PLUMBERS AND STEAMFITTERS LOCAL 60

HEALTH AND WELFARE PLAN

SUMMARY PLAN DESCRIPTION
Revised July 1, 2014

Administrative Office:

P.O Box 8428
3515 I-10 Service Road
Metairie, LA 70011
(504) 885-3062

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BOARD OF TRUSTEES

Union Trustees	Employer Trustees
Mr. Chester Cabirac	Mr. Curtis Mezzic
Mr. Henry G. Heier	Mr. Ronnie Rosser
Mr. Pat Gootee	Mr. Mike Eilers

PREFERRED PROVIDER ORGANIZATION

Blue Cross/Blue Shield

UTILIZATION REVIEW COORDINATOR

Med-Care Management
(800) 367-1934

NOTICE TO MEDICAL SERVICE PROVIDERS

PRIOR AUTHORIZATION is required before all non-emergency and non-childbirth hospital admissions and surgeries. **EMERGENCY** admissions and surgeries must be reviewed within forty-eight (48) hours of admission. Please call the Utilization Review Coordinator above for authorization.

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INTRODUCTION

TO ALL PLAN PARTICIPANTS:

We are pleased to provide you with this updated Summary Plan Description (SPD) benefit booklet. This SPD provides a brief description of the benefits, limitations, and exceptions that are provided under the Plumbers and Steamfitters Local 60 Health and Welfare Plan (the "**Plan**"), and its plan of benefits described in the Plan documents adopted by the **Trustees**.

This booklet includes a description of your **Plan**. It includes important information about your eligibility, your benefits and other Plan provisions and rules. We encourage you to use this booklet, rather than the 8-page "Summary of Benefits and Coverage".

We urge you to read this new booklet carefully so that you will understand the benefits to which you and your **Dependents** may be entitled. While it is hoped that everyone will enjoy good health at all times, we believe that you will feel, as we do, that the **Plan** benefits will provide financial security in times of need.

Other changes and improvements in your **Plan** may be made from time to time. An explanation of any such changes in your **Plan** will be sent to your last known address.

Please remember that for your protection, only we, as the **Trustees**, are authorized to interpret this **Plan**.

The Plumbers and Steamfitters Local 60 Health and Welfare Plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act, or "ACA"). As permitted by the ACA, a grandfathered plan can preserve certain basic health coverage that was already in effect when that law was passed. Being a grandfathered health plan means that your plan does not include certain consumer protections of the ACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered plans must comply with certain other consumer protections in the ACA, for example, the elimination of lifetime limits on benefits.. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the administrative office.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans..

If you have any questions about your eligibility or benefits, please do not hesitate to contact the administrative office.

Board of Trustees

SCHEDULE OF BENEFITS

ACTIVE EMPLOYEES

Death Benefit $7,500.00

Accidental Death and Dismemberment Benefit
Loss of life or 2 hands, feet, eyes or any combination $7,500.00
Loss of 1 hand, foot or eye.....$3,750.00

Non-occupational accidental Injury or Sickness (Temporary Disability Income) Benefits

Benefits to begin on the fourth day of disability and are payable for a maximum of 91 continuous days of disability:

per day.....$ 25.00
per week.....$ 175.00
maximum $2,275.00

EMPLOYEES AND DEPENDENTS

COMPREHENSIVE MAJOR MEDICAL BENEFITS

Calendar Year Deductible: $300 per individual.
(Any **Eligible Charge** incurred in the last 3 months of a calendar year in which you do not satisfy your deductible will be carried over and counted toward your deductible in the next calendar year)

Co-insurance: 80% of **eligible charges** within the **network**, 70% for eligible charges **out-of-network**. 80% for emergency medical care for a serious condition and for Participants living more than 35 miles from any network provider. 50% for covered dental work, treatment and/or x-rays required by accidental traumatic injury.

Exceptions and special limits:

Room and Board Allowance: Limited to the average semi-private room rate.

Assistant Surgeon Fees: Limited to 20% of **Eligible Charges** for principal surgeon.

Out-patient Chiropractic: Limited to 30 visits per calendar year.

Pre-Hospital admission (non-emergency) and pre-outpatient surgery authorization requirements apply; however, Hospital stays for childbirth require pre-authorization only for the portion of the stay, if any, that exceeds 48 hours for normal vaginal delivery and 96 hours for Caesarian section. Notice to Plan's Utilization Review Program coordinator of emergency Hospital admission must be given within 48 hours following admission.

Surgery or treatment intended to correct vision (includes Lasik surgery, laser surgery, RK surgery, PRK surgery and similar surgeries): Limited to one surgery per eye with a lifetime maximum of $500 per eye.

Hospice Care: $25,000 lifetime maximum.

Hearing Aids: $1,400 per ear with hearing loss over 36-month period (Dependents under age 18 only).

PRESCRIPTION DRUG BENEFITS

	Co-pay for retail pharmacy purchases (30 day supply)	Co-pay for home delivery purchases (90 day supply)
Generic	$10	$20
Preferred Brand	$25	$50
Non-Preferred Brand	$25	$50

The prescription drug benefits are subject to other use programs or restrictions that might apply from time to time. There may be restrictions on the number of refills, or the use of certain brand drugs, or requirements to try generic drugs first. We will notify you of these programs or restrictions as they are implemented. For more information contact the administrative office.

Note: If you enroll in a Medicare prescription drug plan (Medicare Part D) you will <u>not</u> be eligible for the prescription drug benefits under this Plan.

DOING YOUR PART

The **Trustees** of the Plumbers and Steamfitters Local 60 Health and Welfare Plan constantly work to provide you the best healthcare coverage possible within the financial means of the **Plan**. The Fund Office staff does it best to answer your questions, to see that your claims are paid as promptly as possible, and to notify you of information that is important to you.

You, as a Participant in this Plan, must also assume certain responsibilities in order to protect your eligibility and to receive your benefits from the Plan. An Employee will become a Participant under the Plan when, and as long as, the Employee is eligible for benefits under the Plan.

Be sure you have an up-to-date Participant Enrollment/**Beneficiary** form on file at the Fund Office and notify the Fund Office immediately if any of following situations occurs:

1. There is a change of address.
2. There are new **Dependents** to be covered. (Provide certified copies of the birth certificates or other documents applicable to acquiring a new **Dependent**).
3. There is a divorce/legal separation. (Provide court certified divorce/legal separation papers).
4. There is a marriage. (Provide a certified copy of the marriage license or other state's equivalent document.
5. There is a death. (Provide a certified copy of the death certificate).
6. There is a change of **beneficiary**. (You can change your **beneficiary** at any time, but you must submit a new enrollment form).
7. There is an accident, which results in Workers' Compensation benefits. (Advise the Fund Office of the date of the accident, the claims number and the duration of the disability).
8. An injury is suffered or you have an illness, which results in permanent and total disability.
9. **Dependent** ceases to be a **Dependent**.
10. There is an accident or incident that results in medical claims under the **Plan**, for which a third-party (or their insurer) is or may be legally responsible.

NINE WAYS TO CONTROL YOUR HEALTH CARE BILLS

You **can** control your health care expenses. Start now. Although you may already be a conscientious user of the health care system, by practicing **all** nine ways listed below to control your health care expenses, you will positively affect your pocketbook and your health.

1. **Treat** yourself **right.** Many illnesses and Injuries can be prevented. Major illness such as heart disease is often connected with lifestyle. Smoking, excessive drinking of alcoholic beverages, improper diet and stress are a few of the factors that can cause heart disease. By eating right, getting enough sleep and exercising regularly, you can be on the road to preventing illness, both major and minor. Remember to wear your seatbelts when driving and take the time to be careful around your home to avoid unnecessary household accidents.

2. **Ask "dumb" questions.** Actually, the only dumb questions are the ones you don't ask.
   - Verify that all of the providers of service meet the definition of Physician as listed in this booklet.
   - Ask about charges on your Hospital bill if you don't understand them. Hospitals have people who can help answer your billing questions.
   - Patients who are informed about what to expect during their Hospital treatment usually recover faster and with fewer complications than patients who are uninformed. Many Hospitals have patient information programs to help you. Use them!
   - Inquire about the costs of medications. Generic drugs often cost less than name brands and your Physician may prescribe them if you ask.
   - If you have any doubts or questions about a treatment or procedure your Physician has recommended for you, get a second opinion from another Physician or health care professional.

3. **Don't be in when you can be out.** Ask your Physician about the use of outpatient services in your Hospital or Physician's office for tests, treatments and many types of minor surgery. Outpatient care is always less expensive than a stay in the Hospital and can often accomplish the same objective.

4. **Use the emergency room for "emergencies."** Your Hospital's emergency room is an expensive place to treat minor aches and ailments. When possible, contact your Physician before deciding to use the emergency room.

5. **Understand your coverage before you have to use it.** Make sure you understand your health coverage. Read this Booklet. It describes how the benefits will work and what is and what is not covered.

6. **The shorter your stay, the less you pay.** When it is practical, have tests performed before you enter the Hospital. Except in emergencies; avoid being admitted to the Hospital at night or on the weekend because you may spend unnecessary time waiting for surgery or special treatment. Also, it is important to leave the Hospital as soon as your Physician tells you that you are ready.

7. **Don't expect a "free lunch."** Be a cost-conscious consumer. Even though our Fund or the government may pay for most of your health care needs, the services and treatment you receive are **never** free. If you make an effort to control how you use health care services, everyone will benefit, especially you.

8. **Watch for early warnings!** Learn the early warning signs of diseases such as heart disease and cancer. Early detection of illnesses could save your life and **will** save you money.

9. **Use Network Providers**. The Fund pays 80% of the Covered Charges when you and your Dependents use an in-network provider for medical services (rather than 70% for an out-of-network provider). The in-network providers discount their medical fee so you and the Plan will save money from the discounted medical charge.

These 9 steps may lead you to better health and lower medical expenses!

DEFINITIONS

The following general definitions of terms used in the **Plan** may be helpful in understanding the benefits which are provided and your rights under the **Plan**. These special terms are **bolded** throughout this booklet.

Accidental Injury means a condition that occurs as a direct result of a traumatic bodily injury sustained solely from accidental means from an external force. With respect to teeth, injuries caused by an intrinsic force such as biting, chewing, clenching or grinding are not caused by an external force.

Allowable Amount means the maximum amount payable for an **Eligible Charge** under the **Plan**, and is the lowest of the following amounts: (a) the provider's actual charge; (b) for an **In-Network** provider, the negotiated discounted amount; and (c) for an **Out-of-Network** provider, the amount allowed by the **Plan** under the methodology and/or fee schedule approved for use by the **Trustees** from time to time.

Beneficiary means a person or persons who is or may become entitled to receive a benefit under the **Plan** by reason of the death of a covered **Employee**, determined in accordance with the terms of the **Plan** and any policy of insurance in effect, or applicable law.

Board of Trustees or Trustees means the persons who serve as the Employer Trustees and Union Trustees for the **Plan** and **Fund**, and their successors.

Chemical Dependency Inpatient Care Unit means a unit in a **Hospital** or other properly equipped medical setting, licensed and operating in accordance with the law of the jurisdiction in which it is located, that is under the direction of a **Physician** and provides medical and social services on a twenty-four (24) hour basis for the diagnosis and treatment of alcohol and drug abuse and, incident thereto, any psychiatric or other medical disorders related to the misuse of alcohol or drugs.

Collective Bargaining Agreement, or **CBA,** means the written agreement between any **Employer** and the **Union** which requires the **Employer** to make contributions to the **Fund** on behalf of its **Employees** in **Covered Employment**.

Covered Employment means employment for which an **Employer** is obligated to make contributions to the **Fund** on behalf of its **Employee**, pursuant to a **Collective Bargaining Agreement** or **Participation Agreement**.

Custodial Care means care consisting of services, supplies, room and board and/or other institutional services, furnished to an individual for the primary purpose of assisting him in the activities of daily living, whether or not he is disabled and regardless of whether such care has been prescribed or recommended by a **Physician** or other provider.

Dependent means:

(a) the **Employee's** lawful spouse; and

(b) An **Employee's** child, stepchild or child who is legally adopted by or placed for adoption with the **Employee** (irrespective of whether the adoption becomes final), who has not attained age 26; and

(c) An **Employee's** unmarried child, stepchild, or child who is legally adopted by or placed for adoption with the **Employee** before age 26 (irrespective of whether the adoption becomes final), who is incapable of self-sustaining employment by reason of a mental or physical handicap which begins before age 26, and who is chiefly dependent upon the **Employee** for support and maintenance. Satisfactory proof of the incapacity and dependency must be furnished to the **Trustees** whenever requested; and

(d) an Alternate Recipient.

The term "placed for adoption" means the **Employee** has assumed and retains a legal obligation for the total or partial support of the child in anticipation of adoption, regardless of whether the adoption becomes final. A child's placement for adoption with the **Employee** terminates when the **Employee's** legal obligation for the child ends. The **Plan** may from time to time require acceptable documentation and proof that a **Dependent** qualifies as a **Dependent** under the **Plan**.

If a person qualifies for coverage under the **Plan** in more than one capacity (for example, as an eligible **Dependent** and an eligible **Employee** or as an eligible **Dependent** of more than one eligible **Employee**), he will be covered under the **Plan** in one capacity only. If there is a difference in the level of benefits available for the different capacities, he will be covered in the capacity that has the highest level of benefits.

Eligible Charge means the charge incurred by a **Participant** while covered under the **Plan**, for **Medically Necessary** services and/or supplies which are covered for medical benefits under the **Plan**, not to exceed the **Allowable Amount**.

