Plumbers and Pipefitters Local No. 172 Welfare Fund

Summary Plan Description

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Plan Document

2015 Edition

PLUMBERS AND PIPEFITTERS LOCAL NO. 172 WELFARE FUND

Stewart C. Miller & Co., Inc.
2111 West Lincoln Highway
Merrillville, Indiana 46410
Telephone: (219) 769-6944
Toll Free number: (800) 759-6944

WWW.SCMILLER.COM

BOARD OF TRUSTEES
(ADMINISTRATOR AS DEFINED BY LAW)

Union Trustees	Employer Trustees
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Mr. Broc Buczolich	Mr. Kevin Conery

THIRD PARTY ADMINISTRATOR

Ms. Carolyn Fredrick
Stewart C. Miller & Co., Inc.

FUND COUNSEL

AND

AGENT FOR THE SERVICE OF LEGAL PROCESS

Dennis R. Johnson
Johnson & Krol, LLC

CONSULTANT

TFBC, LLC

CERTIFIED PUBLIC ACCOUNTANTS

Legacy Professionals LLP

A MESSAGE FROM THE BOARD OF TRUSTEES

We are pleased to provide you with this updated booklet describing your health benefits under the Plumbers and Pipefitters Local No. 172 Welfare Fund, effective January 1, 2015 unless otherwise indicated. Although this booklet is meant to be an easy-to-understand description of your Plan benefits, it also serves as the Plan Document, the Plan's official Rules and Regulations.

This booklet describes the benefits and the Plan's eligibility rules. The following are the significant changes that were made to your Plan of Benefits since the booklet was last printed:

Important terms used throughout this booklet are capitalized and defined. Please keep this booklet with your other important papers and share this information with your family. If you have questions about information in this booklet, you should contact the Third Party Administrator.

This booklet replaces and supersedes any previous written explanation of the Plan.

IMPORTANT REMINDERS

- Tell your family, particularly your spouse, about this booklet and where it is located.
- Please notify the Third Party Administrator promptly if you change your address.
- Only the full Board of Trustees is authorized to interpret the benefits described in this booklet.
- No Employer, the Union, nor any representative of any Employer or Union, in such capacity, is authorized to interpret this Plan, nor can any such person act as agent of the Trustees.
- The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant. You will be notified in writing of any Plan changes.

The following table provides a list of the benefits that apply to each type of Participant provided that you meet the individual eligibility requirements as provided in the applicable Section:

Benefit	Active Bargaining Unit Employee	Active Non-Bargaining Unit Employee	Bargaining Unit Retiree	Non-Bargaining Unit Retiree
Major Medical	✓	✓	✓	✓
Prescription Drug	✓	✓	✓	✓
Hospice	✓	✓	✓	✓
Death	✓	✓		
AD&D	✓	✓		
Dental	✓			
Vision	✓			
Weekly Disability	✓			

PLAN VENDOR INFORMATION AS OF JANUARY 1, 2015

The **Third Party Administrator** is responsible, under the oversight of the Board, for providing various administrative services for the Plan, including maintaining eligibility records, ensuring that Plan provisions are followed on the payment of claims, handling member requests for information and for providing various reports and other services that the Plan requires. ***The Trustees selected Stewart C. Miller & Co., Inc. as the Third Party Administrator***. At www.scmiller.com, you will receive unique passwords that will allow you to access your personal eligibility/claims history and to view the Plan/SPD 24 hours a day, 7 days a week through the use of this option. The site contains additional links and services you will find valuable in understanding and using your coverage effectively. Please take full advantage of this service. Additionally, Stewart C. Miller's Customer Service Department will be available for any questions members may have regarding Plan benefits in general, as well as questions specific to an individual member's eligibility at (800) 759-6944 or claims at (800) 552-6550, Mon.-Fri. 8:00 to 4:30 EST, or visit Stewart C. Miller's website at www.scmiller.com.

The **Preferred Provider Organization (the "PPO" or "network")** provides access to medical providers offering discounted fees in exchange for the Plan's reimbursement of their services at a higher level than for non-network providers. ***The Trustees selected Anthem as its PPO***. The Anthem ID card is accepted by an extremely wide range of Hospitals, Physicians and other health care providers who have agreed to participate in the network program. Please call the number provided on your ID card, the Third Party Administrator or visit www.scmiller.com to identify PPO providers.

The **Pre-Certification/Utilization Review Organization ("UR")** helps you and the Plan reduce costs and wasteful expenses by reviewing, authorizing and certifying certain medical procedures, admissions and other medical expenses. This process is called the Pre-Certification Program (also known as the Utilization Review Program). ***The Trustees selected Hines & Associates to provide Pre-Certification and UR services to the Plan.*** You can contact Hines & Associates for any Pre-Certification questions and/or to request Pre-Certification at 800-670-7718.

The **Pharmacy Benefit Manager ("PBM")** provides access to pharmacies and mail order services offering discounted prices for covered Prescription Drugs in exchange for the Plan's coverage of such services at a higher level than for non-participating pharmacies or mail order providers. ***The Trustees selected Catamaran to provide the Plan's preferred prescription drug coverage.*** The Catamaran ID card is accepted by a wide range of pharmacies participating in the Catamaran network program for the purchase of covered Prescription Drugs. Call Catamaran at **(888) 354-0090** with questions or visit www.myCatamaranRx.com. Additionally, the **Plan's Specialty Drug Program** is administered by **Briova**. If you are prescribed a Specialty Drug, you should call **(800) 850-9122** as soon as possible to enroll in the program.

