dependent children | 36 months |
| Member dies | Spouse and/or dependent children | 36 months (Begins after the Plan's extension under the "if You Die" section below) |
| Member is divorced or legally separated from spouse. | Spouse and/or dependent children | 36 months |
| Child is no longer considered a dependent child by this Fund's definition | Dependent child | 36 months |

If a qualifying event that is termination of employment or reduction in hours occurs less than 18 months after the date you become entitled to Medicare (Part A, Part B or both), the period of coverage for your dependents who are qualified beneficiaries may last until 36 months after the date of your Medicare entitlement.

[1] If you retire at age 62 or older, you, your spouse and dependents may continue COBRA coverage for an additional 6 months.

# Qualified Beneficiaries

Under the law, only "qualified beneficiaries" are entitled to COBRA Continuation Coverage. Qualified beneficiaries are:

- You, as the member,
- Your spouse, and
- Your dependent child.

A child who becomes a dependent child by birth, adoption, or placement for adoption with you during a period of COBRA Continuation Coverage is also a qualified beneficiary. However, a new spouse who becomes your spouse and is covered during the COBRA continuation period is not considered a qualified beneficiary. Refer to the paragraph in this section entitled "Special COBRA Enrollment Rights" for more information.

One or more of your family members may elect COBRA even if you do not. However, in order to elect COBRA Continuation Coverage, the members of the family must have been covered by the Plan on the date of the Qualifying Event. A parent may elect or reject COBRA Continuation Coverage on behalf of dependent children living with him or her.

# How to Elect COBRA Continuation Coverage

**Step 1:** In order to elect COBRA Continuation Coverage, you must notify the Fund Office when you experience a Qualifying Event. You (or your Employer) must notify the Fund Office within 60 days from the date that the Qualifying Event occurs, or the date that you would lose coverage under the Fund because of the Qualifying Event, whichever is later.

In some cases, your Employer will notify the Fund Office. In other cases, you or your dependent must notify the Fund Office, as shown in the chart below.

| Your Employer Should Notify the Fund Office of Your: | You (or your Dependent) Must Notify the Fund Office of: |
|---|---|
| Termination of employment | Divorce |
| Reduction in hours | Legal Separation |
| Retirement | A beneficiary ceasing to be covered under the Plan as your dependent child. |
| Entitlement to Medicare | The occurrence of a second qualifying event after a qualified beneficiary has become entitled to COBRA with a maximum of 18 (or 29) months. This second qualifying event could include an employee's death, entitlement to Medicare, divorce or legal separation or a beneficiary ceasing to be covered under the Plan as your dependent. |

In addition to these qualifying events, there are two other situations when a covered employee or other qualified beneficiary is responsible for providing the Fund Administrator with notice within the timeframe noted in this section:

- When a qualified beneficiary entitled to receive COBRA coverage with a maximum of 18 months has been determined by the Social Security Administration to be disabled. If this determination is made at any time that an individual is disabled during the first 60 days of COBRA coverage, the qualified beneficiary may be eligible for an 11-month extension of the 18 months maximum coverage period, for a total of 29 months of COBRA coverage.
- When the Social Security Administration determines that a qualified beneficiary is no longer disabled.

**You must make sure that the Fund Administrator is notified of any of the six qualifying events or situations listed above. Failure to provide this notice within the form and timeframes described below may prevent you and/or your dependents from obtaining or extending COBRA coverage.**

## How Should a Notice be Provided?

Notice of any of the six qualifying events or situations listed above must be provided in writing. You may send a letter to the Fund containing the following information: your name, address, which of the six qualifying events or situations listed above you are providing notice, and the date of the event.

## To Whom Should the Notice be Sent?

Notice should be sent to Fund Administrator, Rhode Island Laborers' Health & Welfare Fund, 410 South Main Street, Providence, RI 02903. Notice should be sent by first class mail.

## When Should the Notice be Sent?

If you are providing notice due to a divorce or legal separation, a dependent losing eligibility for coverage or a second qualifying event, you must send the notice no later than **60 days after the later** of (1) the date of the relevant qualifying event; or (2) the date upon which coverage would be lost under the Plan as a result of the qualifying event.

If you are providing notice of a Social Security Administration determination that you **are no longer** disabled, Notice must be sent no later than **30 days after** the date of the determination by the Social Security Administration that you are no longer disabled.

These time periods to provide these notices will not begin until you have been informed of the responsibility to provide these notices and these notice procedures through the furnishing of a Summary Plan Description or a general (initial) notice by the Plan.

**Notify the Fund Office:** You or a family member should notify the Fund Administrator as soon as any Qualifying Event occurs to assure your opportunity to elect COBRA.

## Who Can Provide a Notice?

Notice may be provided by the covered employee or other qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the covered employee or other qualified beneficiary. Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event. For example, if an employee, her spouse, and her child are all covered by the Plan, and the child ceases to be a dependent under the Plan, a single notice sent by the spouse would satisfy this requirement.

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

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

**Step 2**: When the Fund Administrator receives notice of the Qualifying Event, he or she will mail you an election form, information about COBRA, and the date on which your coverage will end. Under the law, you and/or your covered dependents have 60 days from the later of the date:

- You would have lost coverage because of the Qualifying Event; or
- You and/or your covered dependents received the election form and COBRA information.

**If you and/or any of your covered dependents do not elect COBRA within 60 days of the Qualifying Event (or, if later, within 60 days after receiving that notice), you and/or your covered dependents will not have any group health coverage from this Fund after your coverage ends.**

Each qualified beneficiary with respect to a particular qualifying event has an independent right to elect COBRA continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. A parent or legal guardian may elect continuation coverage for a minor child.

# Paying for COBRA Continuation Coverage

You are responsible for the entire cost of COBRA Continuation Coverage. When you and/or your dependents become eligible for this coverage, the Fund Administrator will notify you of the COBRA premium amounts that you must pay.

Your COBRA premiums may be as high as 102% of the Plan's cost, except in the case of Social Security disability. (See the section below entitled "COBRA Continuation Coverage for Disabled Participants.")

You must make payments so that your COBRA coverage is continuous. To prevent a lapse in coverage, you must send the first COBRA payment to the Fund Office within 45 days from the date on which you or your dependent received his or her COBRA election form, as determined by postage cancellation. Payments for subsequent months are due on the first day of the month for which coverage is provided. You will have a

30-day grace period to submit payments. If you do not make payment by the end of the grace period, your coverage will be cancelled retroactively to the last day of the previous month, and you will lose all rights to continuation coverage under the Plan.

If you choose COBRA within the election period but after the date your eligibility ended, you must pay the required COBRA premiums retroactively to cover the elapsed period.

### What You Need to Do:

If you lose coverage due to a Qualifying Event:

- Inform the Fund Office of the Qualifying Event and request a COBRA election form.
- Complete and mail back the election form within 60 days of the date you received it, or 60 days of the date the Qualifying Event occurred, whichever is later.

Make your first payment to the Fund Office within 45 days from the date you receive your COBRA election form.

# Cobra Continuation Coverage for Disabled Participants

If you are covered under COBRA for 18 months, and within the first 60 days of coverage you (or your covered dependent) become disabled, you (or your dependent) may be eligible to continue your COBRA coverage for an additional 11 months for a total of 29 months.

To be eligible, the Social Security Administration must make a formal determination that you (or your dependent) are disabled and therefore entitled to Social Security Disability income benefits. You (or your dependent) must notify the Fund Office of the Social Security determination of disability within 60 days from the date you received the determination.

If you are eligible for the 11-month extension, your COBRA premiums may be as high as 150% of the regular premiums for the additional 11 months of coverage.

This extended period of COBRA coverage will end on the earlier of:

- The last day of the month that occurs 30 days after Social Security has determined that you and/or your dependent(s) are no longer disabled;
- The end of the 29 months COBRA Continuation Coverage;
- The date the disabled person becomes entitled to Medicare.

If you recover from your disability before the end of the initial 18 months of COBRA Continuation Coverage, you will not have the right to purchase extended coverage. You must notify the Fund Office within 30 days of:

- The date that you receive a final Social Security determination that you and/or your dependent(s) are no longer disabled; or
- The date that the disabled person becomes entitled to Medicare.

# Multiple Qualifying Events While Covered under COBRA

The maximum period of coverage under COBRA is 36 months, even if you experience another Qualifying Event while you're already covered under COBRA. If you're covered under COBRA for 18 months because of your termination of employment or reduction in hours, your affected spouse or dependent may extend coverage for another 18 months if

- You get divorced or legally separated;
- You become entitled to Medicare;
- You die; or
- Your child is no longer a dependent under the Fund's definition.

For example, Jason stops working (the first COBRA-Qualifying Event) and enrolls himself and his family in COBRA Continuation Coverage for 18 months. Three months after his COBRA Continuation Coverage begins, Jason's child turns 26 and no longer qualifies as a dependent child under the Fund's definition. Jason's child can continue COBRA coverage for an additional 33 months, for a total of 36 months of COBRA Continuation Coverage.

You, as the member, are not entitled to COBRA Continuation Coverage for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional COBRA Continuation Coverage because of a disability). Therefore, if you experience a reduction in hours followed by a termination of employment, the termination of employment is not treated as a second Qualifying Event, and you may not extend your coverage.

## Coverage for your Dependents if You're Enrolled in Medicare

If you are entitled to (already enrolled in) Medicare and you have a termination of employment or reduction in hours, you and your eligible dependents are eligible to enroll in COBRA coverage for a period of 18 months (29 months if the 11-month Social Security Disability extension applies) from the date of your termination of employment. In this case, Medicare is your primary insurance, and COBRA is secondary.

If you initially enroll in Medicare while on COBRA coverage, the Plan will terminate your COBRA coverage. However, your enrolled spouse and dependents may keep COBRA for up to 36 months.

## Special COBRA Enrollment Rights

If you marry, have a newborn child, adopt a child, or have a child placed with you for adoption while you are enrolled in COBRA, you may enroll that spouse or child for coverage for the balance of the period of COBRA Continuation Coverage. You must enroll your new dependent within 31 days of the marriage, birth, adoption, or placement for adoption.

In addition, if you are enrolled for COBRA Continuation Coverage and your spouse or dependent child loses coverage under another group health plan, you may enroll that spouse or child for coverage for the balance of the period of COBRA within 31 days after the termination of the other coverage.

To be eligible for this special enrollment right, your spouse or dependent child must have been eligible for coverage under the terms of the Plan but declined when enrollment was previously offered because they had coverage under another group health plan or had other health insurance coverage.

Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage. To find out about COBRA rates, contact the Fund Office.

If you have any questions or need additional information about COBRA coverage, please contact the Fund Administrator at:

Rhode Island Laborers' Health & Welfare Fund
410 South Main Street
Providence, RI 02903
Telephone: 401-942-8690

## Confirmation of Coverage to Health Care Providers

Under certain circumstances, federal rules require the Fund to inform your physician and health care providers as to whether you have elected and/or paid for COBRA Continuation Coverage. This rule only applies in certain situations where the physician or provider is requesting confirmation of coverage and you are eligible for, but have not yet elected, COBRA coverage, or you have elected COBRA coverage but have not yet paid for it.

# Termination of COBRA Continuation Coverage

COBRA Continuation Coverage will terminate on the last day of the maximum period of coverage unless it is cut short for any of the following reasons:

- You do not make all required payments on time;
- The person receiving the coverage becomes entitled to Medicare;
- The Plan terminates its group health plan and no longer provides group health insurance coverage to its members; **or**
- The Employer that you worked for before the Qualifying Event has stopped contributing to the Plan; **and**
- The Employer establishes one or more group health plans covering a significant number of the Employer's employees formerly covered under this Plan; **or**
- The Employer starts contributing to another multiemployer plan that is a group health plan.

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

# Interaction of COBRA and the Affordable Care Act—Other Options

If you lose group health coverage under the Plan and become eligible for COBRA coverage, you may also become eligible for other coverage options that may cost less than COBRA coverage. For example, you and your family may be eligible to buy an individual plan through the Health Insurance Marketplace (the "exchange"), Medicaid, or other group health plan coverage (such as a spouse's plan) through a 30-day "special enrollment period," even if the other plan generally does not accept late enrollees. If you enroll in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. You can learn more about many of these options and about your rights under the Affordable Care Act at www.healthcare.gov.

# Name, Address and Telephone Number of the Party Responsible for COBRA Administration

Rhode Island Laborers' Health & Welfare Fund
410 South Main Street
Providence, RI 02903
Telephone: 401-942-8690

# Unavailability of Coverage

If you provide notice to the Fund Office of a qualifying event, but are not entitled to COBRA, the Fund Office will send you a written notice stating the reason why you are not eligible for COBRA. This will be provided within the same timeframe that the Fund Office is required to provide an election notice.

## Notice of Termination of COBRA

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

## Keep the Fund Informed of Address Changes

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

## If You Have Questions

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

# Life Events

Your benefits are designed to adapt to your needs at different stages of your life. This section describes how your coverage is affected when you experience certain "life events" and what you must do to make sure you get the most from your coverage.

### Fast Facts

- You should notify the Fund Office as soon as possible if you experience a life event that may affect your coverage.
- You and/or your dependents may qualify to continue coverage under COBRA in the event of a loss of eligibility, divorce, or termination or reduction of your work hours.

The following life events may affect your coverage:

**Life events**

- Moving to a new address
- Getting Married
- Having a baby
- Adopting a child
- Experiencing a medical emergency
- Taking Family Medical Leave
- Entering military service
- Losing eligibility (dependents)
- Terminating employment
- Becoming disabled
- Retiring
- Becoming eligible for Medicare
- Death

## If You Move

If you have a change of address, contact the Fund Office as soon as possible to make sure your records are up to date and to avoid a delay in payment of your claims.