Employee means a person who is employed by an **Employer** in **Covered Employment**.

Employer means any Employer that is signatory to a **Collective Bargaining Agreement** or a **Participation Agreement** that requires contributions to the **Fund** on behalf of the **Covered Employment** of its **Employees**. **Employer** includes the **Union** and the Plumbers and Steamfitters Local 60 Pension, Health and Welfare, and Education Funds.

Experimental or **Investigative** means a drug, device, medical treatment or procedure that is determined by the **Plan** to meet one or both of the following criteria in relation to the condition for which it is being dispensed or rendered:

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

(b) Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials may be necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with a standard means of treatment or diagnosis. Reliable evidence includes but is not limited to published reports and articles in the authoritative medical and scientific literature; the written protocol(s) used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Fund Office means the Plumbers and Steamfitters Local 60 administrative office located at 3515 I-10 Service Road, Metairie, Louisiana 70011.

Hospital means an institution in the United States or any of its territories or possessions which makes charges and is engaged primarily in providing medical care and treatment to sick and injured persons on an inpatient basis at the patient's expense, and which fully meets all of the following requirements:

(a) it is an institution operating in accordance with the law of the jurisdiction in which it is located pertaining to institutions identified as hospitals;

(b) it is primarily engaged in providing medical diagnosis, treatment and care of injured or sick persons by or under the supervision of a staff of physicians or surgeons for compensation from its patients on an inpatient basis;

(c) it continuously provides twenty-four (24) hour nursing services by Registered Nurses on the premises; maintains facilities on the premises for major operative surgery and is not, other than incidentally, a nursing home, a place for rest, a place for the aged, or a place for the mentally ill or emotionally disturbed; and

(d) it is accredited by the Joint Commission on Accreditation of Hospitals or is recognized by the American Hospital Association and is qualified to receive payments under the Medicare program.

Inpatient means a person receiving services and/or supplies for the treatment of an injury or condition as a registered bed patient in a Hospital, being charged for the room and board facilities of the **Hospital** for a full day.

In Network means any **Hospital**, **Physician** or medical provider which, by contractual agreement with the **Plan** or its Preferred Provider Organization, has agreed to charge reduced or discounted rates whenever services and/or supplies are provided to **Participants**.

Medically Necessary means services or supplies provided by a **Hospital**, **Physician** or other medical provider to identify or treat an illness or injury which a **Physician** has diagnosed or reasonably suspects, that satisfy all of the following conditions as determined by the Administrator:

(a) They are consistent with the diagnosis and treatment of the condition;
(b) They are not primarily for the convenience of the **Participant**, **Physician** or provider;
(c) They are in accordance with nationally accepted standards of medical practice;
(d) They are not **Experimental**, **Investigative** or of an educational nature;
(e) They are not provided primarily for medical or other research; and
(f) They are performed in the least costly setting required by the condition.

The fact that a **Physician** prescribes, recommends, orders or approves a service or supply does not necessarily mean that it is Medically Necessary.

Out of Network means any Hospital, Physician or medical provider that is not **In Network**.

Outpatient means a person receiving services and/or supplies for the treatment of an injury or condition in a **Hospital** but not on an **Inpatient** basis.

Participant means any **Employee** or former **Employee** or **Dependent** thereof, who satisfies the eligibility requirements and qualifies for coverage under the **Plan**.

Participation Agreement means a written agreement between the **Trustees** and an **Employer**, which provides for the participation of the **Employer's Employees** in the **Plan** and requires the **Employer** to make payments to the **Plan** for such participation.

Physician means a Doctor of Medicine or a Doctor of Osteopathy legally qualified and licensed to practice medicine and practicing within the scope of the license at the time and place the service is rendered, as well as a clinical psychologist when referred by a Doctor of Medicine or Doctor of Osteopathy, and a Board Certified Social Worker when rendering services in connection with a diagnostic consultation provided by a Doctor of Medicine or Doctor of Osteopathy.

Plan means the Plumbers and Steamfitters Local 60 Health and Welfare Plan, most recently amended and restated effective July 1, 2014.

Plan Administrator means the **Board of Trustees**, whose official address is the Fund Office.

Room and Board means all of the charges commonly made by a **Hospital** on its behalf for room and meals and for all general services and activities essential for **Inpatient** care.

Trust Fund or **Fund** means the trust estate of the Plumbers and Steamfitters Local 60 Health and Welfare Trust as established and maintained pursuant to its trust agreement, and all property of whatever nature including but not limited to Employer Contributions, insurance policies issued to and held by the **Trustees**, investments held and made by the **Trustees** and income from investment held by the Trustees, which is held in trust pursuant to the Trust Agreement for the uses and purposes set forth therein.

Union or **Local Union** means the Plumbers and Steamfitters Local Union 60 of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada, AFL-CIO ("United Association"), and any other union that is affiliated with the United Association and which becomes a party to the trust agreement.

ELIGIBILITY FOR COVERAGE RULES

1. Initial Eligibility for Employees

a) General Rule

You become eligible to participate in the **Plan** at 12:01 a.m. on the day after the day you are credited with at least seven hundred (700) hours in **Covered Employment** during a period of six (6) or fewer consecutive calendar months. Your coverage continues through the last day of the first Benefit Quarter that begins on or after your initial effective date of coverage. The "Benefit Quarters" are: (a) February, March and April; (b) May, June and July; (c) August, September and October; and (d) November, December and January. Thereafter, your continuing eligibility for coverage will be determined in accordance with the rules set forth in part 2 below.

b) Special Initial Eligibility Rule for Certain New Employers and Certain Targeted Employees:

If you are (i) employed by a non-bargaining unit employer in the building and construction trades industry and geographic area covered by the **Collective Bargaining Agreement**, in work that is not **Covered Employment** but would have qualified as **Covered Employment** if the non-bargaining unit employer had been covered by the **CBA**, and (ii) you become an **Employee** covered by the **CBA** for either reason described below, you will initially qualify for coverage under the **Plan** beginning at 12:01 a.m. on the first day of your **Covered Employment** (ignoring the minimum hour requirement in (a) above):

(1) Your non-bargaining unit employer becomes an **Employer** under the Plan; or

(2) At the **Union's** request (and exercisable only once for an individual), you leave your non-bargaining unit employer to work for an **Employer** in **Covered Employment** and you submit to the **Plan** a written certification from the **Union** that you are a "targeted employee".

If you qualify under this special rule, your initial period of coverage will continue through the last day of the first Benefit Quarter that begins on or after your initial effective date of coverage. Thereafter, your continuing eligibility for coverage will be determined in accordance with the rules set forth in part 2 below. You may initially qualify for **Plan** coverage (or reinstatement of **Plan** coverage) under this special rule by reason of being a "targeted employee" only once.

2. Continuing Eligibility

Once you satisfy the initial eligibility requirements, your coverage will continue on a quarterly (3 month) basis for future Benefit Quarters as long as you continue to work 400 hours of **Covered Employment** (including any Hour Bank hours) in the corresponding Qualifying Quarter, according to the following schedule:

Qualifying Quarter	**Benefit Quarter**
January, February, March	May, June, July
April, May, June	August, September, October
July, August, September	November, December, January
October, November, December	February, March, April

3. Hour Bank

The **Plan** provides to you an excess hours accumulation account known as an "Hour Bank." Your Hour Bank is credited with your hours in Covered Employment in excess of 1,600 per calendar year, up to a maximum of 800 hours.

After hours have been credited to your Hour Bank for at least one calendar year, these hours may be used, as needed, to satisfy your requirements for continuing eligibility coverage or to offset the self-payment due for COBRA coverage.

However, if you became eligible according to the terms of section 1(b) above (i.e., the "Special Initial Eligibility Rule for Certain New Employers and Certain Targeted Employees"), your Hour Bank will begin with a balance of negative eight hundred (-800) hours, and excess hours earned will first be used to reduce this negative balance. Once this negative balance is eliminated, your excess hours will accumulate and may be used as needed to satisfy your requirements for continuing eligibility coverage.

If you (a) who leave **Covered Employment**, (b) go to work in any position with a non-participating employer, or have an ownership interest in a non-participating employer, that is engaged in the plumbing and pipefitting industry (as determined by the **Trustees** in their sole discretion) in the geographic jurisdiction of the **Fund**, and (c) have any balance remaining in your Hour Bank, then you will forfeit any remaining hours available in your Hour Bank as of the first day you go to work for or obtain an ownership interest in the non-participating employer. Forfeiture of your Hour Bank means that your Hour Bank is reduced to zero, and the forfeited hours will not be reinstated or made available for any purpose, including but not limited to satisfaction of the continuing eligibility requirements or offset of any self-payment that is due.

4. Self-Payment Option

If you are covered by the **Plan** and earn at least one hour, but less than 400 hours, in **Covered Employment** during a Qualifying Quarter, and you do not have sufficient hours in your Hour Bank to make up the difference needed to qualify for continuing eligibility, you may elect to continue coverage for yourself and your **Dependents** on a self-pay basis. To elect this self-pay option, you must: (a) submit a written notice to the **Plan's** Administrative Office that you want to self-pay; (b) waive your COBRA entitlement in writing; and (c) self-pay the needed number of hours to continue eligibility to the Plan before the beginning of the relevant Benefit Quarter, at the rate determined by the **Trustees**. If you select this option, you waive your rights to COBRA coverage. If you instead elect COBRA coverage, you will lose your right to elect this self-pay option.

This self-payment option is offered in lieu of the right to continue coverage on a self-payment basis under COBRA. Once you elect to continue coverage on a self-payment basis under COBRA, you cannot self-pay under this self-payment option.

The amount of the self-payment is determined by multiplying the number of hours for which self-payment is due, times the hourly contribution rate applicable to your **Employer** under the **Collective Bargaining Agreement**. However, the Trustees can set higher self-payment rates (not to exceed the maximum monthly COBRA self-payment that may be charged under the law), for the following two classes of **Employees**:

(1) An **Employee** who had been certified by the Union as a "targeted employee", who had been given a negative balance in his Hour Bank at the time of his initial eligibility for the Plan, and then leaves **Covered Employment** to work for an employer (or in self-employment) in the plumbing and pipefitting industry that does not

participate in the Plan with a negative balance in his Hour Bank remaining; and

(2) Any **Employee** who leaves **Covered Employment** and goes to work in any position with a non-participating employer, or obtains an ownership interest in a non-participating employer, that is engaged in the plumbing and pipefitting industry (as determined by the **Trustees** in their sole discretion) in the geographic jurisdiction of the Fund.

In addition, if you belong to either class described above, you will forfeit any remaining hours available in your Hour Bank as of the date you first go to work for, or obtain an ownership interest in, a nonparticipating employer in the plumbing and pipefitting industry, and you will not be permitted to use any banked hours to offset a required self-payment amount.

5. Continued Eligibility During Disability

If, after becoming covered under the **Plan**, you are unable to work because of a Certified Disability, you will be credited with 40 hours of **Covered Employment** per week for each full week of Certified Disability up to a maximum of 800 for any 12 month period, solely for the purpose of maintaining eligibility under the **Plan**. A Certified Disability is one where you either: (a) draw disability benefits from the **Plan**; or (b) draw weekly Workers Compensation benefits as the result of a disability incurred within the jurisdiction of the **Union**.

6. Continued Eligibility and Self-Pay Coverage for Certain Pensioners

a) If you and your **Dependents** are covered by this **Plan** when you retire with a Plumbers and Steamfitters Local 60 Pension Plan pension, you will receive three (3) additional months of coverage under this **Plan** following the date your coverage would otherwise end, at a cost, if any, determined by the **Board of Trustees**.

b) In addition, if you are covered by this **Plan** when you retire with a Plumbers and Steamfitters Local 60 Pension Plan pension, and you elect and exhaust your COBRA coverage, you are eligible to continue your and your **Dependents'** medical benefit coverage only, on a self-pay basis. You must elect this coverage by written notice to the **Plan's** Administrative Office before the last day of your COBRA coverage, and make timely premium payments. Payment is due by the 10th day of the first calendar month in the quarter for which payment is made, with no grace period. The **Trustees** determine the cost of this coverage and will notify you of this cost before the due date. The cost may change, as determined by the **Board of Trustees**.

7. Eligibility of Dependents

Your Dependent(s) may become covered under the Plan on the latest of the following dates: a) the date you become covered under the Plan as an active Employee; b) the date you acquire the Dependent; or c) if applicable, the date stated in a Qualified Medical Child Support Order ("QMCSO"). However, your Dependent(s) will not be covered by the Plan, and Dependent coverage will not be effective, unless and until you list your Dependent(s) on an authorized enrollment form and submit the enrollment form, and all documentation required by the Plan, to the Plan Administrator.

If you or your Dependent is eligible but not covered under the **Plan** have coverage through Medicaid or a State Children's Health Insurance Program ("CHIP") and loses eligibility for such coverage, or becomes eligible for a premium assistance program through Medicaid or CHIP, you will have 60 days after the loss of the Medicaid or CHIP coverage or determination of eligibility for the premium assistance program, to enroll in the **Plan**. In order to exercise this right, a written request for enrollment must be made to the Administrator. If the written request is received within this 60-day period, enrollment will be effective no later than the first day of the first calendar month following receipt of the enrollment request. Otherwise, the general rules for eligibility and enrollment will apply.