The **Dental PPO** provides access to dental providers offering discounted fees. ***The Trustees selected Delta Dental to provide the Plan's Dental PPO***. Call Delta Dental at **(800) 524-0149** or visit www.deltadental.com for further information regarding PPO providers.

The **Vision Benefit** is exclusively provided through a contract with a vision network that provides access to vision providers offering discounted prices for Covered Expenses under the Plan. ***The Trustees selected VSP as the Vision Benefit provider***. Call VSP at **(800) 877-7195** or visit www.vsp.com for more information about the Vision Benefit.

Table of Contents

SECTION 1: SCHEDULES OF BENEFITS

A Schedule of Benefits is a list of benefit amounts and exclusions that apply to benefits offered by the Fund. Each specific benefit is described in more detail in the section concerning that particular benefit. When reading the specific benefit section, you should reference the applicable Schedule of Benefits and vice-versa.

Death Benefit for Active Bargaining Unit Employees & Active Non-Bargaining Unit Employees	
Active Participants in the Pension Plan	$20,000
All other Active Bargaining and Non-Bargaining Unit Employees	$10,000

AD&D Benefit for Active Bargaining Unit Employees & Active Non-Bargaining Unit Employees	
Active Participant in the Pension Plan	
For loss of: • Life • Both hands, both feet or sight of both eyes • One hand and one foot, one hand and sight in one eye, or one foot and sight in one eye • One hand or one foot	 $20,000 $20,000 $20,000 $10,000
All other Active Bargaining and Non-Bargaining Unit Employees	
For loss of: • Life • Both hands, both feet or sight of both eyes • One hand and one foot, one hand and sight in one eye, or one foot and sight in one eye • One hand, one foot or one hand	 $10,000 $10,000 $10,000 $5,000

Weekly Disability Benefit for Active Bargaining Unit Employees	
Weekly amount	$300 per week for a maximum of 13 weeks

Major Medical Benefit		
Plan Deductibles for Covered Medical Expenses	***PPO Charges***	***Non-PPO Charges***
Calendar year Deductible	$800 individual $1,600 family	$1,200 individual $2,400 family
Emergency room/urgent care *If admitted to Hospital, the $100 Emergency Deductible is waived; however, benefits will be subject to the Plan's calendar year Deductible listed above.	$100 per visit*	$100 per visit*
Pre-Certification Penalty	***PPO Charges***	***Non-PPO Charges***
Non-Emergency Inpatient hospitalizations* Outpatient surgical procedures Convalescent Care/Skilled Nursing Home Health Care Hospice Durable Medical Equipment Genetic Testing *Notification of Emergency hospitalizations is required within 1 business day following admission	$250 penalty	$250 penalty
Major Medical Out-of-Pocket Maximum	***PPO Charges***	***Non-PPO Charges***
Out-of-pocket maximum per calendar year Once you reach the out-of-pocket maximum, the Plan pays 100% of Allowable Expenses for the calendar year up to the maximum benefit listed. *The maximum does not include Non-PPO Deductibles (except for Emergency Deductible), Non-PPO Co-Payments, or Prescription Drug Co-Payments.	$5,000 per person* $10,000 per family*	$10,000 per person*

Major Medical Benefits Subject to Visit Maximums		
Chiropractic care (not including x-rays or laboratory services)	20 visits per calendar year	
Covered Medical Expenses	***PPO Charges***	***Non-PPO Charges***
Preventive Services	100% (not subject to Deductible)	60% after Deductible
Physician office visit	$20 Co-Payment	60% of UCR
Emergency services	80% of negotiated rate (subject to Emergency Deductible)	80% of the greater of the following amounts: (a) the median of the amount negotiated with each PPO provider, (b) the PPO negotiated rate or (c) the Medicare rate (subject to Emergency Deductible)
Outpatient Hospital treatment and Inpatient Hospital treatment including room and board	80% of negotiated rate	60% of UCR
Mental Nervous Disorders and/or Substance Abuse		
Inpatient treatment	80% of negotiated rate	60% of UCR
Outpatient treatment	$20 Co-Payment	60% of UCR
Convalescent Care/Skilled Nursing Facility	80% of negotiated rate	60% of UCR
Home Health Care	80% of negotiated rate for up to 40 visits/calendar year	60% of UCR for up to 40 visits/calendar year
Temporomandibular joint syndrome (TMJ)	80% of negotiated rate	60% of UCR
Hospice Benefits	80% of negotiated rate	60% of UCR
All other Covered Medical Expenses	80% of negotiated rate	60% of UCR

Prescription Drug Benefit		
Calendar year Deductible	$100 per person $200 per family (two individual Deductibles)	
Out of Pocket Maximum	$1,600 per person $3,200 per family	
Your Co-Payment Amount	***Retail (30-day supply)***	***Mail (90-day supply)***
Generic	$15	$30
Preferred	$40	$80
Non-Preferred	$60	$120
Specialty	20% up to a maximum of $150 per fill	20% up to a maximum of $150 per fill