## If You Get Married

If you legally marry, your spouse and any dependent child acquired through marriage are eligible for dependent benefits under the Fund.

If you notify the Fund within 30 days of the date of your marriage, your eligible dependents will be eligible for coverage under the Fund as of the date of your marriage. If you wish to name your spouse as your beneficiary for your life insurance benefit or accidental death and dismemberment benefit, contact the Fund Office for a "Change of Beneficiary" form.

If your newly acquired spouse or child dependent is covered under another group medical plan, you must report this other coverage to the Fund Office. The amount of benefits payable under this Fund will be coordinated with such other coverage. Benefits for your dependents under this Fund will be paid after any benefits are payable from the other plan. For more information, see the "Coordination of Benefits" section.

### What You Need to Do

If you get married, you must provide the Fund Office with the following information within 31 days:

- A copy of your marriage certificate; and
- Your spouse's date of birth.

# If You Have a Baby

Once your child is born, notify the Fund Office within 30 days of delivery in order to have your child covered under the Plan.

### What You Need to Do

If you have a baby, you should provide the Fund Office with the following information:

- The baby's birth date;
- A copy of the baby's birth certificate; and

A copy of your baby's other medical insurance information if he or she is covered under another group insurance plan.

# If You Adopt a Child

If you adopt a child, contact the Fund Office. Your child will be covered as of the effective date of the adoption or placement for adoption as long as you are responsible for health care coverage and your child meets the Fund's definition of a dependent child.

### What You Need to Do

If you need to add a child to your coverage, you should provide the Fund Office with the following information:

- Your child's birth date;
- The effective date of adoption or placement for adoption; and
- A copy of your child's other medical insurance information if he or she is covered under another group insurance program.

# If You Take FMLA Leave

## Federal Family Medical Leave Act

You and your eligible dependents will be covered under this Fund if you are entitled to—and take—leave under the Family Medical Leave Act (FMLA). Under FMLA, you have the right to take up to 12 weeks of unpaid leave for your serious illness, after the birth, adoption, or placement of a child with you for adoption, or to care for your seriously ill spouse, parent, or child without losing your coverage. In addition, you may take up to 12 weeks of FMLA leave for any "qualifying exigency" arising out of the fact that a covered military member is on active duty or has been notified of an impending call or order to active duty, in support of a contingency operation. You may also take up to 26 weeks of FMLA leave to care for a covered service member with a serious injury or illness.

When it is medically necessary, you may take FMLA leave intermittently; however generally leave to care for or bond with a newborn child or for a newly placed adopted or foster child may only be taken intermittently with the employer's approval and must conclude within 12 months after the birth or placement.

During your leave, you and your eligible dependents can continue your medical coverage and certain other benefits offered through the Fund. You are generally eligible for a leave under FMLA if you:

- Have worked for a covered employer for at least 12 months;
- Have worked at least 1,250 hours over the previous 12 months; and

- Work at a location where at least 50 employees live within 75 miles of the Employer.

### Rhode Island Family Medical Leave Act

Rhode Island's state FMLA law, called the Parental and Family Medical Leave Act (PFMLA), gives employees the right to take up to 13 consecutive weeks of unpaid leave for a serious health condition, the birth of the child of an employee, or placement of a child 16 years of age or less, in any two calendar years. You are eligible for leave under the PFMLA if you have been employed continuously for at least 12 months and average at least 30 hours of work per week. Note, PFMLA leave cannot be taken intermittently like federal FMLA leave.

### Additional Information

In instances where you are eligible for both federal and state FMLA leave, your leave periods generally will run concurrently. The Fund will maintain your eligibility status until the end of your FMLA leave, provided the contributing employer that grants your FMLA leave provides the required notification **and payment** to the Fund. Call your employer to determine whether you are eligible for FMLA leave and to obtain additional information.

## If You Divorce

If you divorce from your spouse, notify the Fund Office as soon as possible. Your spouse's coverage under the Rhode Island Laborers' Health & Welfare Fund will end on the date your divorce becomes final, unless otherwise required by law.

Your former spouse may continue coverage under COBRA for up to 36 months. He or she must apply within 60 days of the day the divorce becomes final.

A Qualified Medical Child Support Order (QMCSO) could also have an effect on your benefit coverage or elections.

### What You Need to Do

If you get legally divorced, you must provide the Fund Office with the following information:

- A copy of your divorce decree; and
- If you have children and you do not have custody, a copy of any Qualified Medical Child Support Order (QMCSO), if applicable.

If your spouse wants to continue coverage, he or she must:

- Contact the Fund Office; and
- Enroll in COBRA Continuation Coverage.

### Qualified Medical Child Support Order (QMSCO)

A Qualified Medical Child Support Order (QMCSO) is a court order, judgment or decree that recognizes that an alternative recipient may be entitled to benefits under this Fund in the event of a divorce or other family law action. Orders must be submitted to the Fund Office to determine whether the order is a QMCSO under federal law. As required under the Employee Retirement Income Security Act (ERISA), this Fund will recognize a QMCSO that:

- Provides for health coverage to the child(ren) under state domestic relations law (including a community property law); and
- Relates to benefits under this Fund.

Please notify the Fund Office if your situation involves a QMCSO and you need information about how such orders are handled. You and/or your and beneficiary(ies) can obtain, without charge, a copy of the Plan's QMCSO procedures from the Fund Administrator.

# If You Enter Military Service

If you enter military service for 31 days or less, you will continue to receive health care coverage for up to 31 days, according to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you are on duty for more than 31 days, USERRA permits you to continue medical, dental, vision and prescription drug coverage under COBRA you and your dependents at your own expense for up to 24 months. Your dependent(s) may be eligible for health care coverage under TRICARE. The Rhode Island Laborers' Health & Welfare Fund will coordinate coverage with TRICARE. Your coverage under the Fund based on hours worked ends on your 31st day of military service.

### What You Need to Do:

If you are called to military leave, you should:

- Notify your employer and the Fund Office that you wish to elect continuation for yourself and/or your family under the provisions of USERRA; and
- Make any required self-payments to the Fund Office to continue your coverage.

Coverage under this Fund will not be offered for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service-connected disabilities.

When you are honorably discharged from "service in the uniformed services," your full eligibility will be reinstated on the day you return to work with a Contributing Employer, provided that you return to employment within:

- Ninety (90) days from the date of discharge if the period of service was more than one hundred eighty days; or
- Fourteen (14) days from the date of discharge if the period of service was 31 days or more but less than or equal to one hundred eighty days; or
- At the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than thirty-one (31) days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits can be extended for to two years.

# If You Stop Working

If your coverage ends due to your termination or a reduction in hours, you may elect to purchase COBRA Continuation Coverage for yourself and your family for up to 18 months. You must inform the Fund Office within 60 days after the later of the date of your reduction in hours or termination of employment or the date of loss of coverage or you will lose your right to elect COBRA Continuation Coverage.

### What You Need to Do

If you stop working, you should:

- Inform the Fund Office; and
- Enroll in COBRA, if you wish to continue your coverage under this Plan.

# If You Retire

Retirees and their families are not covered under the Plan. However, if you retire while eligible, your coverage will continue as long as you meet the eligibility requirements. After this, you can pay for coverage for up to 18 months or, in some cases, 24 months, under COBRA.

# If You Become Eligible for Medicare

If you or your covered spouse become eligible for Social Security Retirement Benefits at age 65, you are also eligible for Medicare. Medicare is the federally sponsored health care program consisting of hospital insurance (Part A) and supplementary medical insurance (Part B).

You should enroll in Medicare Part A and B as soon as you are eligible—three months before your 65th birthday or in certain cases when you become disabled—in order to avoid a gap in coverage.

If you leave employment and have not applied for Medicare Part B within three months from the date you turn 65, it may cost you more to enroll in Part B coverage.

For information about how your benefits are paid through the Rhode Island Laborers' Health & Welfare Fund when you are enrolled in Medicare.

### To Enroll in Medicare:

- Visit your local Social Security Office;
- Call 800-MEDICARE (800-633-4227); or
- Go to the Medicare website at www.medicare.gov.

# If Your Child Becomes Disabled

If your child becomes mentally or physically disabled before he or she reaches age 19, coverage under this Plan will continue for your child as long as your child is primarily dependent on you for support and care.

You must fill out a special application for continued coverage for your child within one month of his or her 19th birthday. In the application, you must show proof of the disability. Periodically, you may be asked to show proof that the disability still exists.

# If You Become Disabled

If you become temporarily disabled while you are covered by this Plan, your coverage will be extended during your disability for up to one year. This rule applies only to occupational disability (i.e., Worker's Compensation). You must submit proof to the Fund Office of your temporary disability.

### Extension of Coverage

If you become totally and permanently disabled before age 65 while you are covered under this Plan, you are eligible to remain covered under this Plan for up to 24 months during your disability provided you apply for and qualify for Social Security Disability benefits. Once you are covered by Medicare, your coverage under this Plan will stop.

# If You Die

Your beneficiary(ies) may be eligible to receive a life insurance benefit from this Plan. Your designated beneficiary must provide a certified copy of the death certificate and a written request for the life insurance benefit in order to receive a benefit. In addition, if eligible when you die, your spouse and dependent will have medical, vision, and dental benefits extended until the later of: (i) the date your accrued eligibility ends; or (ii) one year from the date of death. Thereafter, the spouse and eligible dependents may elect COBRA continuation coverage for up to 36 months.

## What Your Beneficiary Needs to Do

In the event of your death, your spouse or beneficiary must:

- Notify the Fund Office;
- Provide the Fund Office with a copy of your death certificate;
- Apply for your life insurance benefit (and AD&D benefit, if applicable); and
- Enroll in COBRA, if your dependent(s) would like to continue their coverage.

# Medical Coverage

The Trustees of the Rhode Island Laborers' Health & Welfare Fund want you and your family to be protected from high costs that are often associated with illness or injury. That is why we have chosen the Blue Cross & Blue Shield of Rhode Island (BCBSRI) HealthMate Coast to Coast Plan.

HealthMate Coast to Coast offers the highest quality medical care and prescription drug benefits, as well as convenience and cost savings through the **BlueCard PPO** network. And, with HealthMate Coast to Coast, you have the added benefit of being able to receive the same coverage at home or when you travel. The BlueCard PPO network has providers all over the country.

## BCBSRI Benefit Booklets

This SPD should be read in combination with the Benefit Booklets provided by BCBSRI. Copies of these Benefit Booklets can be found at: https://rilbf.com/en/resources/ or you can call the Fund Office to have a paper copy mailed to you.

The BCBSRI Benefit Booklets describe covered benefits, exclusions, conditions, and limitations provided under your medical care plan, including information about copayments, deductibles, and benefit limits. You will also find other valuable information about your medical care plan, including:

- how your health coverage works;
- when prior authorization is needed;
- how BCBSRI processes claims for the health services you receive;
- your rights and responsibilities as a BCBSRI member;
- BCBSRI's rights and responsibilities; and
- tools and programs to help you stay healthy and save money.

Please refer to the chart below to find the BCBSRI Benefit Booklet that is applicable to you:

| If you are in this Plan: | Use this BCBSRI Benefit Booklet: |
|---|---|
| • Construction Plan | RI Laborers Construction<br>Group #'s 6820-0001 |
| • Non-Construction Plan<br>• Twin River Casino Dealers Plan<br>• Sodexo Providence Schools Plan | RI Laborers Non-Construction<br>Group #'s 6820-0003, 6820-0004 & 6820-0005 |

**Additional information about medical benefits under the Plan can be found at the Fund's website:**
https://rilbf.com/en/health/medical/

## Using the BlueCard PPO Network

You are covered in full (excluding your copayments) for most covered medical expenses when you use a BlueCard PPO provider. You will not be billed for any charges that may be above the Plan's allowance. Refer to the BCBSRI Benefit Booklets for details about covered medical expenses.

The Blue Cross & Blue Shield of Rhode Island HealthMate Coast to Coast Plan bases payment on an "allowance"—a pre-determined fee for medical expenses. Providers that are part of the BlueCard PPO network accept the allowance as payment in full.

When you use a provider in the BlueCard PPO:

- Most medical expenses are covered at 100%.
- You don't have to meet a deductible before the Plan will begin paying benefits (except for certain services under the Non-Construction Plan).
- Your PPO provider will file your claims for you.
- Your PPO provider will get the necessary pre-authorization for you for certain medical expenses.

### Finding a Provider

BlueCard PPO participating providers include doctors, dentists, hospitals, laboratories, and other treatment facilities. To find a provider that participates in the BlueCard PPO network, call

(401) 459-5000 or 1-800-639-2227 (TTY/TDD: 711)
Monday through Friday, 8:00 a.m. to 8:00 p.m.
Saturday and Sunday, 8:00 a.m. to noon

or visit the website at www.bcbsri.com.

The Plan will not discriminate with respect to participation under the Plan against any health care provider who is acting within the scope of that provider's license or certification under applicable state law.

## Using an Out-of-Network Provider

You always have the freedom to visit any provider that you choose. However, if you visit an out-of-network provider, the provider may charge more than the Plan's allowance. If this is the case, you must pay for the service out of your own pocket and apply for reimbursement. If you use an out-of-network provider, you are generally covered at 80% of the allowance (excluding your copayment), and you will be billed for charges that may be above the Plan's allowance. Also, when you use an out-of-network provider, you must meet your annual deductible before the Plan will pay benefits, as further explained below.