8. Qualified Military Service

If you take a qualified military service leave of absence protected under the federal law known as the Uniformed Services Employment and Re-employment Rights Act or "USERRA" (such as active or inactive duty training or active duty in the United States Armed Forces or National Guard), any hours in Covered Employment you earned with respect to initial or continued eligibility, including amounts in your Hour Bank, are protected to the extent required under USERRA. If you are discharged from your qualified military service under other than dishonorable conditions and you return to work or seek re-employment with an **Employer** within the minimum time period protected under USERRA, any service, Hour Bank credit and **Plan** coverage that you and your **Dependents** had immediately before your leave began, will be reinstated. If you receive a dishonorable discharge or do not return to work or seek re-employment within the protected time period, you will forfeit the right to reinstatement under USERRA, and the treatment of any pre-leave service, Hour Bank credit and **Plan** coverage will be governed by the initial and continuing eligibility rules. *You are obligated*

to notify the Plan Administrator as soon as reasonably possible after you are called up for military service to ensure protection of your rights under USERRA.

If you are covered under the **Plan** at the time your qualified military service leave of absence begins, your health coverage and your **Dependents'** health coverage will terminate on the last day of the month in which your leave of absence begins, unless you elect to continue health coverage for the period of the leave, up to a maximum of 24 months. If the qualified military service exceeds 31 days, you must self-pay for such continued health coverage based on the Plan's self-payment rates for COBRA Coverage. However, only you may elect to continue health coverage under USERRA for your **Dependents**, since **Dependents** do not have an independent right to continue coverage under USERRA.

When discharged (not less than honorably) from qualified military service, your eligibility will be reinstated on the day you apply for re-employment with an **Employer**, provided that you make yourself available for re-employment by signing the **Union's** out of work list within: a) 90 days from the date of discharge if the period of service was more than 180 days; b) 14 days from the date of discharge if the period of service was more than 30 days and less than 181 days; or c) at the beginning of the first full regularly scheduled work period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than 31 days. If you are hospitalized for or convalescing from an illness or injury incurred or aggravated during your uniformed service, these time limits will be extended during your period of recovery for up to two years.

TERMINATION OF COVERAGE

1. Termination of Employee Coverage

Your coverage terminates on the earliest of the following dates to occur, subject to your right, if any, to continue coverage under COBRA:

a) at 12:01 a.m. on the first day of the Benefit Quarter for which you do not have the required number of hours in **Covered Employment** for the corresponding Qualifying Quarter, after withdrawing all available hours in your Hour Bank, and do not self-pay the shortfall;
b) the date of your death;
c) the last date for which coverage has been paid timely if you are required to make self-payments in order to continue coverage;
d) the date on which you are no longer eligible for coverage;

e) for qualified military service that exceeds 31 days, the first day for which a required self-payment has not been paid timely;
f) the date the **Plan** and/or **Fund** is terminated or amended, the result of which is the termination of coverage for you; or
g) if you are a "targeted employee," the date you terminate **Covered Employment** for any reason.
h) upon a determination by the **Trustees** that you have made an intentional misrepresentation of a material fact or engaged in fraud in seeking eligibility or coverage for benefits. In this case: (1) written notice of termination and the effective date will be provided to you; (2) for a retroactive effective date, you will be provided with at least 30 days advance written notice before the retroactive termination takes effect (provided that advance notice is not required for a retroactive termination due to failure to pay a required premium or self-payment); and (3) the **Trustees** may declare that you are ineligible for coverage or benefits under the **Plan**, notwithstanding the initial and continuing eligibility requirements to the contrary, for a period of up to four consecutive Benefit Quarters following your termination of coverage. An intentional misrepresentation of a material fact or engagement in fraud may include, without limitation, an intentional misrepresentation or failure to notify the **Plan** with regard to a family member's eligibility based on age, relationship, handicap or financial dependency or your total disability, resulting in improper payment of benefits; failure to notify or misrepresentation regarding the existence of other coverage resulting in improper coordination of benefits or a failure to coordinate); and submitting false benefit claims.

2. Termination of Dependent Coverage

Coverage of your **Dependents** terminates on the earliest of the following dates to occur, subject to their right, if any, to continue coverage under COBRA:

a) the date and time your coverage terminates other than by reason of your death;
b) if your coverage terminates by reason of your death, the date and time your coverage would have ended under section 1.a) above had you not died, based upon your hours in **Covered Employment** earned and any available hours in your Hour Bank at the time of your death;
c) the day on which the **Dependent** ceases to qualify as a **Dependent**;
d) the date specified in a Qualified Medical Child Support Order;
e) the date the **Plan** or **Fund** is terminated or amended, the result of which is the termination of coverage for the **Dependent**;
f) the date of **Dependent's** death; or

g) upon a determination that the **Dependent** has made an intentional misrepresentation of a material fact or engaged in fraud in seeking eligibility or coverage for benefits. The rules in part 1(h) above also apply to a **Dependent**, including the **Trustees'** right to declare him ineligible for coverage for up to four consecutive Benefit Quarters following termination.

3. Termination of Self-Pay Retiree Coverage

If you or your Dependents are covered under the self-pay retiree coverage, coverage will terminate on the earliest of the following to occur:

a) the date you become eligible to enroll in Medicare Part A or Part B, whether you actually enroll or not;
b) the date you turn age 65;
c) the date of your death;
d) 12:01 a.m. on the first day of the first quarter for which your required self-payment is not timely received; or
e) the date on which the **Plan** is terminated or amended to exclude your retiree coverage.

See "Termination of Dependent Coverage" above for other cases in which your Dependent's coverage could end. If your coverage ends, your Dependent spouse can continue retiree coverage until they first become eligible to enroll in Medicare Part A or Part B (whether they actually enroll or not).

4. Reinstatement of Eligibility

If your eligibility is terminated because of your failure to acquire the necessary minimum hours of **Covered Employment**, you will be reinstated to coverage as an active **Employee**, and your **Dependents** will be reinstated to coverage, starting at 12:01 a.m. on the first day following the day you complete 400 hours in Covered Employment in a three (3) consecutive month period during the first six calendar months following the date your eligibility terminated. If you do not satisfy this hours requirement for reinstatement, you will instead be required to satisfy the initial eligibility coverage requirements.

COBRA CONTINUATION OF COVERAGE OPTION

1. Eligibility and Benefits

a) *Employee* – If you would otherwise lose health coverage due to termination of employment (other than for gross misconduct) or insufficient hours in **Covered Employment** (the "Qualifying Event"), you are entitled to continue health coverage on a self-payment basis in accordance with the requirements of the federal law known as COBRA ("COBRA Coverage"), on behalf of yourself and any covered **Dependents** who would also lose coverage due to such Qualifying Event.

b) *Dependents* – Dependents who would otherwise lose health coverage due to one of the following Qualifying Events are also entitled to elect COBRA Coverage: (i) termination of your employment (other than for gross misconduct) or insufficient hours in **Covered Employment**; (ii) your death; (iii) your divorce or legal separation; (iv) your becoming entitled to Medicare benefits (enrollment in Medicare Part A or Part B); and (v) a **Dependent** child ceasing to qualify as a **Dependent** under the **Plan**. If your coverage terminates due to the same Qualifying Event that affects a **Dependent** and you fail to elect COBRA Coverage, each of your affected **Dependents** may elect COBRA Coverage on his own behalf.

c) *Qualified Beneficiary* – A "Qualified Beneficiary" is an **Employee** or **Dependent** who, on the day before a Qualifying Event, has health coverage under the **Plan** and would otherwise lose health coverage due to the Qualifying Event, as well as any **Dependent** child who is born to or placed for adoption with a covered **Employee** during a period of COBRA Coverage. If a Qualified Beneficiary who is self-paying for COBRA Coverage acquires a **Dependent** for whom coverage would be available if the Qualified Beneficiary were an active **Employee**, the Qualified Beneficiary may add such **Dependent** to his coverage for the remainder of the COBRA Coverage period. In addition, if a Qualified Beneficiary who is self-paying for COBRA Coverage has a **Dependent** (i) who was eligible but did not enroll in the Plan at the time of the Qualified Beneficiary's initial enrollment because the **Dependent** had other COBRA or group health coverage at that time, and (ii) who lost such other coverage due to exhaustion of COBRA coverage, loss of eligibility or termination of employer contributions (but not due to a failure to pay timely any required premiums or termination of coverage for cause), the Qualified Beneficiary may add that **Dependent** to his coverage for the remainder of the COBRA period, provided they make written notice to the plan administrator within 30 days after termination of such other coverage. If COBRA Coverage ends for a Qualified Beneficiary, it will also end for any of his family members who are enrolled but are not Qualified Beneficiaries in their own right.

2. Length of COBRA Coverage

a) *18-Months of COBRA Coverage* – If your health coverage is terminated due to a termination of employment (other than for gross misconduct) or insufficient hours in **Covered Employment** Qualifying Event, you and any **Dependents** who are Qualified Beneficiaries are eligible to elect COBRA Coverage for up to 18 months from the date of termination of coverage.

Further, if you experience a termination of employment or insufficient hours in **Covered Employment** Qualifying Event after you first become entitled to Medicare benefits, the period of COBRA Coverage available to any **Dependents** who are Qualified Beneficiaries will be 36 months from the date you are entitled to Medicare or 18 months from your termination of employment or loss of coverage due to insufficient hours in **Covered Employment**, whichever is longer.

b) *36-Months of COBRA Coverage* – Any Qualified Beneficiary whose health coverage is terminated due to a Qualifying Event, other than your termination of employment or insufficient hours in **Covered Employment**, is eligible to elect COBRA Coverage for up to 36 months from the date of termination of coverage. If a Qualified Beneficiary experiences another Qualifying Event while he is receiving 18-months of COBRA Coverage, his maximum period of COBRA Coverage, by reason of such multiple Qualifying Events, is 36 months measured from the earliest date of his eligibility for COBRA Coverage due to the first Qualifying Event.

c) *29-Months of COBRA Coverage* – If you or your **Dependent** is receiving COBRA Coverage by reason of a termination of employment or insufficient hours in **Covered Employment** Qualifying Event, and you or your **Dependent** is determined by the Social Security Administration ("SSA") to have been totally disabled at any time during the first 60 days of such COBRA Coverage, then subject to the notification requirements described below, the disabled individual and all other individuals receiving COBRA Coverage by reason of the same Qualifying Event is entitled to extend their 18-months of COBRA Coverage to 29 months or, if earlier, through the last day of the month which includes the 30th day after a final determination by SSA that the individual is no longer disabled. In order to qualify for this 11-month extension for disability, the covered individuals must notify the **Plan Administrator**, within 60 days of the SSA disability determination and prior to the end of the initial 18-month period of COBRA Coverage, and provide the **Plan Administrator** with a copy of the SSA disability determination. The covered individuals must also notify the Plan Administrator within 30 days after a final determination that the disabled individual is no longer disabled.

d) *Earlier Termination of COBRA Coverage* – Your COBRA coverage can terminate early if (1) you fail to timely pay the COBRA self-payment, (2) you first

become covered under Medicare or another group health plan after you elect COBRA Coverage, that does not have a limitation or exclusion for any pre-existing condition affecting you, or (3) this Plan terminates as permitted under COBRA.

3. COBRA Self-Payment

a) *Amount of Self-Payment* – You and/or your **Dependents** must pay the required self-payment amount as determined by the **Trustees**. The self-payment cost will not exceed the actual cost of the group health coverage plus an additional amount permitted by law. The monthly self-payment rates will remain constant for a 12-month period to the extent required by law. If you or your **Dependent** fail to make a COBRA self-payment within the grace period, eligibility for COBRA Coverage will end and cannot be reinstated.

b) *Self-Payment Due Dates* – The first COBRA self-payment must cover the cost of COBRA Coverage from the date **Plan** coverage would otherwise have terminated through the end of the month in which payment is made. This payment must be made no later than 45 days after the date you elect COBRA Coverage. All subsequent self-payments are payable monthly and due on the first business day of each month, subject to a 30-day grace period following the due date.

4. Notice Requirements

a)Required *Notice from the Plan* – The **Plan Administrator** will notify you and your **Dependents** of your rights under COBRA when you first become covered under the **Plan**. The Plan Administrator will also notify you and/or your **Dependents** with specific information regarding when and how to elect COBRA Coverage in the event of a loss of coverage due to your death, termination of employment, insufficient hours or entitlement to Medicare benefits, within 30 days after receiving notice of the resulting loss of coverage. The **Plan Administrator** will also notify you and your **Dependents** when your coverage ends, and in certain circumstances if COBRA Coverage is unavailable to you and/or your **Dependents**.

b) *Required Notice from Employees and Dependents* – You and/or your **Dependents** must notify the **Plan Administrator** in writing no later than 60 days following a divorce or legal separation, or loss of a child's **Dependent** status. Your notice must include the names of the affected **Employee** and/or **Dependents**, the type of Qualifying Event and date it occurred, and (if applicable) a copy of the divorce decree or written proof of legal separation. Failure to do so will result in forfeiture of the right to elect COBRA Coverage. The Plan Administrator will

notify the affected individuals of when and how to elect COBRA Coverage within 30 days after receiving such notice from you or your **Dependents**. Notice given to you or your **Dependent** spouse will be considered to be notice to all affected **Dependent** children living with your or your **Dependent** spouse.

c) *Financial Responsibility for Failure to Give Notice* – If you or your **Dependent** fail to give proper and timely notice of a Qualifying Event as required by the **Plan** and, as a result, the **Plan** erroneously pays a claim for you or your **Dependent**, you or your **Dependent** will be obligated to reimburse the **Plan** for the erroneous claim paid. If you or your **Dependent** fail to reimburse the **Plan**, the **Plan** may deduct the amount of reimbursement due from future benefits payable to or on behalf of you or your **Dependent** or a covered family member.