Dental Expense Benefit for Active Bargaining Unit Employees and Dependents	***Delta Dental PPO Charges***	***Delta Premier Charges***	***Nonparticipating Charges***
Calendar year maximum (Does not apply to expenses incurred by Dependent children under age 19 for Diagnostic and Preventative services)	$1,250 per person	$1,000 per person	$1,000 per person
Diagnostic and Preventative Services Emergency Palliative Treatment, and Radiographs	100% of PPO amount	100% of maximum approved fee	100% of nonparticipating Dentist fee
Basic Services, including Minor Restorative, Endodontic Services, Non-Surgical Periodontic Services, Oral Surgery Services, Other Basic Services, Relines and Repairs to bridges, dentures and implants	80% of PPO amount	80% of maximum approved fee	80% of nonparticipating Dentist fee
Major Services, including Surgical Periodontic Services, Major Restorative Services, and Prosthodontic Services	60% of PPO amount	60% of maximum approved fee	60% of nonparticipating Dentist fee
Orthodontic Care for Dependent children under age 19 *Lifetime limit does not apply to expenses incurred where the Child meets or exceeds a score of 42 from the modified Salzmann index or Medically Necessary expenses as determined by the utilization review organization.	50% of PPO schedule amount up to $1,500 per lifetime per Child	50% of maximum approved fee up to $1,500 per lifetime per Child	50% of nonparticipating Dentist fee up to $1,000 per lifetime per Child

Vision Expense Benefit for Active Bargaining Unit Employees and Dependents	***PPO Charges***	***Non-PPO Charges***
Eye exam (One every calendar year)	$0 copayment, Plan pays 100%	Plan pays up to $35 per person (not applicable to Dependent Child under age 19)
Lenses (One pair every calendar year) Single vision, lined bifocal and lined trifocal lenses Polycarbonate lenses for dependent children	$0 copayment, Plan pays 100%	Plan pays up to: Single vision lenses: $60 Lined bifocal lenses: $80 Lined trifocal lenses: $95 For Dependent children under age 19, the Plan pays 50% over the stated Plan maximums
Frames (One every other calendar year) *For Dependent Children under age 19, the Plan pays 50% over the stated Plan maximums.	Plan pays up to $125* and you receive a 20% discount off the amount over $125	Plan pays up to $70*
Contact lenses in place of frames and lenses (No more than once per calendar year) If you choose contacts, you will be eligible for a frame in 12 months from the date you obtain contacts.	Plan pays up to $115 for contacts and contact lens exam every 12 months	Plan pays up to $100 every 12 months

SECTION 2: ELIGIBILITY

2.01 Active Benefits

A. Eligibility for Active Non-Bargaining Unit Employees

1. Initial Eligibility Requirements

   As an Active Non-Bargaining Unit Employee, you and your Dependents are eligible to participate in the Plan on the first day of the month following the month in which your Contributing Employer submits the required Contributions on your behalf and the following conditions are met:

   (a) Your Contributing Employer has executed a Welfare Fund Participation Agreement;

   (b) Your Contributing Employer makes timely Contributions on your behalf; and

   (c) You did not previously opt out of the Plan. However, if you opted out because you were covered (1) under another employer sponsored group health plan or (2) under the Plan as a Dependent, you may be eligible for coverage under the Plan, provided that you apply for coverage within 60 days of the loss of your other coverage.

   Coverage under the Plan for Active Non-Bargaining Unit Employees* includes Death Benefits, AD&D Benefits, Major Medical Benefits and Prescription Drug Benefits. Dependents are not eligible for Death or AD&D Benefits.

   *If you were an Active Non-Bargaining Unit Employee of the Union as January 1, 2014, you are treated as an Active Bargaining Unit Employee for the purposes of determining eligibility for Vision, Dental, Weekly Disability Benefits, Dollar Bank Account Benefits and Retiree Benefits under the Plan provided that you remain otherwise eligible for Active benefits under the Plan due to contributions made by the Union on your behalf.

2. Continued Eligibility Requirements

   You will continue to be eligible for benefits under the Plan for each calendar month in which your Contributing Employer submits the required Contributions on or before the last day of the previous month. The Board of Trustees determines the amount of Contributions required for eligibility.

3. When Coverage Ends

   Your coverage under the Plan will end on the last day of the calendar month during which Contributions were contributed on your behalf. However, if your Contributing Employer submits the required Contributions on or before the 15th of the month after they are due, the Fund will reinstate your coverage for that month.

   In the event that you lose coverage under the Plan, the only methods of coverage available to you are to reestablish initial eligibility and/or to elect COBRA Continuation Coverage.

For Example: Your Contributing Employer first submits Contributions on your behalf on January 31 and then submits timely Contributions on February 28 and March 31 but does not submit timely Contributions before April 30. You will be eligible for coverage in February, March and April but your coverage would end April 30, unless the Contributions for May are submitted on your behalf on or before May 15. If no Contributions are received for May but your Contributing Employer submits Contributions on your behalf before May 31, your coverage will begin again on June 1.

B. Eligibility for Active Bargaining Unit Employees

1. Initial and Continued Eligibility Requirements

As an Active Bargaining Unit Employee, you and your Dependents are eligible to participate in the Plan on the first day of the third succeeding calendar month following the month in which Contributions are required to be submitted on your behalf. The Board of Trustees determines the amount of Contributions required for eligibility.