### Annual Deductible

Before the Plan will reimburse you for covered medical expenses incurred out-of-network, you must first meet an annual deductible. Your annual deductible is $200 per person ($600 maximum per family). Once you've met your annual deductible, you send in your claim to HealthMate for reimbursement. HealthMate generally reimburses out-of-network provider expenses at 80% of the allowance. You are responsible for the other 20% – your coinsurance. In addition to paying 20% coinsurance, you are responsible for the amount, if any, that your out-of-network provider charges in excess of the Plan's allowance.

### For Example:

Nick, a participant in the Construction Plan, has incurred a medical expense. The Plan allowance for his expenses is $1,000. The chart below shows the difference in the amount Nick must pay when he visits a BlueCard PPO provider vs. an out-of-network provider.

| Item | BlueCard | Out-of-Network Provider |
|---|---|---|
| Amount the provider charges for covered medical expenses | $1,000 (the allowance) | $1,300 |
| Out-of-Network Deductible | $0 | $200 |

| Item | BlueCard | Out-of-Network Provider |
|---|---|---|
| Nick's coinsurance | $0 | 20% of the allowance – $200 |
| Charges in excess of the allowance | $0 | $300 ($1,300 – $1,000 = $300) |
| Billing | Blue Cross & Blue Shield pays the provider directly | Nick must file a claim and pay the following amount: |
| Nick's out-of-pocket cost | $0 | $700 |

# Prescription Drugs

## BCBSRI Prescription Drug Benefits

The Plan covers prescription drugs and diabetic equipment and supplies. When purchased from a pharmacy, prescription drugs and diabetic equipment or supplies are covered as a pharmacy benefit. The Construction and Non-Construction BCBSRI Benefit Booklets describe your coverage for prescription drugs purchased at a retail, mail order, or specialty, pharmacy and contains copayment information for medical prescription drugs requiring administration by a licensed health care provider.

The BCBSRI prescription drug plan formulary has four-tiered copayment structure. There is a 20% copayment for under all tiers. Maximum copayment amounts apply to most drugs. There is no charge for certain preventive drugs. The tier placement of a prescription drug on the formulary is subject to change. Please refer to your BCBSRI Benefit Booklet and Summary of Benefits and Coverage which are available at https://rilbf.com/en/resources/#Docs-HealthFund. You can also request paper copies the Fund Office free of charge.

You can also find information about your prescription drug benefits at the Fund's website at https://rilbf.com/en/health/prescription-drugs/.

### For information about the BCBSRI Pharmacy Network

Visit http://www.bcbsri.com/ or call:

- Customer Service:
  In state: 401-459-5000
  Out of state: 1-800-639-2227
- Hearing impaired: 711
  Home Delivery (Mail Order): 1-855-457-1204
  Preauthorization: 1-855-457-0759

## Supplemental Drug Program

The Supplemental Drug Program is for members who are no longer eligible or are unable to afford COBRA. The program provides generic maintenance drugs for diabetes, high cholesterol, hypertension, and asthma through mail order. The member is responsible for a 20% copayment, the Fund will pay the remaining cost. The program covers the member, spouse, and eligible dependents.

To be eligible, you must have been covered by the Fund and later lost your coverage due to unavailability of work. You must remain available for work as evidenced by the out-of-work list and be currently seeking employment with a signatory contractor. The Supplemental Drug Program is provided through Express Scripts, Inc. If you want to apply for this benefit, obtain a list of covered generic drugs or have any questions, please contact the Fund Office at 401-942-8690.

# What's Not Covered

The following are not covered under this Plan:

- Over the counter drugs (except in certain circumstances);
- Experimental drugs;
- Biological products for immunization;
- Drugs used for cosmetic purposes;
- Drugs administered to you while you are an inpatient at a hospital, rest home, sanitarium, nursing home, home care program, or other institution that provided drugs as part of its services or that operated a facility for dispensing prescription drugs; and
- Drugs that have not been proven effective according to the Federal Food and Drug Administration or that have been placed on notice of opportunity hearing status by the Federal D.E.S.I. Commission.

# Vision and Hearing Care

The Plan provides coverage for routine exams for your eyes and your ears.

## Vision Benefits

The Fund provides vision benefits through Davis Vision. This is a fully insured stand-alone arrangement that is intended to be an excepted benefit for purposes of the Affordable Care Act.

**Fast Facts:**
**For you and your eligible family members, Davis Vision provides:**

- $10 co-pay for annual eye exams and lens with an additional 15% discount for contacts lens follow-up
- A $250 annual allowance at Visionworks and a $200 annual allowance at other locations for frames with an additional 20% off for any overage
- A $200 annual allowance for contacts with an additional 15% off for any overage

Higher cost-sharing applies for out-of-network benefits.

A summary of these benefits can be found at: https://rilbf.com/en/resources/#Docs-HealthFund.

### Finding a Participating Vision Care Provider

Check out the Davis Vision website at www.davisvision.com/member or call 877-923-2847 to find a participating optometrist or ophthalmologist. Log in using your Client Code: 8583 to find a list of in-network providers near you and to access your benefit information.

In addition, when you use a BlueCard PPO provider, you can receive an annual eye exam and a hearing exam for a $30 copayment.

## Hearing Care Benefits

You and your eligible family members may receive a hearing screening, assessment, fitting and evaluation for hearing aids once per calendar year. The Plan provides a $1,500 per ear per occurrence hearing aid allowance for you and your eligible family members. Refer to your BCBSRI Benefit Booklet for more details about the hearing care benefits under the Plan.

# Dental Care

### The Fund's dental benefits are not provided under the Twin River Casino Dealers Plan.

Healthy teeth and gums are an important part of your overall health. That is why the Plan provides dental care benefits for you and your eligible family members. Many dental services, like cleanings, x-rays, and fillings are covered at 100% of the allowance. Your dental benefits are provided through Blue Cross Dental, a stand-alone plan that is intended to be an excepted benefit for purposes of the Affordable Care Act.

**Fast Facts:**

- You do not have to meet an annual deductible to receive dental care benefits.
- Most dental services are covered at 100%.
- Orthodontia is covered at 50% up to the separate $2,000 lifetime maximum.
- The Plan will pay up to $2,000 per year for each covered person in dental expenses.

## Your Dental Benefits at-a-Glance

| Covered at 100% of the allowance |
|---|
| Exams |
| Cleanings |
| X-Rays |
| Fillings |
| Sealants |
| Periodontal Cleanings |

| Covered at 50% of the allowance |
|---|
| Bridges and Dentures |
| Braces |

For complete details about your dental benefits please read the BCBSRI Dental Booklet found at https://rilbf.com/en/resources/#Docs-HealthFund or you can call the Fund Office to receive a paper copy.

## Participating Dentists

You'll get the most out of your dental plan if you use a dentist that participates in the Blue Cross Dental Plan. Blue Cross dentists accept the allowance as payment in full, so most dental services are covered at 100%. In addition, participating dentists will file your dental claims for you. To find a participating provider, contact Blue Cross Dental Customer Relations at 401-831-7300 or 800-527-7290 or online at www.bcbsri.com.

**Need to Find a Participating Dentist?**

Call Blue Cross Dental Customer Relations
at 401-831-7300 or 800-527-7290 or visit their website at www.bcbsri.com.

# Out-of-Network Dentists

Of course, you are always free to see any dentist you choose, even one that does not participate in the Blue Cross Dental Plan; however, you may have to pay more for services. That's because an out-of-network dentist may charge more than the Blue Cross allowance for a particular service. If so, your claim will be reimbursed up to the allowance, but you'll have to pay the difference.

### For Example:

The chart below shows how a dental service is reimbursed when both participating, and out-of-network providers charge $550 for a dental service. For the purposes of this example,let's assume the Blue Cross allowance for this service is $500 and it's a service that is reimbursed at 100% of the allowance.

| Item | Blue Cross Dentist | Out-of-Network Dentist |
|---|---|---|
| Dental Service | $550 | $550 |
| Blue Cross Allowance | $500 | $500 |
| Blue Cross Pays | $500 | $500 |
| You Pay | $0 | $50 |

**Remember, if the Blue Cross & Blue Shield allowance for a dental service is $500, all Blue Cross dentists will accept $500 as payment in full for that service.**

## Submitting Claims

If you visit an out-of-network provider, you may have to submit your own claims to Blue Cross & Blue Shield for reimbursement. You must file your claims within 90 days of the date you receive services. To file a claim, send the following information:

- Itemized bill with the patient's name;
- Name of the dentist who performed the service on provider letterhead;
- The date the service was received;
- A detailed description of the service; and
- Your Blue Cross & Blue Shield of Rhode Island subscriber number (on your identification card).

Submit your claims to:
Blue Cross Dental
P.O. Box 219
Providence, RI 02903

## Pre-Authorization Required

Certain services require pre-authorization. Your dentist should complete a claim form detailing the proposed treatment to determine whether or not you are covered before you receive the following services:

Crowns and inlays/onlays;
Periodontics (treatment of gums);
Prosthodontics (bridges and dentures); and
Orthodontics (braces)

Blue Cross & Blue Shield will verify your eligibility for the proposed treatment upon receipt of the claim form.

## What's Not Covered

Blue Cross Dental will not cover the following dental services:

- Anesthesia, unless rendered in conjunction with a covered oral surgical procedure;
- Benefits available from other sources;
- Cosmetic services;
- Drugs;
- Implants;
- New or experimental services that are not approved by Blue Cross;
- Specialty oral examination;
- Replacement services;
- Services performed by hospital staff employees;
- Services that are not dentally necessary;
- Temporomandibular Joint Syndrome (TMJ);
- Travel expenses; and
- Veneers.

# Member Assistance Program

**The Fund's member assistance program is not provided under the Twin River Casino Dealers Plan.**

The member assistance program (MAP) is provided through Spring Health. MAP provides free, confidential assistance for you and your family members when confronting stress, depression, alcoholism, drug abuse, and job or family problems.

**Fast Facts:**

- The Member Assistance Program is available at no cost to you and your family members.
- When you call, a MAP counselor will assess your situation and set up an appointment for short-term counseling or refer you to the appropriate provider for treatment.
- Treatment you receive through the Membership Assistance Program is strictly confidential.

## How Can MAP Help?

You can contact MAP 24 hours a day, seven days a week to make an appointment to discuss your problem. MAP will arrange for you to meet with a medically and professionally qualified counselor for assistance in identifying and treating the problem. MAP can help with concerns such as:

- Emotional and Mental Problems
- Substance Use Disorder
- Family Problems
- Marital Problems
- Work-Related Problems

You may meet up to five times with a MAP counselor to address a particular problem.

If you need additional help, you can use the Fund's mental health and substance use disorder benefits through Blue Cross & Blue Shield HealthMate Coast to Coast Plan for treatment.

**Learn more and get started:**

- rilhf.springhealth.com
- Spring Health mobile app
  Work-life code: rilhf
- Contact Spring Health:
  springhealth.com/support
  1-855-629-0554
  General support: M-F, 8am-11pm ET
  Crisis support: Available 24/7: Phone: 1-855-629-0554 (press 2)

# Accident & Sickness (Loss of Time) Benefit

## Employees of Catholic Cemeteries Only

The Fund will pay benefits to you if you become totally disabled due to an accident or sickness while insured by the Fund.

This benefit is for non-occupational accident or sickness only.

**Totally disabled** means your inability to perform your regular occupation, as verified by a licensed physician.

| Benefit | Amount/Time |
|---|---|
| Maximum Weekly Benefit | $550 |
| Benefits begin on: | |
| • Day of accident<br>• Day of sickness | • 8th day<br>• 15th day |
| Maximum Number of Weeks | 13 weeks |

**Accident** means an event that is sudden, unexpected, and unintended and over which you have no control.

**Sickness** includes pregnancy, childbirth, and miscarriage.

You must be treated by a licensed physician prior to the first period for which benefits are payable.

Periods of disability due to the same or related causes will also be considered the same periods of disability unless they are separated by your complete recovery and your return to or availability for active full-time work.

Claim forms are available from the Fund Office.

All claims should be submitted directly to the Fund Office at:

Rhode Island Laborers' Health & Welfare Fund
410 South Main Street
Providence, RI 02903
Telephone: 401-942-8690

# Life Insurance

**The Fund's life insurance benefits are not provided under the Twin River Casino Dealers Plan.**

You want your family to be protected in case something happens to you. The Fund provides a life insurance benefit of $30,000 payable to your beneficiary in the event of your death.

### Fast Facts:

- Your life insurance benefit is paid to your designated beneficiary when you die.
- To change your beneficiary, contact the Fund Office.
- If you are no longer eligible for benefits under this Plan, you may convert your life insurance benefit to an individual policy.

## Naming a Beneficiary

You may name anyone you wish to be your beneficiary, and you may change this designation at any time. To change your beneficiary, call the Fund Office for the appropriate form. You do not need to get your beneficiary's consent to make this change. Your change will be effective when the Fund Office receives your completed form.

Your beneficiary designation must be on file at the Fund Office at the time of your death to be valid.

If you do not have a designated beneficiary form on file at the Fund Office at the time of your death, or if your designated beneficiary does not survive you, your life insurance benefit will be paid in the following order:

- To your surviving spouse;
- To your surviving children, if any;
- To your surviving parents;
- To your surviving brothers and sisters; or
- To the executors or administrators of your estate.

### Keep Your Beneficiary Information Up-to-Date

Contact the Fund Office if you'd like to change your beneficiary if you get married, have a child, or get divorced.