5. Election of COBRA Coverage

Written Election – Following notification that a Qualifying Event has occurred, the **Plan Administrator** will send to the affected individuals specific information regarding when and how to elect COBRA Coverage, including the cost of the COBRA self-payment. In order to elect COBRA Coverage, the Qualified Beneficiary must sign a written election form and return it to the **Plan Administrator** no later than 60 days after the later of (i) the date coverage under the **Plan** terminates by reason of the Qualifying Event, or (ii) the date the Qualified Beneficiary is notified of his right to elect COBRA Coverage. If elected, and subject to the timely payment of the required COBRA self-payment, COBRA Coverage will be effective retroactive to the date coverage would otherwise have terminated due to the Qualifying Event. If COBRA Coverage is initially waived during the 60-day election period, this waiver may be revoked and COBRA Coverage elected any time within the 60-day period, but the COBRA Coverage will be provided only from the date of the revocation of the original waiver and not retroactive to the loss of coverage.

6. Terms and Conditions

COBRA Coverage is always optional and each Qualified Beneficiary may make an independent election to receive COBRA Coverage. The cost of COBRA Coverage must be paid entirely by the Qualified Beneficiary electing coverage, and no contributions will be made by the **Plan** to cover the cost of COBRA Coverage. The health benefits available under the **Plan** during the COBRA Coverage period are the same as those provided by the **Plan** to similarly situated participants with respect to whom a Qualifying Event has not occurred.

7. 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 doesn't 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.

CERTIFICATE OF CREDITABLE COVERAGE

If your coverage under the **Plan** terminates or you become eligible for COBRA coverage, the **Plan** will provide you with a Certificate of Creditable Coverage which indicates the period or periods during which you had health coverage under the **Plan**. If a **Dependent's** health coverage under the **Plan** terminates or the **Dependent** becomes eligible for COBRA Coverage at a different time or for a different reason than you and the **Plan** is notified of that fact, the **Plan** will provide a separate Certificate of Creditable Coverage to the **Dependent** or the **Dependent's** guardian which indicates the period of coverage. You may also request a copy of a Certificate of Creditable Coverage at any time within 24 months after coverage has terminated. This Certificate may be used in certain circumstances to reduce or eliminate a pre-existing condition exclusion or limitation under a new health plan under which you become covered. However, effective December 31, 2014, these certification requirements will no longer apply.

EMPLOYEE DEATH BENEFIT

In the event of your death while you are covered for the death benefit, the sum of $7,500.00 will be paid to your surviving **Beneficiary** (however, up to $500 of the benefit may instead be paid to an individual who has incurred expenses for your burial). This death benefit covers active **Employees** only. This benefit is provided through an insurance policy purchased by the **Plan** and is subject to the terms and conditions of the policy in effect at the time of your death (the "Policy").. The Policy is currently with Union Labor Life Insurance Company (the "Insurance Company").

Your coverage for the death benefit begins when your Plan coverage begins, and continues under the rules of the Plan and the terms of the Policy. Death benefit coverage terminates when you enter full-time active duty with the armed forces, unless you elect to continue coverage on a self-pay basis.

You may designate any person or persons as your **Beneficiary** by completing a beneficiary designation form. The **Beneficiary** must survive you in order to qualify for the death benefit. If there is more than one surviving **Beneficiary**, they will share equally in any benefit that is payable, unless you indicated otherwise in your **Beneficiary** designation. You may change a **Beneficiary** designation at any time and as often as you wish without the consent of or notice to your previously named **Beneficiary**, unless you had named an irrevocable **Beneficiary** who cannot be changed without their consent. If there is no valid written designation of **Beneficiary** on file with the **Plan** at your death, or no surviving designated **Beneficiary** the **Beneficiary** is presumed to be the first surviving class of heirs determined in the following order of preference: (a) your surviving spouse; (b) your surviving natural or legally adopted children, in equal shares; (c) your surviving parents, in equal shares; (d) your surviving brothers and sisters, in equal shares; and (e) your estate. In identifying your Beneficiary, the Insurance Company or the Plan may rely on an affidavit by any individual listed above. If the Beneficiary is a minor, or is incompetent, payment can be made to the legal guardian, or if none, to the person or institution that has (in the payer's opinion) custody and principal support of the Beneficiary.

Notice of Conversion Rights - If all or a portion of your death benefit coverage terminates, you may be able to convert the terminated coverage to an individual life insurance policy (payable at your expense) without having to show proof of good health. The conversion must be allowed under the Policy, and you must send a written application with the first premium to the Insurance Company within 31 days after losing coverage (unless additional time is allowed under the

Policy). Generally, conversion is allowed if coverage terminates for any of the following reasons:

(a) You cease to be eligible due to your employee classification or change in classification;

(b) Your age or retirement; or

(c) Policy termination or Policy amendment to terminate coverage for a class of eligible persons to which you belong (provided you have been continuously covered for at least five years).

Conversion is not allowed more than 91 days after termination of your death benefit coverage. If you are eligible for conversion and die within the 31-day conversion period, a death benefit will be paid to your Beneficiary in the amount that was eligible for conversion. As always, the terms of the Policy govern, and questions should be directed to the Fund Office or Insurance Company.

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If an accidental injury occurs while you are covered by the **Plan**, and you suffer a "covered loss" within 90 days as a direct result of the accident (and independent of all other causes), an accidental death and dismemberment benefit will be paid. If the "covered loss" is your death, $7,500 will be paid to your surviving **Beneficiary**. If your accidental death occurs while you are also covered by the Employee Death Benefit, the total death benefit payable under the **Plan** will be $15,000.00. Your **Beneficiary** will be determined in the same way as for the "Employee Death Benefit".

If your "covered loss" is the permanent loss of a hand by complete severance at or above the wrist joint, a foot by complete severance at or above the ankle joint, or an eye involving irrecoverable and complete loss of sight in an eye, you will be paid a dismemberment benefit as follows:

Loss of 1: hand, foot or eye	$3,750.00
Loss of 2: hands, feet, eyes, or any combination thereof	$7,500.00

If you suffer more than one "covered loss" in an accident, payment will be made only for the loss for which the largest amount is payable.

Exclusions- No accidental benefit will be payable for a "covered loss" caused directly or indirectly, in whole or part, by any of the following:

(a) Bodily or mental Illness or disease of any kind;

(b) Ptomaines or bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound);
(c) Suicide or attempted suicide while sane or insane;
(d) Intentional self-inflicted injury;
(e) Participation in, or the result of participation in, the commission of an assault, felony, riot or civil commotion;
(f) War or act of war, declared or undeclared, or any act related to war or insurrection;
(g) Medical or surgical treatment of an illness or disease;
(h) Service in the armed forces of any country while such country is engaged in war; or
(i) Police duty as a member of any military, naval or air organization.

This accidental death and dismemberment benefit covers active **Employees** only, is provided through an insurance policy purchased by the **Plan** and is subject to the terms and conditions of the policy in effect at the time of the accident (the "Policy"). The Policy is currently with Union Labor Life Insurance Company (the "Insurance Company"). If the benefit is payable to an estate or person who is a minor or incompetent, up to $1,000 of the benefit may be paid to any relative by blood or connection by marriage.

DISABILITY BENEFIT

The **Plan** provides a Temporary Disability Income Benefit to eligible active **Employees** only. Subject to the terms of the **Plan** and any policy purchased by the **Plan** to cover these benefits, for each day on which you are disabled and unable to perform any duties pertaining to your occupation as a result of a non-occupational accidental bodily injury or sickness or pregnancy, you will receive $25.00 up to a maximum of $175.00 per week. This benefit is payable beginning on the fourth (4^{th}) day of disability and for a maximum 91 continuous days of disability (the maximum benefit is $2,275.00). It is not necessary to be confined to your home or a hospital to collect these benefits, but you must be under the personal care of a physician who must certify your disability. **Occupational injuries or sickness are not covered by this benefit.**

COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFITS

1. Comprehensive Major Medical Benefits

Once you are eligible for coverage under the **Plan**, you and any covered **Dependents** become eligible for the Comprehensive Medical Benefits described below and in the Schedule of Benefits, subject to the exclusions and limitations provided and all other rules of the **Plan**. The Medical Benefits are self-insured by the **Fund**.

2. Calendar Year Deductible

The Calendar Year Deductible, as shown in the Schedule of Benefits, is the dollar amount of your out-of-pocket **Eligible Charges** which must first be paid by each **Plan Participant** during the calendar year before any other **Eligible Charges** incurred during the calendar year are payable under the **Plan**. To ensure that covered medical expenses incurred later in the calendar year will not be subject to two deductibles, any covered expenses incurred in the last three months of a year in which the Deductible is not satisfied will be carried over to the following calendar year to reduce the Deductible for that year.

3. Network of Participating Providers, Co-Insurance and Copay

Coinsurance means the sharing of the **Allowable Amount** for **Eligible Charges**, calculated as a percentage. The Co-Insurance percentage shown in the Schedule of Benefits is the percentage paid by the **Plan** after you (or your **Dependent**) satisfies the Calendar Year Deductible. You (or your **Dependent**) are responsible for the remaining amount of charges.

The **Plan** may contract with a network administrator to offer a preferred provider option network ("Network") that provides discounted fees. You may obtain a copy of the Network provider list, without charge, upon written request to the **Plan Administrator**. The Co-Insurance percentage is higher for **In Network** providers than for **Out-of-Network** providers, as reflected in the Schedule of Benefits. Please note that if a **Participant** uses an **Out-of-Network** provider, only the **Allowable Amount** for **Eligible Charges** will be eligible for coverage at the **Out-of-Network** Co-Insurance percentage. However, if you do not live within 35 miles of an **In-Network** provider for a type of service needed, or you require

immediate serious emergency care, use of an **Out-of-Network** provider for such service or emergency care is covered at the **In-Network** Co-Insurance percentage.

The choice of a provider, and whether to use an **In Network** or **Out of Network** provider, is up to you.

A Copay is the amount you must pay to a pharmacy for a covered prescription drug. The copays are shown in the Schedule of Benefits.

4. Covered Medical Services

Eligible Charges incurred for the following services, supplies and/or treatments, prescribed by the attending Physician for a non-occupational injury or illness or for pregnancy care, subject to utilization review and/or claims management, where applicable, are covered by the **Plan**, subject to all applicable Deductibles, Co-Insurance percentages, maximum limitations, exclusions and conditions:

a) **Hospital** Room and Board - The regular **Hospital** daily charge for room, meals and general nursing care not exceeding the average semi-private rate;
b) Other **Hospital** Charges - **Hospital** services and supplies other than room and board charges, and drugs and medicines prescribed by a **Physician** while you are confined in a **Hospital**;
c) Medical Service - Medical care and treatment by a **Physician** including office visits; Medical care and treatment rendered by a Physician Assistant if there are no **Physician** charges for the same services. A Physician Assistant is a licensed professional who has received specialized training to perform certain tasks usually performed by a **Physician**, is under a supervising **Physician's** direction, and is acting within the scope of his license.
d) Nursing Care - Private nursing care by a R.N. or L.P.N.;
e) Surgical Charges – Surgical procedures and treatment by a **Physician** who is a surgeon, whether or not performed in a **Hospital**;
f) Physiotherapy - Treatment by a physiotherapist;
g) Anesthesia - Cost and administration of anesthetics by a **Physician** or certified registered nurse anesthetist;
h) X-ray and Laboratory Test - Charges for X-ray examinations and treatment by a **Physician** who is a radiologist, and laboratory tests for diagnosis and treatment;
i) Ambulance – Transportation by professional ambulance service to and from a **Hospital** equipped to furnish required treatment;

j) Radiation and X-ray Therapy - Radiation and X-ray therapy and treatment whether performed in or out of the **Hospital**;

k) Assistant Surgeon - Services of a **Physician** as an assistant surgeon, not to exceed 20% of the principal surgeon's fee;

l) Blood - Blood or blood plasma and its administration except if replaced on behalf of the patient;

m) Chemical Dependency Inpatient Care Treatment - Care or treatment of chemical dependency, drug addiction or alcoholism on an inpatient basis in a Chemical Dependency Inpatient Care Unit;

n) Pregnancy Benefits – Pregnancy care for **Employees** and **Dependent** spouses only (**Dependent** children are not covered for Pregnancy Benefits), which are covered on the same basis as any other injury or illness. Pregnancy care includes treatment and services related to pregnancy care before delivery, delivery, post-delivery care, and complications arising from pregnancy. Benefits are not restricted for any **Hospital** length of stay in connection with childbirth for an eligible mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a Caesarean section. The **Plan** does not require prior authorization from the Plan or the utilization reviewer for prescribing a length of stay not in excess of these time periods. The length of Hospital stay may be shorter than the required minimum period if agreed to by the patient in consultation with the attending **Physician**;

o) Mental or Nervous Disorders - Care or treatment of Mental or Nervous Disorders, including the services of a **Physician**, a licensed clinical psychologist and a licensed social worker if referred by a **Physician**;

p) Structural Imbalance, Distortion or Subluxation – Chiropractic services provided by a licensed Doctor of Chiropractic, on an **Outpatient** basis only, in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation of the human body for purposes of removing nerve interference that results from or is related to distortion, misalignment, or subluxation of or in the vertebral column, subject to the maximum number of visits described in the Schedule of Benefits;

q) Reconstructive surgery when performed to correct damage caused by an **Accidental Injury**, provided it is performed within a reasonable period of time not to exceed 90 days following the **Accidental Injury**, subject to any **Medically Necessary** delay;

r) Breast reconstruction surgery following a partial or total mastectomy, which includes the following: (I) reconstruction of the breast on which the mastectomy has been performed; (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (iii) prosthesis and physical complications for all stages of the mastectomy including

lymphedemas, all in the manner determined in consultation with the treating **Physician** and the patient.