Once you meet the initial eligibility requirements, your benefits will continue for subsequent Benefit Months if you were credited with sufficient Contributions during the corresponding Eligibility Month.

An Eligibility Month is the month you worked in for which Contributions are paid to the Fund on your behalf to qualify for Continued Eligibility for Active Benefits under the Plan. A Benefit Month is a period of time during which you are eligible for Active Benefits under the Plan.

The Eligibility Months and corresponding Benefit Months for each calendar year are as follows:

Eligibility Month	**Corresponding Benefit Month**
January	April
February	May
March	June
April	July
May	August
June	September
July	October
August	November
September	December
October	January
November	February
December	March

2. Dollar Bank Account for Active Bargaining Unit Employees

When you accumulate more than the 150 hours per month worth of Contributions required in an Eligibility Month, you will receive Excess Eligibility Credits. The Dollar Bank Account is where the Excess Eligibility Credits are stored. You are limited to accumulating 6 months of eligibility worth of Excess Eligibility Credits in your Dollar Bank Account.

(a) Using Excess Eligibility Credits to Maintain Eligibility.

Excess Eligibility Credits may be used to maintain your eligibility for future Eligibility Months in the event that you do not meet the required Contributions for an Eligibility Month. If you are short Contributions, the Third Party Administrator will automatically deduct the necessary amount from your Dollar Bank Account in order to maintain your eligibility.

In the event of your death, your surviving spouse or eligible Dependents may exhaust the remaining Excess Eligibility Credits in your Dollar Bank Account to continue coverage, subject to the eligibility rules provided in Section 2.04(C).

(b) Using Excess Eligibility Credits for Reimbursable Expenses.

(1) Reimbursable Expenses.

If you have more than three months of Excess Eligibility Credits in your Dollar Bank Account, you may request reimbursement by the Plan once per calendar quarter for certain reimbursable expenses. The Fund will send you monthly statements informing you about whether your Dollar Bank is available for reimbursement requests.

Reimbursable expenses are "qualified medical expenses" under Section 213 of the Internal Revenue Code. The following types of expenses are considered reimbursable expenses:

a. Expenses for dental treatment, including orthodontia;

b. Guide dogs for blind and deaf persons;

c. Travel expenses of the patient's when necessary to receive medical care, and the travel and lodging expenses of another family member whose presence is necessary for the treatment as certified by the patient's Physician;

d. Special telephone or television equipment for hearing-impaired persons;

e. Hearing aids and batteries;

f. Medical expenses not covered by or in excess of benefits provided by another benefit plan, insurer or Medicare;

g. Certain costs of modifying a home or vehicle to accommodate a disabled eligible family member;

h. Healthcare insurance premiums not paid by another source;

i. Special schooling for the mentally impaired or physically disabled;

j. Acupuncture;

k. Vision expenses including surgery or laser treatments to correct vision;

l. Smoking cessation programs;

m. Weight loss programs for the treatment of a specific disease as diagnosed by a Physician;

n. Treatment for alcoholism or Chemical Dependency;

o. Convalescent home charges that are necessary for medical care;

p. Nursing services, including room and board and meals, that are necessary for medical care;

q. Insulin treatments;

r. Prescription medications; and

s. Orthopedic shoes.

(2) Non-Reimbursable Expenses.

The following expenses are not considered reimbursable expenses under the Plan:

a. Cosmetic surgery, procedures and supplies;

b. Child and elder care;

c. Funeral expenses;

d. Hair transplants;

e. Household help other than that qualifying as long-term care;

f. Health club membership and expenses;

g. Non-prescription drugs and vitamins;

h. Personal use items;

i. Teeth whitening;

j. Expenses not provided for in Section 213 of the Internal Revenue Code.

(3) Submitting Reimbursement Requests.

Reimbursements from your Dollar Bank Account are subject to the following provisions:

a. The Plan will not issue a reimbursement that will cause your Dollar Bank Account balance to be less than an amount equal to 3 months of eligibility at the Employer Contribution rate at the time the reimbursement request is processed.

b. Reimbursement requests may be submitted at any time; however, such requests are limited to once per calendar quarter.

c. The minimum claim amount is $50.

d. You may accumulate numerous claims in order to reach the $50 minimum and submit them together.

e. You must submit your claim request in writing to the Third Party Administrator. Copies of itemized bills and/or proof of payment suitable to the Trustees must also be submitted. Claims must include a copy of the explanation of benefits (EOB) provided by any other plan covering the claimant, if any.

f. In the event of your death, your surviving spouse and Dependents may not use your Dollar Bank Account for reimbursement. However, as discussed above, they may be able to use it to continue eligibility under the Plan.

g. Reimbursement requests must be submitted no more than 24 months after the date the charge representing the loss was incurred. No reimbursement will be provided for a claim that is submitted after 24 months.

h. The Plan will not reimburse you for any expense that is payable by another source, including, but not limited to, another insurance plan or government program. The total combined reimbursement from all benefit/insurance plans when added to the amount of the requested reimbursement cannot exceed 100% of the billed amount.

i. Reimbursements will not be made for any expenses not specifically listed above.

(c) Forfeiture of Excess Eligibility Credits.

If you lose eligibility under the Plan, fail to make a timely Self-Payment, or work one hour for a non-signatory employer that is not excused by the Plan Administrator, the Excess Eligibility Credits in your Dollar Bank Account will be canceled and cannot be used in the future.