# Continuing Coverage if You Become Disabled

If you become totally disabled while you're covered under the Fund, and before you reach age 60, your life insurance benefit will be continued at no cost to you for a 12-month period. You must complete and file an application for total disability with the Insurance Company. The Insurance Company will require proof of your disability. You may be eligible to continue your life insurance coverage for subsequent 12-months periods, provided you submit proof to the Insurance Company three months before each 12-month period expires.

### What is Total Disability?

The Insurance Company considers you totally disabled if you are not working at any job for wage or profit, and you are unable to work in any job that is reasonable suited to you by your education, training, or experience due to an illness or injury.

# If Your Coverage Ends

### Converting Your Coverage

You may convert your life insurance to an individual policy if your coverage under the Fund ends. To apply, contact the Fund Office for an application for conversion. You must make your first premium payment within 31 days of the date your coverage under this Plan ends. If you die during this conversion period, your beneficiary will be paid the life insurance benefit from this Plan.

# Accidental Death and Dismemberment Benefit

### The Fund's accidental death and dismemberment (AD&D) benefits are not provided under the Twin River Casino Dealers Plan.

If you become injured and suffer a loss due to an accident, you (or in the case of your death, your beneficiary) may be eligible to receive a lump-sum benefit from this Plan under the AD&D benefit.

**Fast Facts:**

- This benefit is available for the member only—dependents are not covered under the AD&D benefit.
- The AD&D benefit is payable in addition to and separate from the life insurance benefit.
- Benefits are generally payable if the loss is a direct result of any injury caused by an accident.

The chart below shows the amount that is payable to you in the case of accidental dismemberment. In the event of your death, the benefit is payable to your designated beneficiary.

| Loss Due to Accident | Benefit |
|---|---|
| Loss of life | $30,000 (Paid to your beneficiary) |
| Loss of two limbs, sight of both eyes, or one limb and sight of one eye | $30,000 (Paid to you) |
| Loss of one limb or sight of one eye | $15,000 (Paid to you) |

Loss of limb means dismemberment by severance at or above the wrist or ankle joint. Loss of sight means the entire and irrecoverable loss of sight.

For benefits to be payable, your death or loss of limb must occur within 90 days from the day of the accident. If you lose your sight, benefits are payable if the loss occurs up to 365 days from the date of the accident. If you suffer more than one loss as a result of any one accident, the maximum total benefit is $30,000.

## What's Not Covered

The Fund will not pay an AD&D benefit for death, or any loss resulting from or caused directly, wholly, or partly by:

- Bodily or mental infirmity, ptomains, bacterial infections (except infections cause by pyogenic organisms that occur with and through an accidental cut or wound) or disease or illness of any kind;
- Intentional self-destruction or intentional self-inflicted injury while sane or insane;
- Participating in the committing of a felony; or
- War or act of war or service in any military, naval or air force of any country while that country is engaged in war or police duty as a member of any military, naval or air organization.

**Filing Claims for AD&D Benefits**

- See the Claims section below for information on how to file a claim for an AD&D benefit.

# Maternity Continuation Coverage

**This benefit is provided under the Construction Plan only.**

## Maximum Period

Covered and/or eligible employees who due to pregnancy or complications from pregnancy deemed by your attending physician that you are unable to work are eligible for up to 13 weeks coverage under the medical Plan.

### No impact on hours worked

This benefit does not impact your hours worked at the time the maternity continuation coverage commences. Your hours will be frozen until your maternity continuation coverage ends, up to a maximum of 13 weeks, resulting in no 13 week break in service due to maternity leave.

### You do not have to be covered by the Plan

So long as you are eligible under the Plan, you may be eligible for maternity continuation coverage even if you are not currently covered under the Plan.

## Eligibility Requirements

To be eligible, you must provide the Fund with a note from your attending physician that documents your condition, and the duration of care needed. You must also complete any necessary forms. The Fund, in its sole discretion, determines whether you are eligible and the maximum period of your eligibility.

## What You Can Use this Benefit For

You can use this benefit for either any medical or mental health condition related to your pregnancy, including but not limited to:

- High Blood Pressure
- Gestational Diabetes
- Infections
- Preeclampsia
- Preterm Labor
- Depression & Anxiety
- Pregnancy Loss/Miscarriage
- Stillbirth

## How to Apply

To apply for this benefit please refer to the instructions and complete the application available on the Fund's website.

# Sick/Safe Leave Benefit

**This benefit is provided under the Construction Plan only.**

## Earning Leave

You earn, or accrue, one hour of leave for every 35 hours you work in covered employment on and after January 1, 2024.

At the end of the calendar year, your unused accrued leave will roll over to the next calendar year, up to a maximum of 40 hours. You cannot accrue more than 40 hours of leave per calendar year (including hours that are rolled over).

### New members

If you're a new member, you'll begin to accrue leave on your first day of covered employment. However, you cannot use accrued leave until after you've worked 90 days.

## Amount of Leave Payment

Leave will be paid at the base wage rate under your collective bargaining agreement. If your employer pays you at a rate higher than the base wage rate, your employer will be responsible for paying the difference.

## What You Can Use Leave For

You can use either four or eight hours of leave a day for the following reasons:

- You are ill or injured and unable to work due to my illness or injury;
- You have a medical appointment;
- You accompanied a family member to a medical appointment;
- You need to care for a family member who is ill or injured or under quarantine;
- Your workplace is closed due to a public health emergency;
- You need to care for your child because your child's school or day care was closed due to a public health emergency; or
- You are unable to work for reasons related to the domestic violence, sexual assault or stalking of you or a family member.

For this purpose, "**family member**" means your child, parent, spouse, parent-in-law, grandparent, grandchild, sibling, domestic partner, and any other individual for whom you provide care or who is a member of your household.

- If your request for leave is for more than three consecutive days, the Fund Office may in its discretion require you to provide documentation of your need for leave.
- If the Fund Office has determined in its discretion that you have established a clear pattern of taking leave on days just before or after a weekend, vacation, or holiday, the Fund Office may require you to provide documentation of your need for leave.
- You cannot also receive temporary disability insurance, temporary caregiver insurance, or workers' compensation benefits for days that you take under the Sick/Safe Leave Benefit.

## How to Apply

To apply for this benefit please refer to the instructions and complete the application which are available on the Fund's website.

## Taxation

To the extent required by law, federal, state, and local taxes (if applicable) will be withheld from your benefit and reported at year end on your Form W-2.

# Vacation Benefit

**This benefit is provided under the Construction Plan only.**

## Contributions

Pursuant to the collective bargaining agreement for Laborers' Local Union 271, participating employers have established a vacation benefit for you. Employers make contributions to fund this benefit according to the terms of the collective bargaining agreement.

## Accounts

You'll have an individual benefit balance based on the amount contributed on your behalf.

## Distribution / Payout

On an annual basis, the amount credited to your vacation account will be paid out as follows:

- Contributions accumulated to date will be paid out during the 4th calendar quarter.

  (Any monies for previous work periods not previously distributed to the member will also be distributed at this time.)

## Taxation

To the extent required by law, federal, state, and local taxes (if applicable) will be withheld from your benefit and reported at year end on your Form W-2.

If you have any questions about this benefit, please contact the Fund Administrator at:

410 South Main Street
Providence, RI 02903
Telephone: 401-942-8690

# Fit For Duty

## How this Wellness Program Works

This is a wellness benefit provided under the Health Reimbursement Account Plan (the "HRA").

### Eligibility for HRA Fit-for-Duty Benefit

To receive the Fit-for-Duty Wellness Contribution under the HRA Plan for a Plan Year, you or your spouse must have completed one or both of the following during the preceding calendar year:

- completing an annual physical exam
- getting a dental cleaning

For example, to receive the HRA Fit-for-Duty wellness benefit in 2026, you or your spouse must get a physical exam or dental cleaning during the 2025 calendar year.

### The Fit-for-Duty Benefit

You can receive $100 for each physical exam and $25 for each dental cleaning. That means you and your spouse together can have additional HRA Plan benefits of up to $250 per year.

### When will your Fit-for-Duty benefit appear in your HRA Account?

If you are eligible for the Fit-for-Duty Wellness benefit for a Plan Year, it will be funded in your HRA Account card in June of that Plan Year. The funds can be carried over for use in future Plan Years.

For example, if you and your spouse each get a physical exam and dental cleaning during the 2025 calendar year, your HRA card will be funded with $250 in June of 2026. The HRA card gives you access to the money in your HRA Account. Use the card like a debit card at checkout, to pay for eligible health care expenses for you and your eligible dependents.

### Please refer to the summary plan description for the HRA Plan for more information about benefits under that plan.

## First-Time Access to Your HRA Account Online

To check your HRA account balance, file a claim online, upload receipts and download plan information, get forms, and get notifications, visit rilhf.lh1ondemand.com.

For first-time sign-in, you'll provide your:

- Username: (Initial of your first name + your last name + the last four digits of your social security number)
- Password: (Your social security number—no dashes)

Please visit https://rilbf.com/en/health/fit-for-duty-program/ for more information.

# Coordination of Benefits

**Note that benefit specific coordination rules may be set forth in the BCBSRI Benefit Booklets.**

Members of a family are often covered under more than one group health plan, which could result in duplication of health coverage. To avoid this, the health care benefits provided by this Fund are coordinated with similar benefits payable under other plans.

**Fast Facts:**

- You must report any duplicate group health coverage for yourself and/or your dependents on any claim you submit to Blue Cross & Blue Shield of Rhode Island.
- Benefits under this Plan are coordinated with HMO, PPO, Medicare, or other group health care coverage.
- This Plan has the right to get back benefits that were paid as a result of a disability if that disability was the fault of another individual.

Under the Coordination of Benefits provision, if you are insured under any other group health plan, the total payment you receive from all programs may not be more than 100% of the "allowable expenses." Allowable expenses are the necessary and reasonable expenses for medical services, treatment, or supplies covered by one of the plans you are insured under.

# Methods of Coordination

If you have duplicate health care coverage, your benefits are coordinated by looking at the "primary plan" first. If any charges still need to be paid, they will be applied to the "secondary plan."

The following rules are used to determine whether a plan is "primary" or "secondary":

- A plan is primary if it does not contain a Coordination of Benefits provision. Any other plan that is determined to have responsibility for payment of benefits in addition to that of the primary plan will be known as a "secondary plan."
- Any other health plan, including this Fund that covers you as anything other than a dependent or a spouse is the primary plan.
- If you are covered under two plans through two jobs, or if the order of responsibility for payment cannot be determined by these provisions, the plan that has insured you for a longer period of time is primary.

Where there are two or more secondary plans, this order of responsibility will be repeated until this Fund's responsibility has been determined with respect to each of the other health plans.

## Birthday Rule

If your dependent child is covered by two plans, the plan that covers a person as a dependent of the parent whose birthday is earlier in the calendar year is primary to the plan that covers the individual as a dependent of the parent whose birthday is later in the calendar year. If both parents have the same birthday, the plan that covers one of the parents longer will be primary to the plan that covers the other parent. If the other plan does not have a rule based on birthdays similar to this one, the other plan will be primary to this Plan.

## Child Custody in Divorce

If a dependent child has coverage through both parents' plans and a court order awards custody of the child to one parent, benefits are coordinated as follows:

A. First the plan of the parent who has custody of the child; then

B. The plan of the spouse of the parent who has custody of the child; then

C. The plan of the parent who does not have custody; then

D. The plan of the spouse of the parent who does not have custody.

If a court decree orders one parent to be responsible for health care expenses, the plan of that parent is primary. If a court decree states that both parents share joint custody but does not state which parent is responsible for health care expenses, the order of benefits will be determined by the birthday rule set forth above.

- The parties must provide a copy of the court order to the Plan. **The benefits provided by this Plan (as a secondary plan) will never exceed the benefits that would have been provided by this Plan as a primary plan.**

## Coordination with Medicare

If you are eligible for benefits under this Plan because you are an active employee, but you are also eligible for Medicare because you are 65, then this Plan is your primary plan and Medicare is your secondary plan.

If you become totally disabled and entitled to Medicare while you are actively employed, this Plan is your primary plan and Medicare is your secondary plan. If you become totally disabled and entitled to Medicare while you are not actively employed, e.g., while receiving COBRA continuation coverage, Medicare is your primary plan and this Plan is your secondary plan. Generally, if an eligible dependent under this Plan becomes totally disabled and entitled to Medicare, for that eligible dependent this Plan is your primary plan and Medicare is your secondary plan.

**If, while you are actively employed, you or any of your covered dependents becomes entitled to Medicare because of end-stage renal disease (ESRD), this Plan is your primary plan and Medicare is your secondary plan for 30 months starting the earlier of the month in which Medicare ESRD coverage begins or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare is your primary plan and this Plan is your secondary plan.**

## Right to Make Payments

Whenever payments that should have been made under this Plan have been made under any other health plan, the Board of Trustees has the right to make payment for the amount it determines to satisfy the intent of this provision.

## TRICARE

**If you are covered by both this Plan and TRICARE, this Plan is the primary plan and TRICARE is the secondary plan.**

## Motor Vehicle No-Fault Coverage Required by Law

If you are covered by both this Plan and any motor vehicle no-fault coverage that is required by law, the motor vehicle no-fault coverage pays first, and this Plan pays second.