s) Dental work, dental treatment and/or dental x-rays required due to an **Accidental Injury** and provided within a reasonable period of time not to exceed 90 days following the **Accidental Injury**, subject to any **Medically Necessary** delay; removal of an impacted 3rd molar, up to $75 for each such molar;

t) The following types of durable medical equipment, supplies and appliances: oxygen and equipment for its administration, CPAP, BiPAP, or APAP machine or similar equipment for the non-surgical treatment of sleep apnea (up to one machine every 3 years, with supplies only for the initial machine), casts, splints, braces, crutches, physical therapy apparatuses, hospital type beds and wheelchairs. Any type of durable medical equipment, supplies and appliances not specifically listed is not covered. Any rental of the foregoing item(s) shall be covered only up to the purchase price; and

u) The initial purchase of a prosthetic device needed for loss due to injury, illness or surgical operation, and any replacement thereof provided the replacement is necessitated by natural growth or pathological changes of the affected site.

v) Surgery or treatment intended to correct a person's vision (including but not limited to LASIK surgery, laser surgery, RK surgery, PRK surgery, and all similar types of eye surgery or procedures) but only once for each eye, subject to the maximum limits set forth in the Schedule of Benefits;

w) Body organ transplants subject to the following conditions and limitations:
   (1) The transplant is not **Experimental or Investigational**;
   (2) The patient is admitted to a transplant center program in a major medical center approved by the federal government or appropriate state agency;
   (3) Patient screening, organ procurement, transportation of the organ, patient and/or donor surgery, follow-up care and immunosuppressant drugs are covered;
   (4) Coverage is provided for the **Participant** as the recipient (but not for non-**Participant** recipients);
   (5) Coverage is provided for the **Participant** as the donor (but not for non-**Participant** donors); and
   (6) When a recipient or donor is not a **Participant** and has health coverage that covers body organ transplants, the health coverage for the non-covered person as an employee shall be the primary payer;

x) Speech and language pathology therapy provided by a speech pathologist or audiologist licensed to practice in the state where the services are rendered,

when prescribed by a **Physician** to improve or restore speech language deficits;

y) Hearing aids for **Dependent** children under 18 years of age that are fitted and dispensed by a licensed audiologist or hearing aid specialist, subject to the maximum limits set forth in the Schedule of Benefits;

z) Hospice care services that are provided for a **Participant** who is terminally ill with a life expectancy of six months or less and no reasonable prospect for a cure as certified in writing by the attending **Physician**, and provided by a licensed hospice care facility within 12 months after the first covered hospice care service is rendered, subject to the limits set forth in the Schedule of Benefits; and

aa) Surgery to treat morbid obesity, subject to the following conditions and limitations:

(1) The patient is at least 100 pounds over their medically desirable weight;
(2) The patient has a Body Mass Index (BMI) of 45 or greater;
(3) The obesity is a threat to the patient's life due to life-threatening co-morbidities;
(4) The patient has a medical history of unsuccessful attempts to reduce weight by other measures;
(5) The requested surgery is deemed **Medically Necessary**;
(6) The patient must be between ages 18 and 65; and
(7) Coverage is limited to the **Participant** and their **Dependent** spouse (coverage is not available for **Dependent** children).

5. Utilization Review Program and Claims Management

The **Plan** maintains a Utilization Review Program for evaluation of the necessity, appropriateness and efficiency of the use of medical services, procedures and facilities. This program may require you to obtain pre-admission review for **Hospital Inpatient** admissions and stays (except for medical emergency and childbirth), concurrent review and discharge planning for **Hospital** admissions, and certifications of surgery recommended by a **Physician** on an **Inpatient** or **Outpatient** basis. The **Plan** may change, from time to time, the list of admissions and procedures that require pre-certification and post-admission review, consistent with federal law requirements, and replace its utilization review agent. As a condition of coverage, you and your providers must comply with all requirements of the **Plan's** Utilization Review Program, including but not limited to the following procedures:

a) Hospital Inpatient Admissions and Outpatient Surgery - All **Hospital Inpatient** admissions and **Outpatient** surgery, to the extent required and

except for medical emergency or childbirth, must be reviewed, approved and certified by the **Plan** as **Medically Necessary** prior to admission or surgery. To obtain the necessary certification, you or your provider must contact the Plan's Utilization Review Coordinator (the "UR") prior to the proposed admission or surgery and provide the requested information. It is your responsibility to verify that proper notification has been given to the UR. The UR will make the **Medically Necessary** determination and notify you or your provider of its determination. Failure to receive certification will result in loss of benefits.

b) Medical Emergencies and Extended Stays for Childbirth – Hospital Inpatient admissions for and stays related to a medical emergency must be post-admission reviewed and approved by the UR within 48 hours following admission. To obtain the necessary post-admission review, you or your provider must contact the UR and provide the requested information. The UR will determine if the **Hospital** admission is **Medically Necessary** and notify you or your provider of its determination. Failure to obtain approval will result in loss of benefits.

Hospital stays for childbirth for an eligible mother and newborn child that exceed 48 hours for a normal vaginal delivery or 96 hours for a Caesarian section must be reviewed, approved and certified by the UR as **Medically Necessary** before the end of the 48 or 96-hour period You or your provider must contact the UR before the beginning of the extended stay and provide the requested information. It is your responsibility to verify that proper notification has been given to the UR. The UR will make the **Medically Necessary** determination and notify you or your provider of its determination.

c) Claims Management - The **Trustees** are authorized to employ claims management services as they deem appropriate to protect and benefit the **Plan**. You are obligated to cooperate with any claims management program in effect for the **Plan**.

6. Exclusions and Limitations from Coverage

No Medical Benefits are payable under the **Plan** for any of the following charges, services or supplies, nor do they count toward satisfaction of the Calendar Year Deductible:

a) Charges incurred for: (1) an occupational or job-related injury or sickness for which you have received or are entitled to receive compensation or reimbursement, in whole or part, under any worker's compensation law, occupational disease law or other similar legislation; (2) any recurrent partial or total disability (temporary or permanent) following a settlement

of a claim for the injury or illness causing the disability; or (3) an occupational injury or illness incurred at a job where you receive remuneration or profit for your work and there is no worker's compensation law, occupational disease law or similar legislation involved. If the **Plan** erroneously pays a claim related to an injury excluded from **Plan** coverage by this exclusion, you must reimburse the **Plan** within sixty days of a written demand by the **Plan**. Failure to do so will subject you to interest, costs and attorney's fees incurred to collect the erroneous payment. If your acceptance of **Plan** benefits causes you to be disqualified from receiving workers compensation benefits, the **Plan** is not liable for the payment of any denied workers compensation benefits caused by this error;

b) Charges incurred for disease or injury resulting from war or any act of war, whether declared or undeclared;

c) Habilitation services, acupuncture, bariatric surgery, long-term care, routine foot care, non-emergency care when traveling outside the United Stated, and medical services which you are not required to pay;

d) Medical care, services, and supplies for self-inflicted injuries or injuries sustained in connection with attempted suicide or in the course of the commission of a felony, except to the extent they cannot be excluded under HIPAA;

e) Cosmetic surgery, services, and supplies as well as any medical complications resulting from cosmetic surgery, except for the repair of **Accidental Injuries** to the extent specifically covered as **Eligible Charges**;

f) Abortions except for therapeutic abortions that are recommended by a **Physician** because of a dangerous health condition;

g) Any charges that exceed the **Allowable Amount**;

h) Medical treatment, services and supplies that are not specifically covered by the **Plan** and complications therefrom;

i) **Hospital** admissions of more than 24 hours prior to any voluntary or elective surgery, unless it is determined that it was **Medically Necessary**;

j) Dental work or treatment or dental x-rays except as specifically covered under **Eligible Charges**;

k) Standby surgical fees or charges;

l) Non-prescription drugs and medicines, and drugs and medicines prescribed for a **Participant** who is not confined in a **Hospital** except to the extent covered by the Prescription Drug Program;

m) Durable medical equipment, supplies and appliances, as well as prosthetics, except as specifically covered under **Eligible Charges**;

n) Eye care, including but not limited to eye exams, eye refractions, eyeglasses, and contact lenses; surgery or treatment intended to correct a person's vision (including but not limited to LASIK surgery, laser surgery, RK surgery, PRK surgery and all similar types of eye surgery or procedures); and hearing aids, detachable portable monitors or stimulators

and examinations relating to the necessity, fitting or adjustment thereof, except as specifically covered under **Eligible Charges**;

o) Services or supplies that are not recommended by a **Physician** or are not **Medically Necessary** in treating an injury or sickness or for maternity care of a covered **Employee** or **Dependent** spouse;

p) Charges incurred by a **Participant** or **Dependent** when not covered by the **Plan**;

q) Custodial Care or rest cures;

r) Bariatric surgery and charges incurred for appetite control and treatment of obesity, except as specifically covered;

s) Health examinations or tests not required to treat a sickness or injury, routine checkups, routine newborn care or routine pediatric care;

t) An operation or treatment for realignment of teeth or jaws, including but not limited to atrophy of the lower jaw, occlusion, maxillofacial surgery or any craniomandibular or temporomandibular joint ("TMJ") disorders, except as specifically covered under **Eligible Charges**;

u) Charges incurred for or in connection with sex transformations;

v) Charges incurred for promotion of fertility or treatment of infertility including, but not limited to, fertility tests, reversal of surgical sterilization, attempts to cause pregnancy by hormone therapy, and actual or attempted impregnation or fertilization by artificial insemination, in-vitro fertilization, embryo transfer or otherwise, which involves a **Participant** as either a surrogate, donor or recipient;

w) Pregnancy care including treatment and services related to pregnancy care before delivery, delivery, post-delivery care and complications arising from pregnancy, for a Dependent child;

x) Any service or supply which is: (1) not provided in accordance with generally accepted professional medical standards; or (2) is **Experimental or Investigative** in nature; or (3) is not proven safe and effective; or (4) is not Medically Necessary;

y) Charges incurred while on active duty or training in the Armed Forces, National Guard or Reserves of any state or country and for which any governmental body or its agencies are liable, except to the extent prohibited by USERRA or other federal law;

z) Charges that are made only because the **Plan** exists or that you are not required to pay; and

aa) Charges incurred by a **Participant** for an injury, sickness or condition for which the **Participant** has received or is entitled to receive payment, compensation or other monetary award from a third party who is legally responsible due to negligence or wrongful action. For this purpose, the following are considered third parties: (a) a person or entity alleged to be legally responsible for the injury, sickness or condition due to negligence or wrongful action pending a final determination thereof, at which time an

appropriate adjustment for payment of claims by the **Plan** will be made if and as needed to reflect an exoneration from such legal responsibility; (b) an insurer or other indemnifier of a person or entity described in (a) to the extent provided; and (c) a person or entity who is obligated to provide the **Participant** with benefits or payments under underinsured or uninsured motorist insurance coverage, medical provisions of no-fault or traditional insurance (such as automobile or homeowners insurance), workers' compensation coverage or other insurance or third party coverage. Pending a determination whether a third party is legally responsible for payment of such charges incurred by a **Participant**, the **Plan** may advance or make payment to or for the **Participant** in an amount equal to the benefits otherwise payable under the **Plan** in the absence of a third party's liability for such charges, subject to the **Plan's** subrogation, reimbursement and recovery rights under the **Plan**.

PRESCRIPTION DRUG BENEFITS

1. Coverage

You and your **Dependents** are also eligible for prescription drug benefits. The **Plan** maintains a prescription drug program through a contract with an independent pharmacy benefits manager, the terms of which are hereby incorporated by reference and determine the provisions by which prescription drug benefits are provided. If you enroll in a Medicare prescription drug plan (Part D) or other Medicare Advantage Plan (Part C) that provides Medicare prescription drug coverage, then you are NOT eligible for the prescription drug program provided under the **Plan**, effective as of the date of such enrollment.

2. Benefits

Using a card supplied by the **Plan**, you can obtain various prescription drugs. There is no deductible applied for prescriptions, but you must make a "copay" for each prescription. The amount of your copay depends upon whether you buy a name brand drug or an equivalent generic. The amount of copay also depends on whether you purchase the drug at a retail pharmacy, or you get home delivery. The copays are shown in the Schedule of Benefits.

3. Drugs Covered

Not all prescription drugs are covered by the **Plan**. You, or your pharmacist, can call the telephone number on the back of your prescription drug card to see if a particular drug is covered by the **Plan**.

4. Prior Authorization and Other Programs

The **Trustees** may implement various programs to help improve your use of the prescription drug benefit, or to help control costs to the **Plan**. You will be given specific information about these programs as they are implemented. These programs may include, but are not limited to: (1) the requirement of a prior authorization before the **Plan** will pay for certain drugs; (2) limits on the number of refills or pills for certain drugs; (3) the requirement to use step therapy (i.e., the use of a particular drug to determine if it will work for your condition, before moving on to other drugs); or (4) other restrictions on certain drugs.