(d) The Dollar Bank Account is not a Vested Benefit.

The Trustees reserve the right to eliminate or modify this program at any time and in their sole discretion. The Dollar Bank Account is not a vested benefit for you or your Dependents and shall not be subject to alienation, sale, transfer, assignment, pledge, attachment, qualified domestic relations order, or encumbrance of any kind.

(e) Your Right to Opt-Out.

You may choose to permanently opt-out of the reimbursement component of your Dollar Bank Account and forfeit your right to reimbursement at any time by notifying the Fund in writing. Any balance in your account as of the date the Fund receives notice of such opt-out will be permanently forfeited.

3. Maintaining Coverage by Self-Payment

If you are an Active Bargaining Unit Employee and you receive a notice from the Fund that states you are eligible to make Self-Payments, you may make Self-Payments to continue your eligibility for up to 18 consecutive calendar months. However, in order to be eligible to make Self-

Payments as an Active Bargaining Unit Employee, the Union must provide a written certification to the Third Party Administrator that states that you are not self-employed.

The Third Party Administrator will only send a notice for Self-Payments if you were eligible for benefits during the immediately preceding Benefit Month.

The Self-Payment needed to continue eligibility for the Benefit Month must be paid by check or money order on or before the end of the month immediately preceding the Benefit Month for which you do not have sufficient Contributions or Excess Eligibility Credits.

The amount of the required Self-Payment is determined by the Trustees. As of November 1, 2014, the Active Bargaining Unit Employee Self-Pay Rate is $957 per month. If you are not credited with any Contributions, or if you do not have any credit in your Dollar Bank Account, the full monthly Self-Payment amount is required. However, if some amount of Contributions is credited on your behalf or if you have an insufficient balance in your Dollar Bank Account, the amount of the required Self-Payment would be the difference between the amount required to maintain Continued Eligibility and the amount actually credited on your behalf.

4. When Coverage Ends

   As an Active Bargaining Unit Employee, your eligibility under the Plan will end when you are not credited with the required Contributions during an Eligibility Month to maintain your eligibility during the corresponding Benefit Month and/or you do not have sufficient Excess Eligibility Credits in your Dollar Bank Account to maintain eligibility and you do not make a timely Self-Payment.

   For example, if you are not credited with the required Contributions in January or you do not have sufficient Excess Eligibility Credits to maintain eligibility and you do not make a timely Self-Payment, your coverage will end on March 31 (the corresponding Benefit Month to establishing eligibility in January is April).

   In the event that you lose coverage under the Plan, the only methods of coverage available to you are to reestablish initial eligibility and/or to elect COBRA Continuation Coverage.

5. Eligibility during Periods of Disability Lasting Less than 13 Weeks for Active Bargaining Unit Employees

   If you are an Active Bargaining Unit Employee, for each week that you are Disabled and are receiving Accident and Sickness Benefits from this Plan, you shall receive 20 credited hours per week, for up to 13 weeks during that period of disability.

C. Effect of Military Service on Eligibility

The Plan provides benefits as described below that comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you are called into active service, your coverage under the Plan will not be affected during the initial 31-day period. Your coverage under the Plan will be suspended at the end of this initial 31-day period under Option 1 below (the default option), unless you elect otherwise.

In order to exercise your options, you must notify the Fund in writing when you are called to active service. The Fund will send you an election form with three options regarding your Plan benefits as follows:

Option 1: Suspend eligibility and rely on military coverage for you and your Dependents (as of the date active coverage is suspended, you will be offered the right to pay for COBRA Continuation Coverage for up to 24 months). This is the **DEFAULT OPTION.**

Option 2: Suspend active coverage under the Plan for as long as the Plan's eligibility rules permit, and then elect COBRA coverage for up to 24 months.

Option 3: Continue active coverage for as long as the Plan's eligibility rules permit, and then elect COBRA coverage for up to 24 months.

If your failure to provide advance notice when called to active service is excused under USERRA because of military necessity, then you can make a retroactive election to continue coverage, provided you pay any unpaid amounts that are due.

Option 1

If you elect Option 1 (suspend eligibility and rely on military coverage), your eligibility and Dollar Bank Account will be frozen until you are discharged from active military service. In order to reinstate active eligibility, you must provide the Fund with a copy of your discharge papers within the time periods provided under USERRA as described in the following chart.

Length of Active Military Service	Reemployment/Reinstatement Deadline
Less than 31 days	1 day after discharge (allowing 8 hours for travel)
31 through 180 days	14 days after discharge
More than 180 days	90 days after discharge

Once you provide the Fund with your discharge papers, your Dollar Bank Account, which was suspended when you went into active military service, will be reinstated effective as of your date of discharge, or a later date as agreed to by the Fund, for the balance of the current Benefit Month. Your eligibility for subsequent Benefit Months will be determined as of the corresponding determination dates under the Plan's Continued Eligibility Requirements.

Option 2

If you elect Option 2 (suspend active coverage and elect COBRA), your eligibility and Dollar Bank Account will be frozen until you are discharged from active military service. Under this option, you and your Dependents can pay the monthly COBRA premium for up to 24 months of COBRA coverage. The standard election and payment deadlines under COBRA apply.