## Coordination with Medicaid

For purposes of coordinating with Medicaid, this Plan will assume primary payer status for any Participant or Alternate Recipient who is entitled to benefits under a state plan for medical assistance approved under Title XIX

of the Social Security Act (Medicaid), unless otherwise required by applicable law. Payment for benefits with respect to a Participant or Alternate Recipient will be made in accordance with any assignment of rights made by or on behalf of such Participant or Alternate Recipient as required by Medicaid under Section 1912(a)(1)(A) of the Social Security Act, 42 U.S.C. 1396k(a)(1)(A). If this Plan has the legal obligation to pay benefits and payment has been made under Medicaid, payment for benefits under this Plan will be made in accordance with state Medicaid law, which provides that the state acquires the rights of the Participant or Alternate Recipient for payment of such benefits. The provisions of Section 1908 of the Social Security Act apply to the extent such provisions are in accordance with state Medicaid law.

# Subrogation

You or one of your eligible dependents may incur medical expenses in a situation where a third party—for example, Workers' Compensation or an auto insurance carrier— may be held responsible for their payment. In this case, the Plan has all rights of recovery that you or your dependents would have, including the right to bring suit in your name.

You must cooperate with the Plan to secure the recovery of the payment, and you must do nothing before or after payment by the Plan to prejudice its rights. If you recover from the third party or its insurer, you must reimburse the Fund for expenses that it has paid.

Before paying for expenses that may be the responsibility of a third party, the Plan may require you or your dependents to execute a written assignment to the extent of its payments if you or your dependents recover payment from the third party.

## The Fund's Right to Reimbursement

If you recover payment from a third party, you must reimburse the Plan in-full from the proceeds that you received from the third party, regardless of:

- The amount of the proceeds;
- Whether you're "made whole;"
- Whether the proceeds are paid by way of settlement, judgment or otherwise; and
- How the proceeds are characterized.

The Fund has an equitable interest in the amount recovered, or to be recovered, by the claimant for the entire amount paid by the Fund for the claim. This interest is based upon the Plan's prior payment of benefits. It is not necessary that an agreement be entered into for the Plan to have the right to recover from the claimant any amounts paid to him or her by a third party.

## Claimant's Failure to Reimburse

If you do not reimburse the Fund after you've recovered payment, the Fund will institute legal action against you, the equitable interest in the amount recovered by the claimant from a third party, you are liable for all costs of collection, including interest rate of at least 10% per year as determined by the Trustees and including reasonable attorney's fees.

**Note that specific subrogation provisions may be set forth in the Benefit Booklets.**

# Claims Review and Appeals Procedures

1. **Eligibility Claims:** Claims relating to your eligibility for benefits under the Fund are determined by the Fund using the applicable procedures set forth in the sections below.
2. **Medical and Prescription Drugs:** Medical and prescription drug benefit claims are determined by Blue Cross & Blue Shield of Rhode Island. See the BCBSRI Benefit Booklets for details about the claims and appeals procedures for medical and prescription drug claims.
3. **Life Insurance and AD&D:** Life insurance claims are determined by Union Labor Life. You should contact Union Labor Life or the Fund Office to obtain the appropriate claim forms for Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance. In the event a claim has been denied in whole or in part, you or your beneficiary can request a review of your claim by Union Labor Life. This request for review should be sent to Group Insurance Claims Review at the address of Union Labor Life's office that processed the claim.
4. **Dental:** Claims are determined by Blue Cross Dental. See the Dental Subscriber Agreement for details on the claims and appeals procedures for dental claims.
5. **Vision:** Claims are determined by Davis Vision.
6. **All Other Benefits:** The Fund determines claims for all other benefits.

## Internal Claims and Appeal Procedures

This section describes the procedures followed by The Rhode Island Laborers' Fund in making internal claim decisions and reviewing appeals of denied claims as required under ERISA. These procedures apply to claims for medical, mental health, substance use disorder, Member Assistance Program (MAP), dental, vision, hearing, prescription drug, health reimbursement arrangement (HRA), disability (Accident and Sickness/Loss of Time), life insurance and accidental death and dismemberment benefits.

The Plan's internal claims and appeal procedures are designed to provide you with full, fair, and fast claim review and so that Plan provisions are applied consistently with respect to you and other similarly situated participants and dependents. With respect to health benefit claims, the Plan must consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not medically necessary or appropriate, or is experimental or investigational).

The internal claims process pertains to determinations made by the appropriate Claims Administrator about whether a request for benefits (known as an initial "claim") is payable. If the appropriate Claims Administrator denies your initial claim for benefits (known as an "adverse benefit determination"), you have the right to appeal the denied claim under the Plan's internal appeals process.

For health benefits, you may be able to seek an external review with an Independent Review Organization (IRO) that conducts reviews of adverse benefit determinations either (i) after the Plan's internal appeals process has been exhausted, or (ii) under limited circumstances before the Plan's internal claims and appeals process have been exhausted.

## General Information

### Claims Administrator(s)

The Plan Administrator has delegated responsibility for initial claims decisions to the following companies/organizations:

| Benefit | Appropriate Claims Administrator | Types of Claims Processed |
|---|---|---|
| Medical | BCBSRI | Pre-Service, Urgent, Concurrent and Post-Service Medical Claims |
| Mental Health | BCBSRI | Pre-Service, Urgent, Concurrent and Post-Service Mental Health Claims |
| Substance Use Disorder | BCBSRI | Pre-Service, Urgent, Concurrent and Post-Service Substance Use Disorder Claims |
| MAP | Spring Health | Pre-Service, Urgent, Concurrent and Post-Service MAP Claims |
| Dental | BCBSRI | Pre-Service and Post-Service Dental Claims |
| Vision | Davis Vision | Post-Service Vision Claims |
| Hearing | BCBSRI | Post-Service Hearing Claims |
| Prescription Drug | BCBSRI | Pre-Service, Urgent, Concurrent and Post-Service Prescription Drug Claims |
| HRA/Fit for Duty | Fund Office and WEX | Post-Service HRA Claims |
| Disability (Accident and Sickness) | Fund Office | Disability (Accident and Sickness) |
| Life Insurance | ULLICO | Life Insurance |
| Accidental Death and Dismemberment Insurance | ULLICO | Accidental Death and Dismemberment Insurance |
| Sick/Safe Leave | Fund Office | Sick/Safe Leave Benefit |
| Vacation | Fund Office | Vacation Benefit |

### Days Defined

For the purpose of the initial claims and appeal processes, “days” refers to calendar days, not business days.

### Adverse Benefit Determination

An adverse benefit determination, for the purpose of the internal claims and appeal process, means:

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual’s eligibility to participate in the Plan or a determination that a benefit is not a covered benefit;
- A reduction of a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion, or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not medically necessary or appropriate, or experimental or investigational; or
- A rescission of coverage, whether or not there is an adverse effect on any particular health or disability (e.g., Accident and Sickness/Loss of Time) claims benefit. An adverse benefit determination does not include

rescissions of coverage with respect to life insurance or accidental death and dismemberment benefits.

### Health Care Professional

A health care professional, for the purposes of the claims and appeals provisions, means a Physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

### Definition of a Claim

A claim is a request for a Plan benefit made by you or your covered Dependent (also referred to as "claimant") or your authorized representative in accordance with the Plan's reasonable claims procedures.

## Types of Claims

### Health Benefit Claims

Health benefit claims can be filed for medical, mental health, substance use disorder, Member Assistance Program (MAP), dental, vision, hearing, prescription drug and HRA benefits.

There are four categories of health claims, as described below:

- **Pre-Service Claims** (applicable to certain medical, mental health, substance use disorder, MAP, and prescription drug benefits). A Pre-Service Claim is a claim for a benefit that requires approval of the benefit (in whole or in part) before health care is obtained. Under this Plan, prior approval is required for certain medical, mental health, substance use disorder, MAP, and prescription drug benefits.
- **Urgent Care Claims** (applicable to certain medical, mental health, substance use disorder, MAP, and prescription drug benefits). An Urgent Care Claim is any Pre-Service Claim for health care treatment that (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (ii) in the opinion of the claimant's attending health care provider with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. However, the Plan will not deny benefits for these procedures or services if it is not possible for the claimant to obtain the pre-approval, or the pre-approval process would jeopardize the claimant's life or health.

- **Concurrent Claims** (applicable to certain medical, mental health, substance use disorder, MAP, dental, and prescription drug benefits). A Concurrent Claim is a claim that is reconsidered after an initial approval has been made and results in a reduced or terminated benefit. Also, a Concurrent Claim can pertain to a request for an extension of a previously approved treatment or service.
- **Post-Service Claims** (applicable to medical, mental health, substance use disorder, MAP, dental, vision, hearing, prescription drug and HRA benefits). A Post-Service Claim is a request for benefits under the Plan that is not a Pre-Service Claim. Post-Service Claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim or electronic bill submitted for payment after services have been provided are examples of a Post-Service Claim. A claim regarding the rescission of coverage will be considered to be a Post-Service Claim.

### Disability (Accident and Sickness/Loss of Time) Benefit Claims

A Disability Claim is a request for benefits during a period of disability. Disability Claims are filed after a participant suffers a disability and benefits are paid if the Claims Administrator determines that the participant has suffered a disability as defined by the terms of the Plan.

### Life Insurance and Accidental Death and Dismemberment Insurance Claims

A Life Insurance Claim is a request by a designated beneficiary for benefit payment following the death of the participant. An Accidental Death and Dismemberment Insurance Claim is a request by a designated beneficiary or a participant for benefit payment following the death of the participant or after a participant has provided the Plan with proof of a bodily loss.

## Claim Elements

An initial claim must include the following elements to trigger the Plan's internal claims process:

- Be written or electronically submitted (oral communication is acceptable only for Urgent Care Claims);
- Be received by the Plan Administrator or Claims Administrator (as applicable);
- Name a specific individual participant and his/her Social Security Number;
- Name a specific claimant and his/her date of birth;
- Name a specific medical condition or symptom;
- Provide a description and date of a specific treatment, service or product for which approval or payment is requested (must include an itemized detail of charges);
- Identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and
- When another plan is primary payer, include a copy of the other Plan's Explanation of Benefits (EOB) statement along with the submitted claim.

A request is **not** a claim if it is:

- Not made in accordance with the Plan's benefit claims filing procedures described in this section;
- Made by someone other than you, your covered dependent, or your (or your covered dependent's) authorized representative;
- Made by a person who will not identify himself or herself (anonymous);
- A casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- A request for prior approval where prior approval is not required by the Plan;
- An eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of

lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;

- The presentation of a prescription to a retail pharmacy or mail order pharmacy that the pharmacy denies at the point of sale. After the denial by the pharmacy, you may file a claim with the Plan;
- A request for an eye exam, lenses, frames or contact lenses that is denied at the point of sale from the Plan's contracted in-network vision provider(s). After the denial by the vision service provider, you may file a claim with the Plan.

If you submit a claim that is not complete or lacks required supporting documents, the Plan Administrator or Claims Administrator, as applicable, will notify you about what information is necessary to complete the claim. This does not apply to simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim, or which relate to proposed or anticipated treatment or services, which do not require prior approval.

### Claim Filing Deadline

Claims should be filed within twelve (12) months following the date charges were incurred. Failure to file claims within the time required will not invalidate or reduce any claim if it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible and in no event later than eighteen (18) months from the date the charges were incurred.

## Initial Claim Decision Timeframes

The time period for making a decision on an initial claim request starts as soon as the claim is received by the appropriate Claims Administrator, provided it is filed in accordance with the Plan's reasonable filing procedures, regardless of whether the Plan has all of the information necessary to decide the claim. A claim may be filed by you, your covered dependent, an authorized representative, or by a network provider. In the event a claim is filed by a provider, the provider will not automatically be considered to be your authorized representative.

### Health Care Claims—Decision Timeframes

The Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which notice of an adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

- **Pre-Service Claims** (applicable to medical, mental health, substance use disorder, Member Assistance Program (MAP), and prescription drug benefits)

  Claims for Pre-Service (that are not for Urgent Care) will be decided no later than fifteen (15) days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the initial fifteen (15) day period whether the claim was approved or denied (in whole or in part).

  The time for deciding the claim may be extended by up to fifteen (15) days due to circumstances beyond the Claims Administrator's control (e.g., inability of a medical reviewer to meet a deadline), provided you are given written (or electronic, if a applicable) notification before the expiration of the initial fifteen (15) day determination period.

If you improperly file a Pre-Service Claim, the Claims Administrator will notify you in writing (or electronically, as applicable) as soon as possible, but in no event later than five (5) days after receiving the claim. The notice will describe the proper procedures for filing a Pre-Service Claim. Thereafter, you must re-file a claim to begin the Pre-Service Claim determination process.

If a claim cannot be processed due to insufficient information, the Claims Administrator will notify you in writing (or electronically, as applicable) about what specific information is needed before the expiration of the initial fifteen (15) day determination period. Thereafter, you will have 45 days following your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision is suspended. The claim decision deadline is suspended until the earlier of 45 days or the date the Claims Administrator receives your response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify you in writing (or electronically, as applicable).

- **Urgent Care Claims** (applicable to medical, mental health, substance use disorder, MAP, and prescription drug benefits)

  In the case of an Urgent Care Claim, if a health care professional with knowledge of your medical condition determines that a claim constitutes an Urgent Care Claim, the health care professional will be considered by the Plan to be your authorized representative bypassing the need for completion of the Plan's written authorized representative form.

  The appropriate Claims Administrator will decide claims for Urgent Care as soon as possible, but in no event later than 72 hours after receipt of the claim. The Claims Administrator will orally communicate its decision telephonically to you and your health care professional. The determination will also be confirmed in writing (or electronically, as applicable) no later than three (3) days after the oral notification.