COORDINATION OF MEDICAL BENEFITS

If you or your **Dependents** are also covered by another group health plan whether insured or self-insured, (including any group-type coverage, medical care components of group long-term care contracts, medical, no-fault or personal injury protection benefits under automobile contracts, medical benefits under homeowners insurance, or Medicare or other governmental medical benefits), you must notify the Plan Administrator of this fact, and the following "Coordination of Benefits" rules will apply. This rule does not apply to any individually purchased health insurance, school accident type coverage, Medicare supplement policies, or Medicaid policies and coverage that you or your **Dependents** own.

Coordination of Benefits is a concept of anti-duplication which provides that if an individual is covered under two or more group health plans, the amount of benefits payable under this **Plan** and the other plan(s) will be coordinated so that the total amount paid does not exceed 100% of the "Allowable Expenses" incurred (necessary, reasonable and customary item of expense or negotiated fee for medical services, treatment or supplies, at least a portion of which is covered under one plan or this **Plan** when incurred). Payment is made on a primary-secondary basis. The primary plan will pay without regard to the other plans. The secondary plan(s) will coordinate its payments so that the total of the payments from all plans does not exceed the "Allowable Expenses". However, when a plan has no limitation against payments made under any other group health plan, it will be considered the primary plan and render payment first regardless of the primary-secondary ranking. In no event will any plan pay more than it would have paid if no other plan was involved.

Various rules are utilized to decide which plan is the primary plan and which plan or plans is the secondary plan. These rules vary depending upon whether a second group health plan or Medicare is involved. If you have any questions or would like any information regarding these rules, please contact the **Plan Administrator**.

CLAIMS PROCEDURE, CLAIMS REVIEW PROCEDURE AND HOW TO FILE A CLAIM

1. Claims Procedure

(a) **Definitions:** The following terms, when used in this claims section as capitalized terms, have the meaning set forth in these definitions:

(1) **"Concurrent Care Claim"** means a claim for an ongoing course of treatment over a period of time or number of treatments that is being reconsidered after the original pre-authorization and before the end of the course of treatment;

(2) "**Death/AD&D Claim**" means a claim for a Death Benefit or Accidental Death and Dismemberment Benefit;

(3) **"Denial"** means any adverse benefit determination including a denial, reduction or termination of, or failure to provide or make payment in whole or part for, a claimed benefit under the Plan;

(4) **"Disability Claim"** means a claim for benefits under the **Plan** that is conditioned on a determination of disability made by the **Plan** based on the medical evidence and not by a party other than the **Plan** for non-**Plan** purposes;

(5) **"Health Care Professional"** means a physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law;

(6) **"Post-Service Claim"** means any claim for medical benefits under the Plan that is not a Pre-Service Claim;

(7) **"Pre-Service Claim"** means a claim for medical benefits under the Plan for which the Plan conditions coverage, in whole or part, on approval before the receipt of services or treatment;

(8) **"Relevant"** means, with respect to the relationship of a document, record or other information to a claim, that the document, record or information (i) was relied upon in making the benefit determination; (ii) was submitted, considered or generated in the course of making the benefit determination without regard to whether it was relied upon; (iii) demonstrates compliance with administrative processes and safeguards designed to accomplish consistent and accurate determinations under the **Plan**; or (iv) is a statement of **Plan** policy or guidance concerning a denied benefit for the claimant's diagnosis without regard to whether it was relied upon in making the benefit determination; and

(9) **"Urgent Care Claim"** means a claim for medical care or treatment where application of the normal time periods for pre-service authorization determinations (i) could seriously jeopardize the claimant's

life, health or ability to regain maximum function, or (ii) would subject the claimant to severe pain that cannot be adequately managed without the requested care or treatment.

(b) **Authorized Representative:** A claimant has the right to appoint an authorized representative to act on his behalf for purposes of filing a claim, requesting a review of a Denied claim, receiving correspondence and otherwise acting on the claimant's behalf with respect to the Claims Procedure and Claims Review Procedure under the **Plan**. The claimant must give prior written notice to the **Plan** of the name, address and telephone number of the authorized representative and supporting documentation of appointment and authority as required by the **Plan**. For an Urgent Care Claim, a Health Care Professional who knows the claimant's medical condition may act as his authorized representative even if an appropriate form has not been completed.

(c) **Filing Requirements for Claims:** In order to receive a **Plan** benefit or determination affecting a **Plan** benefit, notice of claim, in a form acceptable to the **Plan**, must be timely filed with the **Plan** in accordance with the following requirements:

(i) **Urgent Care Claims.** The **Participant** or provider must call the **Plan's** coordinator for its Utilization Review Program ("UR") and provide it with the requested information to enable it to make a determination. If a **Physician** with knowledge of the patient's medical condition determines that the claim qualifies as an Urgent Care Claim and notifies the UR of such, it will be treated as an Urgent Care Claim. Otherwise, the UR will determine if the claim qualifies as an Urgent Care Claim by applying the judgment of a prudent lay person who possesses an average knowledge of health and medicine. If the **Participant** or provider improperly submits an Urgent Care Claim but communicates with a person customarily responsible for handling **Plan** benefit matters about the potential claim and provides the patient's name, specific medical condition or symptom, and the specific treatment, service or product for which approval is requested, the **Plan** shall notify the **Participant** as soon as possible but no later than 24 hours after receipt of the information, of the proper procedures to be followed in filing the Urgent Care Claim. Notification may be oral unless written notification is requested. Unless the potential Urgent Care Claim is resubmitted properly, it will not constitute an Urgent Care Claim under the **Plan**.

(ii) **Pre-Service Claims.** The **Participant** or provider must call the **Plan's** coordinator for its Utilization Review Program ("UR") for

pre-certification of a **Hospital** admission or extended stay or **Outpatient Hospital** procedure or service, as applicable, and provide it with the requested information to enable it to make a determination. If the **Participant** or provider improperly submits a Pre-Service Claim but communicates with a person customarily responsible for handling **Plan** benefit matters about the potential claim and provides the patient's name, specific medical condition or symptom, and the specific treatment, service or product for which approval is requested, the **Plan** shall notify the **Participant** as soon as possible but no later than five days after receipt of the information, of the proper procedures to be followed in filing the Pre-Service Claim. Notification may be oral unless written notification is requested. Unless the potential Pre-Service Claim is resubmitted properly, it will not constitute a Pre-Service Claim under the Plan.

(iii) **Concurrent Care Claims.** By definition, these claims are being reconsidered after the initial pre-authorization and before the end of the course of treatment and as such do not involve initial filing requirements. If a **Participant** or provider wishes to extend a previously approved course of treatment beyond the approved time or number of treatments, the **Participant** or provider must file a claim in accordance with the applicable filing requirements based on the nature of the claim.

(iv) **Post Service Claims.** The **Participant** or provider must file a written claim and adequate proof of loss with the **Plan** at its Fund Office (or as otherwise directed by the **Plan**) within 90 days after the date of loss or date the expense for which claim is made was incurred. Failure to file a written claim within the required time period will not invalidate or reduce the claim if it was not reasonably possible to do so, provided a written claim is filed as soon as reasonably possible and within one year after the date of loss or date the expense was incurred. Claims that are not filed timely will not be covered by the **Plan**. The **Plan** may request any information and documents it deems necessary to substantiate the claim.

(v) **Disability Benefits Claims.** The **Participant** must file a written claim and adequate proof of loss with the **Plan** at its Fund Office (or as otherwise directed by the **Plan**), in a form acceptable to the **Plan**, within 90 days after the **Participant** first becomes disabled. Failure to file a written claim within the required time period will not invalidate or reduce the claim if it was not reasonably possible to do so, provided the claim is filed as soon as reasonably possible and within one year after the **Participant** first becomes disabled. Claims that are not filed timely will not be covered by the **Plan**. The **Plan**

may request any information and documents it deems necessary to substantiate the claim.

(vi) **Death/AD&D Claims.** If the Death/AD&D Benefit is insured and provided through a Policy, the **Participant** must file a written claim for a Death/AD&D Benefit in the form and within the time period required by the Policy. If the Death/AD&D Benefit is not insured or if the Policy does not provide for a particular form or time period for filing a claim, the **Participant** must file a written claim for a Death/AD&D Benefit in accordance with the claims filing requirements that apply to Post Service Claims.

If a claim is not filed timely in accordance with the applicable requirements described above, it will not be considered for payment, and no benefits shall be payable. Upon receipt of notice of claim filed timely in accordance with the above requirements, the **Plan** will furnish to the claimant any additional forms that are required for filing the claim. An expense is incurred on the date the service or supply giving rise to the expense is furnished. A claim is considered filed upon receipt by the **Plan** at the Fund Office (or as otherwise instructed by the **Plan Administrator**) during normal business hours on a regularly scheduled work day. Your rights and benefits under the **Plan** are personal to you and may not be assigned.

(d) Processing and Time Period for Initial Claims Determination. Each claim that is filed in accordance with the **Plan's** filing requirements described in subsection (c) above will be processed for determination as to whether and in what amount it is covered under the **Plan** and (if applicable) the Policy, without regard to whether all the necessary information accompanies the filing. The **Plan**, or the UR for the **Plan**, will notify the claimant of its determination within a reasonable period of time appropriate to the medical circumstances after receipt of the claim and in accordance with the following requirements depending on the nature of the claim, provided that nothing will preclude a voluntary extension of the response deadline if agreed to by the claimant and the **Plan**:

(i) **Urgent Care Claims** - The UR will notify the claimant of its determination as soon as possible taking into account the medical exigencies, but no later than 72 hours after the UR has been notified of the claim. If a determination cannot be made because of the failure to provide sufficient information, the claimant will be notified as soon as possible and within 24 hours after receipt of the claim, of the specific information needed with a deadline of at least 48 hours to respond. The UR will then notify the claimant of its

determination as soon as possible but no later than 48 hours after the earlier of the UR's receipt of the requested information or the claimant's deadline to respond. If the claimant does not provide the UR with the requested information by the response deadline, the claim will be denied. Notification of the UR's determination will be confirmed in writing.

(ii) **Concurrent Care Claims** - The UR will notify the claimant of any reduction or termination (other than by **Plan** amendment or termination) of a pre-approved course of treatment before its original pre-authorized ending and sufficiently in advance to allow the claimant to appeal and obtain a determination on review before the treatment is reduced or terminated. If a claim is filed to extend a pre-authorized course of treatment beyond the approved time or number of treatments and it qualifies as an Urgent Care Claims, the UR shall make a determination as soon as possible taking into account the medical exigencies, and if the claim has been filed at least 24 hours before termination of the treatment, the UR shall notify the claimant of its determination within 24 hours after receipt of the claim. Otherwise, the UR shall notify the claimant of its determination within the response time period applicable to the type of claim for which it qualifies as described in this subsection (d);

(iii) **Pre-Service Claims** - The UR will notify the claimant of its determination within 15 days after the UR has been notified of the claim. If additional time is needed due to matters beyond the **Plan's** control, this 15-day period may be extended for up to 15 days if the claimant is notified, before the end of the initial 15-day response period, of the extension, why it is needed and when a decision is expected. If the reason for the extension is that additional information is needed, the notice of extension will describe the specific information needed with a deadline of at least 45 days to respond. In this case, the initial response deadline will be suspended from the date of the notice until the information is provided or, if earlier, until the response deadline. If the information is not provided by the response deadline and it is necessary for the determination, the claim will be Denied;

(iv) **Post-Service Claims** - The claimant will be notified of the determination within 30 days after the claim is filed. If additional time is needed due to matters beyond the **Plan's** control, this 30-day period may be extended for up to 15 days if the claimant is notified, within the initial 30-day period, of the extension, why it is needed and when a decision is expected. If the reason for the extension is that additional information is needed, the notice of extension will describe the specific information needed with a deadline of at least

45 days to respond. In this case, the initial response deadline will be suspended from the date of the extension notice until the information is provided or, if earlier, until the response deadline. The claimant may be given a combined request for information and notice of denial that applies only if the requested information is not provided within the 45-day response period. If a combined notice is used and the requested information is not provided within 45 days, the claim will be treated as denied, and the time period for appealing the denial will begin to run at the end of the 45-day response period;

(v) **Disability Benefits Claims** - The claimant will be notified of the determination within 45 days after the claim is filed. If additional time is needed due to matters beyond the **Plan's** control, this 45-day period may be extended for up to 30 days if the claimant is notified, within the initial 45-day period, of the extension, why it is needed and when a decision is expected, the standards on which entitlement to the benefit is based, the unresolved issues that prevent a determination on the claim, the additional information needed to resolve those issues, and a response deadline of at least 45 days to provide the information or respond. If more time is needed due to matters beyond the Plan's control, the Plan may take up to an additional 30 days if it notifies the claimant before the end of the first 30-day extension, in a form that satisfies the notice requirements for the first extension notice. If an extension is needed because of the failure to submit information necessary to decide the claim, the response time period will be suspended from the date of the extension notice until the information is provided or, if earlier, until the response deadline.

(vi) **Death/AD&D Claims -** The claimant will be notified of the determination within 90 days after the claim is filed. If additional time is needed due to matters beyond the control of the **Plan** or Insurer, this 90-day period may be extended for up to an additional 90 days if the claimant is notified, within the initial 90-day period, of the extension, why it is needed and when a determination is expected. The **Trustees** may delegate their discretionary authority to decide a Death/AD&D Claim to the Insurer or to any other person or entity. If an extension is needed because of the failure to submit information necessary to decide the claim, the response time period shall be suspended from the date of the extension notice until the information is provided or, if earlier, until the response deadline.