In order to reinstate active eligibility upon discharge, you must provide the Fund with a copy of your discharge papers within the time periods provided under USERRA as described in the above chart.

Once you provide the Fund Office with your discharge papers, your Dollar Bank Account, as of the end of the initial 31-day period, will be reinstated effective as of your date of discharge, or a later date as agreed to by the Fund. Your eligibility for subsequent periods will be determined under the Plan's eligibility requirements.

Option 3

If you elect Option 3 (continue active coverage), you and your Dependents will receive active coverage for as long as your Dollar Bank Account permits. Thereafter you will be offered COBRA coverage for up to 24 months. The standard election and payment deadlines under COBRA apply.

Under USERRA, you must provide the Fund with a copy of your discharge papers within the time periods provided in the above chart.

If active eligibility has been exhausted under Option 3, then upon discharge you will not qualify for active eligibility until you satisfy the Initial Eligibility Requirements.

In the meantime, you will have the opportunity to pay for COBRA coverage as of the date of discharge, or a later date as agreed to by the Fund. Upon discharge, you can pay for COBRA coverage until the later of (1) the end of six months of payments or (2) the end of the original 24-month period.

D. Eligibility under the Family Medical Leave Act (FMLA)

When you take leave under the Family and Medical Leave Act of 1993 (FMLA), you must submit an application for leave to your Employer. Your Employer will submit a copy of the approved application to the Trustees so that your rights to health care coverage are protected during your leave.

During your absence, you will continue to receive coverage under the Plan. However, if you fail to return to work for a Contributing Employer at the expiration of your FMLA leave, your coverage will terminate retroactive to the first day of the month in which you were on leave.

If your coverage terminates, you will then be eligible to purchase COBRA Continuation Coverage. Contact the Third Party Administrator for additional information about your coverage during a FMLA leave or continuing your coverage under COBRA. Your rights under the FMLA are summarized below.

You have the right to take unpaid leave if you meet the following criteria:

1. You worked for the same Contributing Employer for at least 12 months;

2. You worked at least 1,250 hours during the previous 12 months; and

3. You work at a location where at least 50 Employees are employed by your Contributing Employer within a 75-mile radius.

The duration of leave available to you will depend upon the reasons for which you are taking the leave.

1. You may qualify for up to 12 weeks (during any 12-month period) of unpaid leave for your own serious illness, the birth or adoption of a child, to care for a seriously ill spouse, parent or child or qualifying exigency to deal with the affairs of your spouse, child, or parent because he or she is called to duty. A qualifying exigency includes short-notice deployment, military events and related activities, childcare and school activities, financial and legal arrangements, counseling,

rest and recuperation, post-deployment activities and additional activities as defined under the FMLA in 29 CFR Part 825.

2. You may qualify for up to 26 weeks (during any 12-month period) of unpaid leave to care for a covered service-member with a serious injury or illness if the Employee is the spouse, child, parent or next of kin of the service-member as defined under the FMLA in 29 CFR Part 825. However, please be aware that this 26 week leave is the maximum time period allowed and is not in addition to the 12 week leave provided above.

2.02 Retiree Benefits

Once you retire and are no longer eligible for Active Benefits, this Plan offers Retiree Benefits to those Retirees and their eligible Dependents.

These Retiree Benefits are in lieu of COBRA Continuation Coverage and if you elect Retiree Benefits you will not be eligible to receive COBRA Continuation Coverage once your coverage terminates under the Plan for any reason.

If you or any of your Dependents are eligible for Medicare, this Plan will always be secondary to Medicare when permissible by law. This means that if you or your Dependents are eligible for Medicare, this Plan will only pay benefits after Medicare has paid benefits.

A. Eligibility Requirements for Active Bargaining Unit Employees upon Retirement

You may be eligible for Retiree Benefits under the Plan if you:

1. Were eligible for benefits under this Plan for the six consecutive calendar month period immediately prior to retirement; and

2. Are totally and permanently disabled as defined by the Social Security Administration; or

3. Are receiving benefits under the Pension Plan or the Plumbers and Pipefitters National Pension Plan.

B. Eligibility Requirements for Active Non-Bargaining Unit Employees upon Retirement

Generally, you may be eligible for Retiree Benefits under the Plan if you:

1. Are eligible for a pension from the Pension Plan or the Plumbers and Pipefitters National Pension Plan;

2. Were eligible for benefits under this Plan for the six consecutive calendar month period immediately prior to retirement;

3. Were covered under this Plan for 36 of the 60 months immediately preceding the month in which you retired; and

4. Are eligible for Medicare due to your age and have enrolled in Medicare Parts A and B.

C. When Retiree Coverage Begins

When you file your retirement application for benefits from the Pension Plan, the Third Party Administrator will supply you with your retirement election form if you are eligible for Retiree Benefits. You will lose eligibility for Active Benefits under the Plan the effective date of your retirement. Once your Active Benefit coverage ends and you are covered under Retiree Benefits, you will not be eligible for the following benefits: Death, AD&D, Weekly Disability, Dental, Vision Benefits, or Dollar Bank Claim Reimbursements.