  If you improperly file an Urgent Care Claim, the Claims Administrator will notify you and your health care professional as soon as possible, but in no event later than 24 hours after receiving the claim. The written (or electronic, as applicable) notice will describe the proper procedures for filing an Urgent Care Claim. Thereafter, you must re-file a claim to begin the Urgent Care Claim determination process.

  If a claim cannot be processed due to insufficient information, the Claims Administrator will provide you and your health care professional with a written (or electronic, as applicable) notification about what specific information is needed as soon as possible and no later than 24 hours after receipt of the claim. Thereafter, you will have not less than 48 hours following receipt of the notice to supply the additional information. If you do not provide the information during the period, the claim will be denied (i.e., an adverse benefit determination). Written (or electronic, as applicable) notice of the decision will be provided to you and your health care professional no later than 48 hours after the Claims Administrator receives the specific information or the end or the period given for you to provide this information, whichever is earlier.

- **Concurrent Claims** (applicable to medical, mental health, substance use disorder, MAP, dental and prescription drug benefits)

  If a decision is made to reduce or terminate an approved course of treatment, you will be provided with a written (or electronic, as applicable) notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to request an appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated.

  A Concurrent Claim that is an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes described above under the Urgent Care Claim section.

  A Concurrent Claim that is not an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes applicable to the Pre-Service or Post-Service Claim, as applicable, provisions described above in this section.

If the Concurrent Care Claim is approved you will be notified orally followed by written (or electronic, as applicable) notice provided no later than three (3) calendar days after the oral notice.

If the Concurrent Care Claim is denied, in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice.

- **Post-Service Claims** (applicable to medical, mental health, substance use disorder, MAP, dental, vision, hearing, prescription drug and HRA claims)

  Claims for Post-Service treatments or services will be decided no later than 30 days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the 30-day initial determination period if the claim is denied (in whole or in part).

  The time for deciding the claim may be extended by fifteen (15) days due to circumstances beyond the Claim Administrator's control (e.g., inability of a medical reviewer to meet a deadline), provided you are given written (or electronic, as applicable) notification before the expiration of the initial 30-day determination period.

  If a claim cannot be processed due to insufficient information, the Claim Administrator will notify you in writing (or electronically, as applicable) about what information is needed before the expiration of the initial 30-day determination period. Thereafter, you will have 45 days after your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date the Claims Administrator receives your written response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify you in writing (or electronically, as applicable).

### Disability (Accident and Sickness/Loss of Time) Claims—Decision Timeframes

Claims for Disability (Accident and Sickness/Loss of Time) benefits will be decided no later than 45 days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the 45-day initial determination period if the claim is denied (in whole or in part).

The time for deciding the claim may be extended by 30 days due to circumstances beyond the Claim Administrator's control, provided you are given written (or electronic, as applicable) notification before the expiration of the initial 45-day determination period. A decision will be made within 30 days of the date the Claims Administrator notifies you of the delay. The period for making a decision may be delayed an additional 30 days if due to matters beyond the control of the Claims Administrator, provided you are notified of the additional delay, before the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If a claim cannot be processed due to insufficient information, the Claims Administrator will notify you in writing (or electronically, as applicable) about what information is needed before the expiration of the initial 45-day determination period. Thereafter, you will have 45 days after your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date the Claims Administrator receives your written response to the request for information. The Claims Administrator then has 30 days to make a decision and notify you in writing (or electronically, as applicable).

### Life Insurance/Accidental Death and Dismemberment Insurance Claims—Decision Timeframe

Generally, you will receive written (or electronic, as applicable) notice of a decision on your initial claim within 90 days of receipt of your claim by the Claims Administrator. If additional time or information is required to make a determination on your claim (for reasons beyond the control of the Claims Administrator, you will be notified in writing (or electronically, as applicable) within the initial 90-day determination period. The 90-day period may be extended up to an additional 90 days.

## Initial Determinations of Benefit Claims

### Notice of Adverse Benefit Determination

If the Claims Administrator denies your initial claim, in whole or in part, you will be given a notice about the denial (known as a "notice of adverse benefit determination"). The notice of adverse benefit determination will be given to you in writing (or electronically, as applicable) within the timeframe required to make a decision on a particular type of claim. The notice of adverse determination must:

- Identify the claim involved (and for health benefit claims—include the date of service, health care provider, claim amount if applicable, denial code and its corresponding meaning);
- Give the specific reason(s) for the denial (and for health benefit claims - include a statement that the claimant has the right to request the applicable diagnosis and treatment code and their corresponding meanings; however, such a request is not considered to be a request for an internal appeal or external review for health benefit claims);
- If the denial is based on a Plan standard that was used in denying the claim, a description of such standard.
- Reference the specific Plan provision(s) on which the denial is based;
- Describe any additional material or information needed to perfect the claim and an explanation of why such added information is necessary;
- With respect to health and disability benefit claims, the opportunity, upon request and without charge, reasonable access to and copies of all documents, records, and other information relevant to an initial claim for benefits;
- Provide an explanation of the Plan's internal appeal and external review for health benefit claims processes along with time limits and information about how to initiate an appeal and an external review for health benefit claims;
- Contain a statement that you have the right to bring civil action under ERISA section 502(a) following an appeal;
- With respect to health and disability benefit claims, if the denial was based on an internal rule, guideline, protocol, standard, or similar criteria, a statement will be provided that a copy of such rule, guideline, protocol or similar criteria that was relied upon will be provided to you free-of-charge upon request;
- If the denial of a health care claim or disability claim was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided to you free-of-charge upon request;
- With respect to disability claims, a discussion of the Plan's initial claim determination, including the basis for disagreeing with: (i) any disability determination by the Social Security Administration (SSA); (ii) the views of a treating health care professional or vocational expert evaluating the claimant, to the extent the Plan does not follow such views as presented by the claimant; or (iii) the views of medical professionals or vocational experts whose advice was obtained on behalf of the Plan, regardless of whether or not the advice was relied upon by the Plan in making an adverse benefit determination;
- For Urgent Care health benefit claims, the notice will describe the expedited internal appeal and external review processes applicable to Urgent Care Claims. In addition, the required determination may be provided

orally and followed with written (or electronic, as applicable) notification; and

- With respect to health benefit claims, provide information about the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with the Plan's internal claims and appeal processes as well as with the external review process.

### Notice of Approval of Pre-Service and Urgent Care Claims

If a Pre-Service claim is approved, you will receive written (or electronic, as applicable) notice within fifteen (15) days of the appropriate Claims Administrator's receipt of the claim. Notice of Approval of an Urgent Care Claim will be provided in writing (or electronically, as applicable) to you and your health care professional within the applicable timeframe after the Claims Administrator's receipt of the claim.

### Internal Appeal Request Deadline

- **Health Care Claims** (applicable to medical, mental health, substance use disorder, MAP, dental, vision, hearing, prescription drug and HRA benefits)

  If an initial health care claim is denied (in whole or in part) and you disagree with the Claims Administrator's decision, you or your authorized representative may request an internal appeal. You have 180 calendar days following receipt of a notice of adverse benefit determination to submit a written request for an internal appeal. The Plan will not accept appeals filed after this 180-day period. Under limited circumstances, explained below in the section on External Review, you may bypass the Plan's internal claims and/or appeal processes and file a request for an external review.

- Disability (Accident and Sickness/Loss of Time) Claims

  If an initial Disability Claim is denied and you disagree with the Claims Administrator's decision, you or your authorized representative may request an internal appeal. You have 180 calendar days following your receipt of an initial notice of adverse benefit determination to submit a written request for an internal appeal. The Plan will not accept appeals filed after this 180-day period.

- Life Insurance/Accidental Death and Dismemberment Insurance Benefits

  If an initial life insurance or accidental death and dismemberment benefit claim is denied and you disagree with the Claims Administrator's decision, you or your authorized representative may request an appeal. You have 60 calendar days following your receipt of an initial notice of adverse benefit determination to submit a written request for an appeal. The Plan will not accept appeal requests filed after this 60-day period.

# Internal Appeals Process

### Appeal Procedures

To file an internal appeal, you must submit a written statement to the appropriate Appeals Reviewer, at the address shown below. Appeal requests involving Urgent Care Claims may be made orally by calling the Appeals Reviewer at the telephone number listed below.

| Type of Claim | Contact | Phone Number | Website/ Email |
|---|---|---|---|
| • Medical Benefits<br>• Mental Health and Substance Use Disorder Treatment<br>• Vision Care<br>• Prescription Drugs | Blue Cross & Blue Shield of Rhode Island<br>500 Exchange Street<br>Providence, RI 02903-2699 | Call (401) 459-5000 or 1-800-639-2227 (TTY/TDD: 711)<br>Monday through Friday, 8:00 a.m. to 8:00 p.m.<br>Saturday and Sunday, 8:00 a.m. to noon | www.bcbsri.com |
| • Dental Benefits | Blue Cross Dental<br>500 Exchange Street<br>Providence, RI 02903-2699 | Call (401) 459-5000 or 1-800-639-2227 (TTY/TDD: 711)<br>Monday through Friday, 8:00 a.m. to 8:00 p.m.<br>Saturday and Sunday, 8:00 a.m. to noon | www.bcbsri.com |
| • Vision Benefits | Davis Vision<br>500 Jordan Road<br>Troy, NY 12180 | Toll Free Number:<br>800-999-5431 | www.davisvision.com;<br>MemberHelp@versanthealth.com |
| • Member Assistance Program (MAP) | Spring Health | 855-629-0554 | https://benefits.springhealth.com/customer/rilhf |
| • Accidental Death and Dismemberment<br>• Life Insurance | Union Labor Life Insurance Company<br>8403 Colesville Road<br>Silver Spring, MD 20910 | Toll Free Number:<br>1-866-795-0680<br>Fax Number:<br>202- 962-2939 | LifeClaims@ullico.com |
| HRA (Fit for Duty), Disability, and All Other Claims | Rhode Island Laborers' Health & Welfare Fund<br>410 South Main Street<br>Providence, RI 02903 | 401-942-8690 | https://rilbf.com/en/health/ |

Your request for an internal appeal must include the specific reason(s) why you believe the initial claim denial was improper. You may submit any document that you feel is appropriate to the internal appeal determination, as well as submitting any written issues and comments.

As a part of its internal appeals process, the Plan will provide you with:

- The opportunity, upon request and without charge, reasonable access to and copies of all documents, records, and other information relevant to your initial claim for benefits;
- The opportunity to submit to the Plan written comments, documents, records, and other information relating to your initial claim for benefits;

- With respect to health and disability benefit appeals, a reasonable opportunity to respond to new information by presenting written evidence and testimony;

- A full and fair review by the Plan that takes into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim determination;
- With respect to health and disability benefit claims, the Plan will automatically provide you free-of-charge, with any new or additional evidence or rationale considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied initial claim. The Plan will automatically provide you with any new or additional evidence or rationale as soon as possible once it becomes available to the Plan and sufficiently in advance of the date on which notice of an adverse determination on appeal is scheduled to be provided to you. New or additional evidence or rationale will be provided to you so that you have a reasonable opportunity, sufficiently in advance of the date on which a notice of an adverse benefit determination upon appeal is required to be provided, to respond to the Plan regarding such evidence. If the new or additional evidence or rationale is received by the Plan so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, then the period for providing a notice of a final adverse benefit determination will be delayed (tolled) until you have had a reasonable opportunity to respond. After you respond (or do not respond after having a reasonable opportunity to do so), the Plan (acting in a reasonable and prompt manner) will notify you of its benefit determination upon appeal as soon as it can provide a notice of determination, taking into account any medical exigencies.
- A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary or fiduciaries of the Plan who is neither the individual who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- With respect to health and disability benefit claims appeals, continued coverage during the pendency of the appeal process; and
- In deciding an appeal of any adverse benefit determination regarding a health benefit claim that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or appropriate, the fiduciary or fiduciaries will:
  - Consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment; and
  - Is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
  - The Plan will provide, upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

### Appeal Determination Timeframes

For certain health benefit claims, the Plan maintains a two-level internal appeals process.

- Health Care Claims
  - **Pre-Service Claims** (applicable to medical, mental health, substance use disorder, Member Assistance Program (MAP), dental and prescription drug benefits).

    The following one-level appeal process applies to all medical, mental health, substance use disorder, dental and prescription drug claims unless services were denied as not medically necessary or as experimental or investigational. The one-level appeal process also applies to MAP claims.

    - A determination will be made and a written (or electronic, as applicable) notice regarding the appeal will be sent to you within 30 days from the date your written request for an appeal is received by the appropriate Appeals Reviewer. No extension of the Plan's internal appeal review timeframe is permitted.
    - The following two-level appeal process applies to all medical, mental health, substance use disorder, dental and prescription drug claims that were denied as not medically necessary or as

experimental or investigational.

- Under the Plan's two-level appeals process, the Appeals Reviewer will make the first level determination on the internal appeal of your initial Pre-Service Claim no later than fifteen (15) calendar days from the Plan's receipt of the appeal. You will be sent a written (or electronic, as applicable) notice of the appeal determination. If you are still dissatisfied with the first level of appeal review, you may request a second level of review by the Appeals Reviewer. You will have 180 calendar days from the date you received the notice of the first level review notice to request a second level appeal review by sending a written request to the Appeals Reviewer. A second level appeal determination will be made no later than fifteen (15) days from the Appeals Reviewer's receipt of your request for a second level appeal review. No extension of the Plan's internal appeal review timeframes is permitted.