(d) Notice of Determination. If a claim is Denied, the notice of the initial claim determination to the claimant will include the following information:

(i) Specific reason(s) for the Denial;

(ii) Reference to the specific **Plan** or Policy provision(s) on which the Denial is based;

(iii) A description of any additional material or information necessary to perfect the claim and the reasons why it is needed;

(iv) A copy of the **Plan's** Claims Review Procedure;

(v) A statement of the claimant's right to bring a civil action under ERISA Section 502(a) if benefits are denied but only after the claimant completes the Claims Review Procedure;

(vi) For claims other than Death/AD&D Claims, if an internal rule, guideline, protocol or similar criterion is relied upon in making the determination, either the specific rule, guideline, protocol or criterion or a statement that it was relied upon and that a copy will be provided free of charge upon request;

(vii) For claims other than Death/AD&D Claims, if the determination is based on **Medical Necessity** or **Experimental Treatment** or a similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the **Plan** to the claimant's medical circumstances, or a statement that it will be provided free of charge upon request; and

(viii) If the determination concerns an Urgent Care Claim, a description of the expedited review process applicable to such claim. If the Denial involves an Urgent Care Claim, the notice of determination may be given orally within the prescribed time period, provided written notice is furnished to the claimant no later than three days after oral notification.

2. Claims Review Procedure

If a claim is Denied on the initial filing, the claimant may appeal the determination and receive a full and fair review in accordance with the **Plan's** Claims Review Procedure described in this section.

(a) Filing Requirements for Appeal:

In order to appeal a Denial of a claim, the claimant must do the following: (i) for Death/AD&D Claims, a written request for review must be filed with the Company or with the **Plan** at the Fund Office (or as otherwise instructed in the notice of Denial) within 60 days after receipt of the Denial; (ii) for Urgent Care Claims and Pre-Service Claims (as well as Concurrent Care Claims that qualify as such), a request for review must be made by calling or filing a written request for review with the **Plan** at the Fund Office (or as otherwise instructed in the notice of Denial) within 180 days after receipt of the Denial; and (iii) for Disability Claims, Post-Service Claims and Concurrent Care Claims that qualify as Post-Service

Claims, a written request for review must be filed with the **Plan** at the Fund Office (or as otherwise instructed in the notice of Denial) within 180 days after receipt of the Denial. If a request for review is not filed timely in accordance with these requirements, the initial decision on the claim shall be final.

If a written request for review is filed timely, the claimant may submit written comments, documents, records and other information relating to the claim. The claimant may also obtain, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information Relevant to his claim. The reviewer on appeal shall take into account all comments, document, records and information submitted by the claimant and relating to the claim, without regard to whether it was submitted or considered in the initial determination.

For appeals of claims other than Death/AD&D Claims, the claimant may obtain the names of any medical or vocational experts whose advice was obtained by the **Plan** in connection with the initial determination, without regard to whether it was relied upon.

The review on appeal shall comply with the following requirements:

(i) For all claims other than Death/AD&D Claims, no deference shall be given to the initial determination;

(ii) For benefits that are insured and provided through a Policy, the review shall be conducted by the Company unless otherwise provided by the Policy or **Board of Trustees**. For all other claims, the review shall be conducted by the **Board of Trustees** or such person(s) or entity designated by the **Board of Trustees** to consider and decide the appeal, provided that the reviewer on appeal shall not be the same person(s) or entity who made the initial determination or a subordinate thereof;

(iii) For all claims other than Death/AD&D Claims, if the initial determination is based in whole or part on medical judgment, the reviewer shall consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who was not consulted and is not a subordinate of any Health Care Professional who was consulted in connection with the initial determination; and

(iv) If the appeal is for an Urgent Care Claim or Concurrent Care Claim that qualifies as such, all necessary information including the Plan's determination on review, shall be transmitted between the Plan and claimant by telephone, facsimile or other available similarly expeditious method.

(b) Time Period for <u>Claims Determination on Appeal:</u> The decision on appeal will be made within a reasonable period of time after receipt of a claim

that is filed in accordance with the Claims Review Procedure without regard to whether of all the necessary information accompanies the filing, and in accordance with the following:

(i) **Urgent Care Claims** - The claimant will be notified of the final determination of the claim as soon as possible taking into account the medical exigencies, but no later than 72 hours after filing;

(ii) **Pre-Service Claims** - The claimant will be notified of the final determination of the claim no later than 30 days after filing;

(iii) **Concurrent Care Claims -** The claimant will be notified of the final determination of the claim within the time period applicable to the nature of the claim;

(iv) **Post-Service Claims and Disability Claims -** The final determination on review will be made no later than the first meeting of the **Board of Trustees** that immediately follows the filing. If the request for review is filed within 30 days before such meeting, the **Board of Trustees** have until their second meeting following such filing to make a determination on review. If a further extension of time is needed due to special circumstances, the **Board of Trustees** have until their third meeting following the filing provided the claimant is notified in writing, before the extension, of the special circumstances and the date by which a determination will be made. The claimant will be notified of the final determination on review as soon as possible but no later than five days after it is made; and

(v) **Death/AD&D Claims -** The claimant will be provided with written notice of the final determination of the claim within a reasonable period of time but no later than 60 days after receipt of the request for review unless additional time is needed. An extension of up to 60 days may be taken if warranted by special circumstances, provided the claimant is notified in writing, before the end of the initial 60-day period, of the extension, why it is needed and when a decision is expected.

Nothing in this Claims Review Procedure will preclude a voluntary extension of the response deadline if agreed to by both the claimant and the **Plan**.

(c) **Notice of Determination:** The reviewer on appeal will provide the claimant with written notification of the benefit determination on review. In the case of a Denial on review, the notification shall set forth the following information in a manner calculated to be understood by the claimant:

(i) The specific reasons for the Denial;
(ii) A reference to the specific **Plan** provisions on which the determination is based;
(iii) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim and a statement of the claimant's right to bring an action under ERISA Section 502(a);
(iv) For all claims other than Death/AD&D Claims, any internal rule, guideline, protocol or other similar criterion that was relied upon in making the Denial or a statement that it was relied upon and that a copy will be provided free of charge upon request;
(v) For all claims other than Death/AD&D Claims, if the Denial is based on **Medical Necessity**, **Experimental Treatment** or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the **Plan** to the claimant's medical circumstances, or a statement that it will be provided free of charge upon request; and
(vi) A statement describing any voluntary alternative dispute resolution options, such as mediation, that are available, and the claimant's right to obtain information about such procedures.

A decision on review of any claim made under the **Plan** in accordance with the Claims Review Procedure shall be final and binding on all persons.

TIME LIMIT ON LEGAL ACTION

No action at law or in equity may be brought by or on behalf of any person to receive benefits under the **Plan** unless the person or a legal representative thereof has first fully and timely complied with and exhausted all of the requirements of the Claims Procedure and Claims Review Procedure under the **Plan**, and in no event may any such legal action be brought later than one year following a final determination of a claim under the **Plan**. For claims involving the Death Benefit and Accidental Death and Dismemberment Benefit, the time limit

for bringing legal action shall be modified by any conflicting provisions of the Policy through which such benefits are provided.

PLAN AMENDMENT AND TERMINATION

In order that the **Plan** may carry out its obligation to maintain, within the limits of its resources, a **Plan** dedicated to providing the health and welfare benefits for you and your **Dependents**, the **Trustees** possess the right, in their sole discretion, at any time and from time to time, to do any of the following: a) to terminate, amend or reduce the benefit coverage or amount, or to modify the eligibility conditions with respect to any benefit; b) to terminate the **Plan** in whole or part; c) to alter or postpone the method of payment of any benefit; d) to enter into a merger with one or more other group plans, providing such merger is accomplished pursuant to applicable law; and e) to amend the **Plan** in whole or part at any time.

Unless and until terminated, the **Plan** remains in full force and effect. Authorized changes take effect as specified by the **Trustees** and apply to all affected persons regardless of status, illness, injury, condition or disability sustained prior to the effective date of change. Eligibility and benefits under the **Plan** are not guaranteed or vested rights and are subject to amendment or termination by the **Trustees** at any time.

Any amendment or termination of the **Plan** will be consistent with all applicable provisions of the Trust Agreement. In the event of **Plan** termination, no further benefits shall be payable under the **Plan** except for all claims and expenses incurred prior to the termination date, which will be paid in accordance with the provisions of the **Plan** or, to the extent not provided, as determined by the **Trustees**. In no event, however, will there be any liability on the **Plan**, **Fund**, **Trustees**, **Employers**, **Union** or any other person to provide payments over and beyond the amounts available in the Fund or any insurance policies issued to the **Fund** for the purpose of providing benefits. Upon termination of the **Plan**, the **Trustees** will, within the limits of the **Plan's** resources, adopt a plan to discharge all outstanding obligations and to provide that all remaining **Plan** assets be used in a manner which best carries out the basic purpose for which the **Plan** was established.

SUBROGATION AND REIMBURSEMENT RIGHTS OF THE PLAN

If you or your **Dependent** files a claim with the **Plan** for medical benefits in connection with charges incurred for an injury, sickness or condition for which a third party is or may be legally responsible due to negligence or wrongful action, or for which benefits may be payable under a workers' compensation law, and the **Plan** advances or pays benefits that are otherwise payable under the **Plan** in the absence of third party liability or worker's compensation benefits, the **Plan** will have the subrogation, reimbursement and recovery rights set forth in this Section with respect to the amount of benefits advanced or paid. The **Plan** will be subrogated to all claims, demands, actions and rights of recovery which you or your **Dependent** has against any third party, arising out of any claim or cause of action which may accrue because of the alleged negligence or wrongful action of the third party, or with respect to the payment of workers' compensation benefits, for the amount of benefits advanced or paid by the **Plan**.

A "third party" may include any of the following: (a) the person or entity alleged to have caused you or your **Dependent** to suffer the injury, sickness or condition or to be legally responsible for it; (b) an insurer or other indemnifier of the person or entity described in (a); (c) a person or entity who is or may be obligated to provide you or your **Dependent** with benefits or payments under any underinsured or uninsured motorist insurance coverage, medical provisions of no-fault or traditional insurance (such as automobile or homeowners insurance), workers' compensation coverage or any other insurance carrier or third party coverage.

The **Plan** may condition payment of benefits for such charges upon the your or your **Dependent's** execution of the **Plan's** subrogation and reimbursement agreement, certifying the following: (a) that no other payments have been made in satisfaction of your or your **Dependent's** claim(s); (b) that your or your **Dependent's** claim(s) are disputed; (c) that the responsible third party is withholding payment pending resolution of the dispute; and/or (d) any additional provisions required by the **Plan**. Failure to require you or your **Dependent** to sign a subrogation and reimbursement agreement prior to receiving payment of benefits will not preclude the **Plan** from requiring you or your **Dependent** to do so at any time thereafter pending the **Plan's** recovery of benefits or adversely affect the **Plan's** right to exercise its subrogation and reimbursement rights set forth in this Section.

If you or your **Dependent** is represented by an attorney for injuries arising out of the incident giving rise to the claim, the attorney may be required to execute the **Plan's** agreement to the effect that all funds received on behalf of you or your **Dependent** will first be applied to satisfy the subrogation lien, and in the event of

a dispute over the amount required to discharge the lien, the sums will be held in escrow by the attorney until the dispute is resolved.

In addition, any benefits paid by the **Plan** for which there may be such third party liability or for which worker's compensation benefits may be payable will be made on the condition and with the understanding that the **Plan** will be reimbursed from any recovery and that you or your **Dependent** is obligated to comply with the following requirements:

(a) To reimburse the **Plan** and **Fund** out of the first proceeds of any recovery or settlement payable by the responsible third party, the responsible third party's insurer or your or your **Dependent's** own insurer with respect to such third party liability (e.g., under uninsured motorist or homeowner's insurance coverage), or pursuant to worker's compensation law, whether by way of litigation, settlement or otherwise and regardless of how the proceeds are characterized. The **Plan's** right of recovery will be a prior lien against any such proceeds, and the **Plan's** right may not be defeated or reduced by the application of any "make-whole doctrine" or other common-fund doctrine that purports to defeat the **Plan's** recovery rights by allocating the proceeds exclusively to non-medical expense damages;

(b) To reimburse the **Plan** and **Fund** from any gross amount recovered by the Participant before payment of attorneys' fees and costs;

(c) To cooperate fully with the **Plan** and to execute and provide all necessary documents and information requested by the **Plan** to protect, enforce and/or facilitate its subrogation, reimbursement and recovery rights;

(d) Not to take any action that would interfere with the **Plan's** subrogation, reimbursement and recovery rights under this Section;

(e) To recognize that the **Plan** has no obligation to pay to you or your **Dependent** or your attorney any amounts expended by them in attorneys' fees and costs of litigation in pursuing their claims against others;

(f) To reimburse the **Plan** and otherwise make the **Plan** whole for any and all attorneys' fees and costs expended by the **Plan** in pursuing litigation or other actions, in whatever forum, to enforce the terms of the **Plan** and the **Plan's** subrogation, reimbursement and recovery rights;

(g) To notify the **Plan** before starting legal action or filing suit against a third party that is allegedly liable (or an insurer with respect thereto), to make no settlement and to grant no release to any third party or insurer without prior notice to and consent of the **Plan**;

(h) To acknowledge the **Plan's** rights and allow the **Plan** to intervene in any claim or action taken by or on behalf of you or your **Dependent** against an allegedly liable third party or insurer; and

(i) To protect the **Plan's** subrogation, reimbursement and recovery rights and do nothing that would in any way prejudice such rights.