If you have a balance in your Dollar Bank Account when your Active Benefit coverage ends, the Third Party Administrator will deduct the necessary amount from your Dollar Bank Account at the monthly Retiree Self-Payment amount to enable you to maintain Retiree Benefits under the Plan. Once you retire, you may no longer use your excess eligibility credits for reimbursable expenses. The credits may only be used for eligibility. Contributions for work months prior to your effective retirement date will be credited to your dollar bank in accordance with the active eligibility rules.

Once your Dollar Bank Account is exhausted, you will be required to begin making required monthly Retiree Self-Payments as discussed below.

D. Retiree Self-Payments

1. If you are eligible for Retiree Benefits, a timely Retiree Self-Payment is required to maintain coverage under the Plan.

2. If you are eligible for Retiree Benefits and you elect to opt out of coverage for you and/or your Dependents or fail to make the required Self-Payments, you and/or your Dependents will not be permitted to opt back into the Plan at any time.

   However, if the reason for opt out is because you and/or your Dependents were covered under another employer sponsored health plan, then you may opt back into the Plan's Retiree Benefits provided that the following conditions are met:

   (a) There is no gap in coverage;

   (b) The other employer sponsored coverage is lost by reason of termination of employment or termination of plan; and

   (c) The application to opt in is made within 30 days of the termination of the other employer sponsored coverage.

3. The amount of your Retiree Self-Payment will generally depend on whether you retired prior to January 1, 2012 or on or after January 1, 2012. This amount is determined by the Trustees and is subject to change at any time. Effective January 1, 2015, the Retiree Self-Payments for current Retirees and future Retirees are provided on the following page.

(a) Retiree Self-Payments for Participants who Retired Prior to January 1, 2012.

If you retired prior to January 1, 2012, your monthly Self-Payment depends on your family status and your family's eligibility for Medicare as follows:

Category of Retiree	Monthly Self-Payment Amount*
Non-Medicare Single or Surviving Spouse	$312
Non-Medicare with Non-Medicare Dependents	$449
Medicare Single or Surviving Spouse	$212
Medicare Married (Both 65 Years and Up)	$424
Medicare Retiree with Non-Medicare Dependents	$424

The monthly Self-Payment amounts are those in effect as of January 1, 2014. The rate will index to automatically adjust each year based on the prior year average cost for the entire Plan.

(b) Retiree Self-Payments for Participants who Retire on or After January 1, 2012.

If you retire on or after January 1, 2012, your rate is determined by where you and your Dependent spouse fall on Chart A and B as follows:

Chart A – Not Eligible for Medicare

Your Age at Initial Retirement	25 + Years of Service in the Pension Plan		20 – 24 Years of Service in the Pension Plan		Less than 20 Years of Service in the Pension Plan	
	% of cost of benefits you pay	Monthly Self-Payment *	% of cost of benefits you pay	Monthly Self-Payment *	% of cost of benefits you pay	Monthly Self-Payment *
55 – 57	70%	$314	85%	$382	95%	$427
58 – 59	60%	$269	70%	$314	80%	$380
60 – 64	45%	$217	60%	$299	70%	$380

Chart B – Eligible for Medicare

Age	25 + Years of Service in the Pension Plan	20 – 24 Years of Service in the Pension Plan	Less than 20 Years of Service in the Pension Plan
65	$217*	$299*	$380

*The monthly Self-Payments shown are those in effect as of January 1, 2015. The rate will index to automatically adjust each year based on the prior year average cost for the entire Plan. If you have Dependent children, there will be a $100 surcharge added to the above rate.

E. When Retiree Benefits End

Retiree Benefits under this Plan are not vested and will not vest at any time. Accordingly, your eligibility for Retiree Benefits will terminate on the first of the following dates to occur:

1. The date you stop meeting the Retiree eligibility requirements under the Plan;
2. The date the Trustees discontinue Retiree Benefits;
3. The last day of the last month for which you made a timely Retiree Self-Payment; or
4. The date of your death.

2.03 Dependent Eligibility

A. Dependents' Initial Eligibility

Your Dependents will become eligible for benefits on the later of the following to occur:

1. The date you are eligible for coverage; or
2. The date he/she meets the definition of Dependent under the Plan, so long as you request enrollment within 30 days of the date he/she meets the definition of Dependent under the Plan.

If you decline coverage for your eligible Dependents because of other health insurance coverage, you will be able to enroll that person in the future; provided you request enrollment within 30 days after the other coverage ends.

B. When Dependent Eligibility Ends

Your Dependents' coverage will end on the later of the following:

1. The date your eligibility ends for a reason other than death;
2. The date he/she no longer meets the definition of a Dependent under the Plan; or
3. The date he/she enters military service.

C. Dependent Eligibility in the Event of Your Death

After your death, your surviving Dependents may be able to run out your eligibility under the Plan and exhaust any remaining Excess Eligibility Credits in your Dollar Bank Account. Once those benefits are exhausted, they may be eligible to either make Self-Payments to continue eligibility **OR** to elect COBRA Continuation Coverage. However, if you were a Non-Bargaining Unit Employee, your surviving Dependents will only have the option of electing COBRA Continuation Coverage.

If your surviving Dependents elect to continue coverage by making Self-Payments, those payments are subject to the following rules:

1. The amount of the Self-Payment will be determined by the Trustees and is subject to change at any time.

2. Your surviving spouse is eligible to make Self-Payments for himself or herself and for his or her Dependents until he or she remarries.