– **Urgent Care Claims** (applicable to medical, mental health, substance use disorder, MAP, and prescription drug benefits). This is an expedited internal appeals process under which a written notice regarding a decision on the approval or denial of the expedited internal appeal will be sent to you (and your health care professional) no later than within 72 hours of the Plan's receipt of your (oral or written) request for appeal. If your situation involves an urgent medical condition, which the timeframe for completing an expedited internal appeal would seriously jeopardize your ability to regain maximum function, and the claim involves a medical judgment or a rescission of coverage, you may seek an expedited external review at the same time that you request an expedited internal appeal (you must seek both).

– **Concurrent Claims** (applicable to medical, mental health, substance use disorder, MAP, dental and prescription drug benefits). You may request an internal appeal of a Concurrent Claim by submitting the request orally (for an Urgent Care Claim) or in writing to the Appeals Reviewer. A determination will be made on the internal appeal, and you will be notified as soon as possible before the benefit is reduced or treatment is terminated.

– **Post-Service Claims** (applicable to medical, mental health, substance use disorder, MAP, dental, vision, hearing, prescription drug and HRA benefits).

The following one-level appeal process applies to all medical, mental health, substance use disorder, dental and prescription drug claims unless services were denied as not medically necessary or as experimental or investigational. The one-level appeal process also applies to MAP claims.

- A written (or electronic, as applicable) notice regarding the Plan's determination on the internal appeal will be sent to you within 60 days from the date your written request for an appeal is received by the Appeals Reviewer. No extension of the Plan's internal appeal review timeframe is permitted.

The following two-level appeal process applies to all medical, mental health, substance use disorder, dental and prescription drug claims that were denied as not medically necessary or as experimental or investigational.

- Under the Plan's two-level appeal process, the appropriate Appeals Reviewer will make the first level determination on the appeal of your initial Post-Service Claim no later than 30 calendar days from the Appeals Reviewer's receipt of the appeal request. There is no extension permitted in the two (2) level appeal process. Within this 30-day period, you will be sent a written (or electronic, as appropriate) notice of the appeal determination. If the first level appeal determination results in an adverse benefit determination, you will have 180 calendar days from your receipt of a notice of adverse benefit determination to request a second level appeal review by writing to the Appeals Reviewer. The Appeals Reviewer will then make a second level determination no later than 30 calendar days from its receipt of the second level appeal. You will then be provided with a written (or electronic, as applicable) notification of the second-level appeal determination no later than 30 days after the Plan's receipt of your request for a second level appeal.

- Disability (Accident and Sickness/Loss of Time) Benefit Claims

  [The Plan will make an appeal determination no later than the date of the meeting immediately following the Plan's receipt of your written request for an appeal, unless the request for an appeal review is filed within 30 calendar days preceding the date of such meeting. In such case, an appeal determination will be made no later than the date of the second meeting following the Plan's receipt of your written request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting following the Plan's receipt of your written request for review. If such an extension is necessary the Plan must provide you with a written (or electronic, as applicable) notice of extension describing the special circumstances and date the appeal determination will be made. The Board of Trustees will notify you of the benefit determination no later than five (5) calendar days after the benefit determination is made.]

- Life Insurance/Accidental Death and Dismemberment Insurance Benefit Claims

  A written (or electronic, as applicable) notice regarding a determination of your appeal will be sent to you within 60 days from the date your written request for an appeal is received by the Plan.

## Notice of Adverse Benefit Determination Upon Appeal

A written (or electronic, as applicable) notice of the appeal determination must be provided to you that includes:

- The specific reason(s) for the adverse benefit determination upon appeal, including (i) the denial code (if any) applicable to a health benefit claim and its corresponding meaning, (ii) a description of the Plan's standard (if any) that was used in denying the claim, and (iii) a discussion of the decision;
- Reference the specific Plan provision(s) on which the denial is based;
- A statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;
- A statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
- An explanation of the external review process, along with any time limits and information about how to initiate a request for an external review regarding the denied internal appeal of a health benefit claim;
- If the denial of a health or disability benefit claim was based on an internal rule, guideline, protocol, standard, or similar criterion a statement must be provided that such rule, guideline, protocol, or criteria will be provided free of charge, upon request;
- If the denial of a health benefit claim or disability claim was based on a medical judgement (medical necessity, experimental or investigational), a statement must be provided that an explanation regarding the scientific or clinical judgement for the denial will be provided free of charge, upon request;
- With respect to disability claims, a discussion of the Plan's initial claim determination, including the basis for disagreeing with (i) any disability determination by the Social Security Administration (SSA); (ii) the views of a treating health care professional or vocational expert evaluating the claimant, to the extent the Plan does not follow such views as presented by the claimant; or (iii) the views of medical professionals or vocational experts whose advice was obtained on behalf of the Plan, regardless of whether or not the advice was relied upon by the Plan in making an adverse benefit determination; and
- With respect to a health benefit claim, disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with internal claims and appeals and external review processes.

This concludes the appeal process under this Plan. The Plan does not offer a voluntary appeal process.

## Authorized Representative

The Plan recognizes an authorized representative as any person at least 18 years old whom you have designated in writing as the person who can act on your behalf to file an initial claim and appeal an adverse benefit determination under the Plan. An authorized representative under the Plan also includes a health care professional. You do not need to designate in writing that the health care professional is your authorized representative if that health care professional is part of the claim appeal. A health care provider with knowledge of your medical condition may act as your authorized representative in connection with an Urgent Care Claim without filing a written statement with the Plan.

The Plan requires you to provide a written statement declaring your designation of an authorized representative along with the representative's name, address, phone number, and email address. To designate an authorized representative, you must submit a completed authorized representative form (available from the appropriate Claims Administrator or Appeals Reviewer).

If you are unable to provide a written statement, the Plan will require written proof that the proposed authorized representative has the power of attorney for health care purposes (e.g., notarized power of attorney for health care purposes, court order of guardianship/conservatorship or is your legal spouse, parent, grandparent, or child over the age of 18).

Once the Plan receives an authorized representative form, all future claims and appeals-related correspondence will be routed to the authorized representative rather than to you. The Plan will honor the designated authorized representative for one (1) year before requiring a new authorization/until the designation is revoked, or as mandated by a court order. You may revoke a designated authorized representative status by submitting a completed change of authorized representative form available from and to be returned to the appropriate Claims Administrator/Appeals Reviewer.

The Plan reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual.

## Limitation on When a Lawsuit May be Started

You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before administrative agencies, until after all administrative procedures have been exhausted (including this Plan's internal claims and appeal procedures described in this section) for every issue deemed relevant by the claimant, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision. With respect to health and disability benefit claims, the law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them properly

In addition, with respect to health care claims, you are not required to exhaust external review before seeking judicial remedy.

No lawsuit may be started more than three years after the end of the year in which services were provided, or, if the claim is for disability benefits, more than three years after the start of the disability.

## Elimination of Conflict of Interest

With respect to health and disability benefits, to ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators, medical professionals and vocational experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

### Facility of Payment

If the Claims Administrator or its designee determines that you cannot submit a claim or prove that you or your covered dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the health care professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, the appropriate Claims Administrator nor any other designee of the Plan will be required to see to the application of the money so paid.

## External Appeal Procedures

If your initial claim for health care benefits has been denied (i.e., an adverse benefit determination) in whole or in part, and you are dissatisfied with the outcome of the Plan's internal claims and appeals process described earlier, you may (under certain circumstances) be able to seek external review of your claim by an Independent Review Organization ("IRO"). This process provides an independent and unbiased review of eligible claims in compliance with the Affordable Care Act.

### Claims Eligible for the External Review Process

Post-Service, Pre-Service, Urgent Care, and Concurrent Care Claims, in any dollar amount, are eligible for external review by an IRO if:

- The adverse benefit determination of the claim involves a medical judgment, including but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, denial related to coverage of routine costs in a clinical trial, or a determination that a treatment is experimental or investigational. The IRO will determine whether a denial involves a medical judgment.
- The denial is due to a rescission of coverage (i.e., the retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.
- The denial involves whether the Plan complied with the surprise medical billing and cost-sharing requirements under the No Surprises Act.

### Claims Not Eligible for the External Review Process

The following types of claims are not eligible for the external review process:

- Claims that involve only contractual or legal interpretation without any use of medical judgment.
- A determination that you or your dependent are not eligible for coverage under the terms of the Plan.
- Claims that are untimely, meaning you did not request review within the four (4) month deadline for requesting external review.
- Claims as to which the Plan's internal claims and appeals procedure has not been exhausted (unless a limited exception applies).
- Claims that relate to benefits other than health care benefits (such as disability benefits, life insurance benefits, and dental/vision benefits that are considered excepted benefits).

In general, you may only seek external review after you receive a "final" adverse benefit determination under the Plan's internal appeals process. A "final" adverse benefit determination means the Plan has continued to deny your initial claim in whole or part and you have exhausted the Plan's internal claims and appeals process.

Under limited circumstances, you may be able to seek external review before the internal claims and appeals process has been completed:

- If the Plan waives the requirement that you complete its internal claims and appeals process first.
- In an urgent care situation (see "Expedited External Review of an Urgent Care Claim"). Generally, an urgent care situation is one in which your health may be in serious jeopardy, or, in the opinion of your health care professional, you may experience pain that cannot be adequately controlled while you wait for a decision on your internal appeal.
- If the Plan has not followed its own internal claims and appeals process and the failure was more than a minor error. In this situation, the internal claims and appeal is "deemed exhausted," and you may proceed to external review. If you think that this situation exists, and the Plan disagrees, you may request that the Plan explain in writing why you are not entitled to seek external review at this time.

## External Review of a Standard (Non-Urgent Care) Claim

Your request for external review of a standard (not Urgent Care) claim must made in writing within four (4) months after you receive notice of an adverse benefit determination.

Because the Plan's internal claims and appeals process generally must be exhausted before external review is available, external review of standard claims will ordinarily only be available after you receive a "final" adverse benefit determination following the exhaustion of the Plan's internal claims and appeals process.

To begin the standard external review process, submit your written appeal to:

Blue Cross & Blue Shield of Rhode Island
Attention: Grievance and Appeals Unit
500 Exchange Street
Providence, RI 02903

### Preliminary Review of a Standard (Non-Urgent Care) Claim by the Plan

Within five (5) business days of the Plan's receipt of your request for external review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:

- You are/were covered under the Plan at the time the health care item or service is/was requested; or, in the case of a retrospective review, you were covered at the time the health care item or service was provided.
- The adverse benefit determination satisfies the above-stated requirements for a claim eligible for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination, or a failure to pay premiums causing a retroactive cancellation of coverage.
- You have exhausted the Plan's internal claims and appeals process (or a limited exception allows you to proceed to external review before that process is completed).
- Your request is complete, meaning that you have provided all of the information or materials required to process an external review.

Within one (1) business day of completing its preliminary review, the Plan will notify you in writing whether:

- Your request is complete and eligible for external review.
- Your request is complete but not eligible for external review. (In this situation, the notice will explain why external review is not available and provide contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).)
- Your request is incomplete. (In this situation, the notice will describe the information or materials needed to make the request complete. You must provide the necessary information or materials within the four (4)

month filing period, or, if later, within 48 hours after you receive notification that your request is not complete.)

### Review of a Standard (Not Urgent Care) Claim by the IRO

If your request is complete and eligible for external review, the Plan will assign it to an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims, and it rotates assignments among these IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

Once the claim has been assigned to an IRO, the following procedures apply:

- The IRO will timely notify you in writing that your request is accepted for external review.
- The IRO will explain how you may submit additional information regarding your claim if you wish. In general, you must provide additional information within ten (10) business days. The IRO is not required to, but may, accept and consider additional information you submit after the ten (10) business day deadline.
- Within five (5) business days after the claim has been assigned to the IRO, the Plan will provide the IRO with the documents and information it considered in making its adverse benefit determination.
- If you submit additional information to the IRO related to your claim, the IRO must forward that information to the Plan within one (1) business day. Upon receipt of any such information (or at any other time), the Plan may reconsider its adverse benefit determination regarding the claim that is the subject of the external review. Any reconsideration by the Plan will not delay the external review. If Plan reverses its determination after it has been assigned to an IRO, the Plan will provide written notice of its decision to you and the IRO within one (1) business day. Upon receipt of such notice, the IRO will terminate its external review.
- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo, meaning that the IRO is not bound by the Plan's previous internal claims and appeal decisions. However, the IRO must review the Plan's terms to ensure that its decision is not contrary to the terms of the Plan, unless those terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, medical necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.
- To the extent additional information or materials are available and appropriate, the assigned IRO may consider the additional information including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).
- In a standard case, the IRO will provide written notice of its final decision to you and the Plan within 45 days after the IRO receives the request for the external review.

The IRO's decision notice will contain:

- A general description of the reason(s) for the request for external review, including information sufficient to identify the claim, including the date or dates of service, the health care provider, the claim amount (if applicable), and the reason for the previous denial.
- The date that the IRO received the assignment to conduct the external review and the date of the IRO decision.
- References to the evidence or documents, including the specific coverage provisions and evidence-based standards, considered in reaching its decision.
- A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards relied upon.
- A statement that the IRO's decision is binding on you and the Plan, except to the extent that other remedies may be available to you or the Plan under applicable state or federal law.

- A statement that judicial review may be available to you.
- A statement regarding assistance that may be available to you from an applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act.