If you or your **Dependent** refuses or fails to comply with its obligations or cooperate in any manner as required under this Section or to reimburse the **Plan** after receiving payment of sums due to the **Plan**, the **Plan** may institute legal action to recover the benefits paid and/or withhold payment of other benefits due under the **Plan** to or for you or your **Dependent** for related or unrelated claims to recover the amounts owed to the **Plan**, until you or your **Dependent** complies or the amounts owed to the **Plan** are fully recovered.

MISCELLANEOUS

1. Qualified Medical Child Support Order (QMCSO)

A QMCSO means any judgment, decree, or order (including approval of a domestic relations settlement agreement), issued by a court of competent jurisdiction and providing for child support or health benefit coverage for a **Dependent** child, which satisfies the requirements of ERISA Section 609(a). A National Medical Support Notice (issued by an appropriate state or local government agency) may also be a QMSCO. A QMCSO must specify the name and address of the **Participant** and each alternate recipient (i.e., the child who is the subject of the support order), describe the type of coverage to be provided and the period for which the coverage is to be provided, and specify the plan to which the QMCSO applies. An individual can obtain from the Plan Administrator a copy of the procedures governing the QMCSO determinations, without charge.

2. Family and Medical Leave Act (FMLA)

If you work at least 1,250 hours over a 12-month period for a contributing **Employer**, at a location where at least fifty (50) employees are employed within a 75-mile radius, you may be eligible to take a leave of absence under the Family and Medical Leave Act of 1993 ("FMLA Leave") and the **Plan's** related policies and procedures. If you qualify, you may receive up to 12 weeks of unpaid leave in a 12-month period for the reasons described below, or up to 26 weeks if the reason is to care for a covered service member who has incurred a serious injury or illness while in the line of active duty. During a FMLA Leave, your pre-leave medical coverage through the **Plan** will continue as though you were still working.

FMLA Leave may be available when needed for the birth and care of a newborn child; a child's placement with you for adoption or foster care; to care for certain family members with a serious health condition or when you are unable to work because of a serious health condition; or for "qualifying exigencies" when

certain family members are called to active duty status in the National Guard or Reserve. If you are considering a FMLA Leave, please contact the **Plan Administrator** immediately for additional details concerning eligibility and your notice obligations.

3. Physical Examination

The **Plan** has the right, at its expense, to have any individual, whose injury or sickness is the basis of a claim, examined by a **Physician** of the **Plan's** choosing when and as often as it may reasonably require during the pendency of a claim, and to make an autopsy in case of death where this is not prohibited by law.

4. Plan Reimbursement and Recovery Rights and False/Erroneous Claims

The **Plan** is entitled to recover any amounts it has improperly paid out as benefits due to error or on any other basis, from any person, including you or the relevant **Dependent**. The **Plan** may also recover any sums improperly or erroneously paid through the offset of any related or unrelated, subsequent or previously existing, benefits due to any person, including you and or the relevant **Dependent**. The **Trustees** may withhold or deny payment of any claim which they reasonably believe may be based on erroneous or misstated facts or representations by any claimant or supplier of covered services or supplies.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

The **Plan** has the right to release to or obtain from another person or entity, information relating to your claim or the claim of your **Dependent** which the **Plan** considers reasonably necessary for administering the **Plan** and determining and paying benefits that may be due. However, what the **Plan** does with your health information is subject to the privacy rules of the Health Insurance Portability and Accountability Act of 1996 ("HIPPA").

The law known as "HIPAA" resulted in federal privacy and security rules that require health plans, such as this **Plan**, to protect the confidentiality of your protected health information, sometimes called "PHI". This also applies to your **Dependent's** PHI. PHI is defined under HIPAA and generally includes health information, including demographic information, that is collected from you or created or received by the **Plan** in any form (oral, written or electronic), from which it is possible to individually identify you. In addition, the information must relate to your past, present or future health or condition (physical or mental), providing health care to you, or paying for your health care. A complete

description of your privacy rights can be found in the **Plan's** Notice of Privacy Practices which was distributed to you upon enrollment. You may also request a copy by contacting the Administrative Office or at our website: www.ualocal60.org.

We will not use or disclose your PHI except as necessary for treatment, payment, health plan operations and **Plan** administration, or as permitted or required by law, or as otherwise authorized by you. We have also required all of our business associates, such as the **Plan's** consultants, that may create or receive PHI on our behalf to observe the privacy and security rules with respect to PHI.

We will not, without your authorization, use or disclose PHI for employment-related actions and decisions or in connection with any of our other benefits or employee benefit plans. If someone other than you, even a friend or relative, contacts us and wants to discuss a claim or matter involving your PHI, your authorization will first be required unless the discussion is otherwise permitted under HIPAA. Written explanations of benefits (EOBs) for **Dependent** spouses and children age 18 or older will be mailed to the spouse or child unless he or she provides other written instructions to the **Plan**.

You have certain rights under the privacy rules with respect to your PHI, including the right to see and copy the information, to receive an accounting of certain disclosures of the information, and to amend the information in certain circumstances. You also have the right to file a complaint with the **Plan** or with the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated. Your rights are explained in greater detail in the **Plan's** Notice of Privacy Practices.

If you have questions about the privacy or security of your health information or wish to file a complaint under HIPAA, please contact the Administrative Manager at the Administrative Office. The Administrative Manager also serves as the Plan's Privacy and Security Officer.

IMPORTANT INFORMATION ABOUT THE PLAN

The following information concerning the **Plan** is being provided to you in accordance with government regulations:

1. Plan Name

The name of the **Plan** is the Plumbers and Steamfitters Local 60 Health and Welfare Plan.

2. Type of Plan

The **Plan** is a self insured group health plan. The Plan also provides a life insurance benefit and accidental death and dismemberment benefits through insurance policies issued to the **Plan**.

3. Plan Sponsor and Plan Administrator

This collectively bargained plan is sponsored and administered by a joint **Board of Trustees** consisting of an equal number or Union and Employer representatives. The address and phone number for the Board of Trustees is:

The Board of Trustees
Plumbers and Steamfitters Local 60 Health and Welfare Fund
3515 I-10 Service Road
Metairie, LA 70002
(504) 885-3062

A copy of the collective bargaining agreement as well as a complete list of the employers and employee organizations participating in the **Plan** are available for inspection without charge at the Fund Office. You may obtain a copy upon written request to the **Board of Trustees** for a minimal copying fee. You may request the amount of the fee before requesting the copies.

4. Type of Administration

The **Plan** is administered by a Joint **Board of Trustees** consisting of an equal number of Union representatives and Employer representatives.

5. Names and Business Addresses of the Plan's Trustees

Union Trustees	**Employer Trustees**
Mr. Curtis Mezzic 3515 I-10 Service Road Metairie, LA 70002	Mr. Chester Cabirac 3001 Jean Lafitte Parkway Chalmette, LA 70043 70119
Mr. Ronnie Rosser 3515 I-10 Service Road Metairie, LA 70002	Mr. Henry G. Heier 139 North Hennessey Street New Orleans, LA 70119
Mr. Mike Eilers 3515 I-10 Service Road Metairie, LA 70002	Mr. Pat Gootee 2400 North Arnoult Road Metairie, LA 70001

6. Name and Address for Agent of Service of Process

The **Board of Trustees** for the **Plan** has been designated as the agent for service of legal process. Service of process may be made at the following address:

The Board of Trustees
Plumbers and Steamfitters Local 60 Health and Welfare Fund
3515 I-10 Service Road
Metairie, LA 70002

In addition, service may be made upon any of the individual Plan Trustees.

7. Plan Number and Employer Identification Number

The Plan Number (PN) assigned by the **Board of Trustees** to the **Plan** is 501. The Employer Identification Number (EIN) assigned by the Internal Revenue Service to the **Board of Trustees** for the **Plan** is 72-0450650.

8. Plan Year-End

The **Plan's** year-end for purposes of keeping the **Plan's** financial books and records is June 30.

9. Contributions Source

All contributions to the **Plan** are made by **Employers** in accordance with collective bargaining and participation agreements between the various **Employers** and the Plumbers and Steamfitters Local Union No. 60. The collective bargaining and participation agreements require contributions to the Plan at a fixed rate per hour. Upon written request the **Plan Administrator** will provide you with information regarding whether a particular **Employer** is contributing to this **Plan** on behalf of **Participants** working under a collective bargaining or participation agreement.

10. Identity of Funding Medium Used for Accumulation of Assets

All **Plan** assets are held in a trust fund established and administered by the **Board of Trustees**. The **Plan** assets are held in the custody of a national bank, which is currently First NBC. The **Board of Trustees** may appoint from time to time certain qualified investment advisors to assist with the investment of **Plan** assets. The **Board of Trustees** may contract from time to time with an insurance company to provide some benefits under the **Plan**. Currently, the Death Benefit

and Accidental Death and Dismemberment Benefit, are insured by the Union Labor Life Insurance Company (1625 Eye Street, NW, Washington DC 20006, telephone 1-500-431-5425). The Board of Trustees has also purchased a stop-loss insurance policy from Union Labor Life Insurance Company to help limit the Plan's financial exposure from catastrophic losses; the stop-loss policy does not provide or guarantee benefits to Participants. All other **Plan** benefits are payable solely out of the assets of the trust fund.

STATEMENT OF ERISA RIGHTS

As a **Participant** in the Plumbers and Steamfitters Local 60 Health and Welfare Plan, 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:

Receive Information About Your Plan and Benefits

(a) Examine, without charge, at the **Plan Administrator's** office all **Plan** documents including insurance contracts, Collective Bargaining and Participation Agreements and all documents filed by the **Plan** with the U. S. Department of Labor, such as detailed annual reports and **Plan** descriptions.
(b) Obtain, upon written request to the **Plan Administrator**, copies of documents governing the operation of the **Plan**, including insurance contracts, Collective Bargaining and Participation Agreements, copies of the latest annual report (Form 5500 Series), and updated Summary Plan Description. The **Plan Administrator** may make a reasonable charge for the copies.
(c) Receive a summary of the **Plan's** annual financial report. The **Plan Administrator** is required by law to furnish each **Participant** with a copy of this summary annual report.

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 this **Plan**. The people who operate your **Plan**, called "fiduciaries" of the **Plan**, have a duty to do so prudently and in the interest of you and other **Plan Participants** and beneficiaries. No one, including your **Employer**, your **Union**, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

(a) If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to receive a written explanation of the reason for the denial. You have the right to have the **Plan** review and reconsider your claim.
(b) Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the **Plan** and do not receive them within thirty (30) days, you may file a 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 one hundred ten dollars ($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 welfare benefits which is denied or ignored, in whole or in part, you may file suit in a federal court. If it should happen that Plan fiduciaries misuse the **Plan's** money, or 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 the court costs and legal fees. If you are successful, the court may order the person you 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. However, in all cases including those described in the above paragraph, a person must first exhaust his administrative remedies under the **Plan** by following the Claims Procedure and Claims Review Procedure described in this document before the person may file a suit in any court. The person will then have one year form the date a final decision on appeal is reached under the **Plan** in which to start a lawsuit. In no event may the person bring legal action in a court later than this one year period.

Assistance With Your Questions

If you have any questions about your **Plan**, you should contact the **Plan Administrator**. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

IMPORTANT NOTIFICATIONS TO THE PLAN

It is important that you notify the **Plan Administrator** whenever:

1. You change your home address;
2. You wish to change your beneficiaries;

3. You wish to add or remove **Dependents**, or you have a new **Dependent**;
4. You are married, separated or divorced;
5. You are receiving Workers Compensation benefits;
6. You return to work after a disability ceases;
7. You enter or return from service in the Armed Forces of the United States;
8. You become totally disabled; or
9. You have qualified for COBRA or Medicare.

NOTICE

This **Plan** does not constitute a contract of employment or give any **Employee** of a contributing **Employer** the right to remain in the service of the **Employer** or to interfere with the right of the **Employer** to discharge any **Employee**. These issues are covered by your Collective Bargaining or Participation Agreement.

You MUST satisfy all of the eligibility provisions in order to be eligible for the benefits of the **Plan**. Possession of this Booklet does not automatically entitle you to **Plan** benefits.

The **Board of Trustees** has full and exclusive authority in its sole discretion to determine all questions of coverage and eligibility, methods of providing or arranging for benefits, amount of payment, and other matters. The **Trustees** also have full power to construe the provisions of the Agreement and Declaration of Trust for the Plan and the Amended and Restated Rules and Regulations of the Plan. Any such determination and any such construction adopted by the **Board of Trustees** in good faith is binding on all entities and beneficiaries of the **Plan**.

The summary in this Booklet in no way limits or expands upon the provisions of the **Plan**. Each provision of the **Plan** is severable from the others and the invalidity of one or more provisions or portions in the **Plan** will not have any effect upon the validity or enforceability of any of the other provisions or portions of the **Plan**.

The medical benefits described in this Booklet are generally not insured and there is no liability upon the **Board of Trustees** or any individual or entity to provide payment over and above the amount in the **Plan** available for such purposes.

From time to time, this Booklet and/or any related insurance contracts may be modified. The **Board of Trustees** reserves the right to revise or discontinue the policies, procedures and/or benefits detailed at any time. This Booklet and all related documents are written to be as understandable as possible. This effort has simplified the language of the **Plan**. It is not intended that this simplification will supersede the coverage and requirements of the **Plan**.

In the event of a conflict between the Plan document and this Booklet, the Plan, and not this Booklet, will govern.