The contact information for the office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes is:

Rhode Island Consumer Assistance Program
Rhode Island Parent Information Network, Inc.
1210 Pontiac Avenue
Cranston, RI 02920
(855) 747-3224
http://rireach.org (website)
rireach@ripin.org (email)

## Expedited External Review of an Urgent Care Claim

You may request an expedited external review in the following situations if:

- You receive an adverse benefit determination regarding your initial claim that involves a medical condition for which the timeframe for completion of an expedited internal appeal 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.
- You receive a "final" adverse benefit determination after exhausting the Plan's internal appeals procedure that (i) involves a medical condition for which the timeframe for completion of an standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or (ii) concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, and you have not yet been discharged from a facility.

### Preliminary Review of an Urgent Care Claim by the Plan

Immediately upon receipt of a request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described above for the standard claim external review process). The Plan will defer to your attending health care professional's determination that a claim constitutes "urgent care." The Plan will immediately notify you (e.g., telephonically, via fax) whether your request for review meets the requirements for expedited review, and if not, it will provide or seek the information described above for the standard claim external review process.

### Review of an Urgent Care Claim by the IRO

Upon a determination that a request is complete and eligible for an expedited external review following the preliminary review, the Plan will assign an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims and rotates assignments among those IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

The Plan will expeditiously provide or transmit to the IRO all necessary documents and information that it considered in making its internal adverse benefit determination.

The IRO, to the extent the information or documents are available, and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review. In reaching a decision, the IRO must review the claim de novo meaning that it is not bound by any previous decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO decision must not be contrary to the terms of the plan, unless the terms are inconsistent with applicable law. For example, the IRO must observe all of

the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above for the standard claim external review process, as expeditiously as your medical condition or circumstances require, but not more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If notice of the IRO decision is not provided to you in writing, the IRO must provide written confirmation of the decision to you and the Plan within forty-eight (48) hours after it is made.

## What Happens after the IRO Decision is Made?

- If the IRO's final external review decision reverses the Plan's internal adverse benefit determination, upon the Plan's receipt of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.
- If the final external review upholds the Plan's internal adverse benefit determination, the Plan will continue not to provide coverage or payment for the reviewed claim.
- If you are dissatisfied with the external review determination, you may seek judicial review to the extent permitted under ERISA section 502.

# Use and Disclosure of Protected Health Information

A. Use and disclosure of Protected Health Information (PHI): The Fund will use protected health information to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Fund will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations.

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

1. Determination of eligibility, coverage, and cost sharing amounts (e.g., cost of a benefit, plan maximums, and copayments as determined for an individual's claim);
2. Adjudication of health benefit claims;
3. Determining appeals and other payment disputes;
4. Coordination of benefits;
5. Subrogation of health benefit claims;
6. Establishing contribution rates for contributing employers;
7. Establishing employee contributions as necessary;
8. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
9. Billing, collection activities and related health care data processing;
10. Claims management and related health care data processing, including auditing payments, investigating, and resolving payment disputes;
11. Responding to member and beneficiary (and their authorized representatives) inquiries about payments;
12. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
13. Medical necessity reviews, or reviews of appropriateness of care or justification of charges;
14. Utilization review, including pre-certification, pre-authorization, concurrent review, and retrospective review;
15. Reimbursement of overpayments to the Fund; and
16. Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, SSN, payment history, account number, and name and address of the provider and/or health plan).

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

1. Quality Assessment;

2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives; and related functions;

3. Rating provider and plan performance, including accreditation, certification, licensing, or credentialing activities;

4. Underwriting, premium rating, and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);

5. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development, or improvement of methods of payment or coverage policies; and

7. Business management and general administrative activities of the entity, including, but not limited to:

   - Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;
   - Customer service, including the provision of data analyses for policyholders, plan sponsors, or other customers;
   - Resolution of internal grievances;
   - Filing Form 5500 and 990 and other activities necessary to ensure compliance with applicable federal laws, including the Internal Revenue Code; and
   - Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.

B. The Fund will use and disclose PHI as required by law and as permitted by authorization of the participant or beneficiary. With an authorization, the Fund will disclose PHI to the following for purposes related to administration of these plans: Fund staff and or insurers when processing a claim for the loss of time (disability) benefit, AD&D and/or life insurance benefits, the pension plan, annuity plan, contributing employers, the Union and workers' compensation insurers.

C. For purposes of this section the Board of Trustees of the Rhode Island Laborers' Health & Welfare Fund is the Plan Sponsor. The Fund will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the plan documents have been amended to incorporate the following provisions.

With respect to PHI, the Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by the plan document or as required by law;

2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI

received from the Fund agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

3. Not use or disclose the information for employment-related actions and decisions unless authorized by the individual;

4. Not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual;

5. Report to the plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

6. Make available PHI to the individual in accordance with the access requirements of HIPAA;

7. Make available PHI for amendment and incorporate any amendments to PHI in accordance with HIPAA;

8. Make available the information required to provide an accounting of disclosures in accordance with HIPAA;

9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health plan available to the Secretary of HHS for the purposes of determining compliance by the group health plan with HIPAA; and

10. If feasible, return or destroy all PHI received from the Fund that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

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

1. The Co-Administrators to oversee the administration of the Fund;

2. Staff responsible for determining eligibility, adjudicating claims or responsible for the administration of the Fund; and

3. Staff designated by the Co-Administrators based on their job title and function.

E. The persons described in section D may only have access to and use and disclose PHI for Fund administration functions that the Plan Sponsor performs for the Fund unless additional use or disclosure is authorized by the individual.

F. If the persons described in section D do not comply with this plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Effective March 26, 2013, HIPAA was modified by the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) and the Genetic Information Nondiscrimination Act of 2008 (GINA) (collectively referred to as the "HIPAA Omnibus Rules"). Effective December 23,2024, HIPPA was amended to restrict disclosure of your lawful receipt of reproductive health care without written authorization or an attestation for the purposes of identifying you or use for criminal, civil, or administrative investigation or liability. The Fund acts in accordance with the uses and disclosures of PHI as modified by HITECH, GINA, and the reproductive healthcare rules.

For purposes of complying with the HIPAA privacy rules, this Fund is a "Hybrid Entity" because it has both health plan and non-health plan functions, including the loss of time (disability) benefit, AD&D, and life insurance. The Fund designates that its health care components that are covered by the privacy rules include only health benefits and not any other plan functions or benefits.

## Notice of Privacy Practices

Please refer to the Fund's website for a copy of the Fund's Notice of Privacy Practices.

# Your ERISA Rights

As a participant in the Rhode Island Laborers' Health & 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 are entitled to the following rights:

## Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all documents governing the Plan. These documents include insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. 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.

## Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

## Prudent Actions by Plan Fiduciaries

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

## Enforce Your Rights

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

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

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status

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

## Assistance with Your Questions

If you have any questions about your plan, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Office, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory. Alternatively, you may obtain assistance by calling EBSA toll-free at 866-444-EBSA (3272) or writing to the following address:

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 obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of EBSA at 800-998-7542 or contacting the EBSA field office nearest you.

You may also find answers to your plan questions and a list of EBSA field offices at the website https://www.dol.gov/agencies/ebsa.

# Other Important Notices

## Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal (or state) law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## Women's Health and Cancer Rights Act of 1998

In accordance with the Women's Health and Cancer Rights Act of 1998, the Plan will provide certain coverage for benefits received in connection with a mastectomy, including reconstructive surgery following a mastectomy as set forth your BCBSRI Benefit Booklet. This coverage applies to any covered employee or dependent, including you, your spouse, and your dependent child(ren).

If the covered person receives benefits under the Plan in connection with a mastectomy and elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the covered person. Coverage may apply to:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses, and
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Benefits for breast reconstruction are subject to annual Plan deductibles and coinsurance provisions that apply to other medical and surgical benefits covered under the Plan.

## Designation of Primary Care Provider/Access to ObGyn

The Plan does not require the designation of a primary care provider (PCP). You have the right to designate any primary care provider who is available to accept you or your family members. For the purpose of this Plan, gynecologists, obstetricians, nurse practitioners, and physician assistants may be credentialed as PCPs.

For children, you may designate a pediatrician as the PCP.

You do not need prior authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology.

### How to Find a PCP or Other Provider

Finding a **PCP** in the BCBSRI **network** is easy. To select a provider, or to check that a provider is in the BCBSRI network, use the "Find a Doctor" tool on the BCBSRI website at http://www.bcbsri.com/ or call the Customer Service Department at In state: 401-459-5000; Out of state: 1-800-639-2227; Hearing impaired: 711.

## Rescission of Coverage

The Fund will not retroactively rescind its coverage of medical, prescription drug, dental or vision benefits. A rescission of coverage is a cancellation or discontinuance of coverage that has a retroactive effect, meaning that it will be effective back to the time that you should not have been covered by the Fund. Generally, the Fund is not permitted to rescind your coverage unless you commit fraud or make an intentional misrepresentation of a material fact, and the Fund provides you at least 30-days advance notice. You are obligated by law to disclose information to the Fund—for example, Medicaid eligibility, divorce, remarriage (you or your ex-spouse). Coverage that is terminated due to the failure to pay premium, where applicable, is not considered a rescission.

## Recovery of Overpayment

Whenever payments have been made exceeding the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these expenses from any individual (including you, and the insurance company or any other organization receiving excess payments). The Plan may also withhold payment, if necessary, on future benefits until the overpayment is recovered. In addition, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

## Non-Assignment of Benefits

Plan participants cannot assign, pledge, borrow against, or otherwise promise any benefit payable under the Plan before receipt of that benefit. However, benefits will be provided to a participant's child if required by a Qualified Medical Child Support Order. In addition, subject to the written direction of a Plan participant, all or a portion of benefits provided by the Plan may, at the option of the Plan, and unless a participant requests otherwise in writing, be paid directly to the person rendering such service. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan and the Fund to the extent of such payment.

## Misstatement of Fact

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

# Plan Facts

| Item | Description |
|---|---|
| **Name of Plan** | The Rhode Island Laborers' Health & Welfare Fund |
| **Type of Plan** | An Employee Health and Welfare Benefit Plan that provides health care, life insurance and accidental death and dismemberment benefits to eligible employees and their qualified dependents. |
| **Name of Plan Sponsor** | Board of Trustees<br>Rhode Island Laborers' Health & Welfare Fund |
| **Fund Administrator** | Rhode Island Fund Office and Solxsys |
| **Fund Office Address** | Rhode Island Laborers' Health & Welfare Fund<br>410 South Main Street<br>Providence, RI 02903<br>Telephone: 401-942-8690 |
| **Agent for Service of Legal Process** | Service of legal process may be made upon any Fund Trustee. |
| **Type of Administration of the Plan** | Collectively Bargained, jointly-trusteed labor management trust |
| **Plan Number** | 501 |
| **IRS Employer Identification Number** | 05-0368200 |
| **Plan Fiscal Year** | January 1—December 31 |
| **Sources of Financing** | Payments made to the trust by individual employers under the provisions of the Collective Bargaining or Participation Agreements, employee contributions, and any income earned from investment of employer and employee contributions. Copies of Collective Bargaining Agreements may be obtained upon written request to the Fund Administrator and are available for examination by participants and beneficiaries.<br>Participants and beneficiaries may receive from the Fund Administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the Fund and, if the employer or employee organization is a Fund sponsor, the sponsor's address.<br>All monies are used exclusively for providing benefits to eligible employees and their dependents, and the paying of all expenses incurred with respect to the operation of the Plan. The Trustees shall review annually the funding status of the Plan. |
| **Organizations Through Which Plan Benefits are Provided** | Medical Care - Blue Cross & Blue Shield of Rhode Island<br>Dental Care - Blue Cross Dental<br>Vision Care - Davis Vision<br>Member Assistance Program - Spring Health<br>Life Insurance and AD&D Insurance - Union Labor Life Insurance Company |

# The Board of Trustees

The Board of Trustees is made up of an equal number of Management Representatives and Union Representatives who serve without compensation. Under a Trust Agreement, the Board has full authority and discretion to operate and administer this Plan.

# Discretionary Authority of the Board of Trustees and its Designees

In carrying out their respective responsibilities under the Plan, the Board of Trustees, the Fund Administrator and other individuals with delegated responsibility for the administration of the Plan will have discretionary authority to interpret the terms of the Plan, make factual determinations regarding all aspects of the Plan and its benefits, and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination will be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious.

# Plan Amendment and Termination

The Board of Trustees reserves the right to terminate or amend the Plan including the right to amend or terminate benefits or eligibility for any class of participant, when in their sole discretion they determine such action is in the best interest of the Fund or its participants. In addition, the Plan may be terminated by the Trustees if there is no longer an agreement in effect between the Employers and the Union requiring contributions to the Fund.

Should the Plan terminate, the Trustees will apply remaining assets of the Fund to continue benefits beyond the date of termination. The Trustees reserve the right to amend the eligibility rules at the time of termination. In any case, the Trustees will use any remaining assets of the Fund to provide benefits and pay administration expenses or otherwise to carry out the purpose of the Plan in accordance with the Plan Document and Trustee Agreement until the entire remainder of the Fund has been disbursed.

## Trust Agreement and Other Attachments Govern

Please note that this SPD is a summary of the Plan. The full plan of benefits is contained in the Attachments. If there is any discrepancy between this summary and the Attachments, the Attachments govern. The Attachments include the Trust Agreement, Benefit Booklets, Collective Bargaining Agreements, and Insurance Contracts, which contain the information on which this Booklet is based. You can access the Benefit Booklets on the Fund's website at https://rilbf.com/en/health/. You can request paper copies of this Booklet and the Attachments from the Fund Office free of charge. In addition, this Booklet and the Attachments are available for inspection or copying at the office of the Fund Administrator.

## Rhode Island Laborers' Health & Welfare Fund

410 South Main Street
Providence, RI 02903
Telephone: 401-942-8690