3. Dependent children may continue to make Self-Payments until they no longer meet the definition of Dependent under the Plan or until the surviving spouse remarries, whichever occurs first. If a Dependent child's coverage is continued by Self-Payments and the child loses Dependent status within the first 36 months of coverage due to Self-Payments, the child may be entitled to elect COBRA Continuation Coverage for the remainder of those 36 months.

4. Surviving Dependents must maintain continuous eligibility under the Plan to maintain coverage. Self-Payments must be made on or before the first day of the month for which continued coverage is desired. If a payment is not made on time, coverage will terminate and the payment may not be made up at any future time.

D. Dependent Eligibility under a Qualified Medical Child Support Order (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is a court order regarding medical coverage for your children (called Alternate Recipients) in situations involving divorce, legal separation or a paternity dispute.

The Fund will honor the terms of a QMCSO regarding communication with the custodial parent of a Dependent and with regard to which plan is primary when a Dependent is covered by more than one group health plan as described in the Plan's coordination of benefits rules.

The Third Party Administrator will notify you if a QMCSO is received. You may request a copy of the Fund's QMCSO procedures, free of charge.

2.04 COBRA Continuation Coverage

A. COBRA Continuation Coverage in General

When you lose coverage because of a Qualifying Event, coverage for you or your eligible Dependents can be temporarily continued at your own expense as required under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Qualifying Events are defined as death of the Participant, a reduction of the Participant's hours or loss of employment (except due to gross misconduct), the Participant's entitlement to Medicare benefits, a Dependent losing their Dependent status under the Plan and legal separation or divorce from the Participant. However, if you and/or your Dependents lose coverage due to a Qualifying Event and elect to make Self-Payments to continue coverage under the Plan instead of electing COBRA Continuation Coverage, you will not be eligible for COBRA Continuation Coverage once your eligibility due to Self-Payments runs out. An example of COBRA and Self-Payment eligibility is provided on the following page.

For Example:

Joe dies while he is eligible for Active Benefits under the Plan. After his death, his surviving spouse, Linda, receives a COBRA election notice and information regarding Self-Payment eligibility. Because the Self-Payments are less expensive than COBRA Continuation Coverage, Linda elects to make Self-Payments. After three years of making timely Self-Payments, Linda remarries and under the terms of the Plan her eligibility for Self-Payments ends. Because Linda has not suffered a Qualifying Event which caused her to lose her coverage under the Plan, she is not entitled to COBRA Continuation Coverage. Thus, her coverage would end on the last day of the month in which she remarries.

If you elect COBRA Continuation Coverage under this Plan, you are entitled to the benefits you were eligible for on the day before the Qualifying Event, but you are limited to the following: medical, dental and vision benefits. Employees and/or Dependents who elect COBRA Continuation Coverage do not receive Disability, Life or Accidental Death and Dismemberment (AD&D) benefits.

If you elect COBRA Continuation Coverage, you pay the full cost of the continued coverage plus a small administrative charge. The continuation of COBRA Continuation Coverage is conditioned on timely and uninterrupted payment of premiums.

If you (as the Employee) have a newborn child, adopt a child or have a child placed with you for adoption (for whom you have financial responsibility) while COBRA Continuation Coverage is in effect, you may add the child to your coverage. You must notify the Third Party Administrator, in writing, of the birth or placement in order to have this child added to your coverage. Children born, adopted or placed for adoption as described above, have the same COBRA rights as your spouse or Dependents who were covered by the Plan before the Qualifying Event that triggered COBRA Continuation Coverage.

There may be other coverage options for you and your family. Effective for coverage beginning on or after January 1, 2014, you may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. You should review your options under the Marketplace and compare them with the Plan's COBRA Continuation Coverage to determine which option is best for you and your family.

If you have any questions about your rights to COBRA Continuation Coverage, you should contact the Fund Office. For information on the Marketplace, please visit www.healthcare.gov.

B. Eligibility

1. 18-Month COBRA Continuation Coverage

   You are eligible to elect COBRA Continuation Coverage when you lose eligibility for benefits because of a Qualifying Event. In such event, you and your eligible Dependents may elect up to 18 months of COBRA Continuation Coverage when your coverage terminates because of the loss of employment, lay-off, retirement or a reduction in your hours of work. Under these

circumstances, the Qualifying Event will result in loss of coverage on the first day of the new Benefit Month where you did not meet the Continued Eligibility Requirements under the Plan.

2. Disability Extension of 18-Month COBRA Continuation Coverage

   If you or an eligible Dependent is determined by Social Security to be disabled, you and all family members previously covered under COBRA may be entitled to receive an additional 11 months of COBRA Continuation Coverage. This means that COBRA Continuation Coverage will continue for a total of 29 months if the required premium is continuously paid. Coverage for the additional 11 months may be at a higher cost.

   You must notify the Third Party Administrator of the Social Security Administration's determination of disability within 60 days of such determination and before the end of the first 18 months of continued coverage. Otherwise, you will not be eligible for the additional 11 months of coverage.

3. 36-Month COBRA Continuation Coverage

   Certain Qualifying Events allow your eligible Dependents to purchase a total of 36 months of COBRA Continuation Coverage. A total of 36 months is allowed if one of the following events occurs during the initial 18-month continuation period or if coverage ends for any of the following reasons:

   (a) Your death;

   (b) Your divorce or legal separation;

   (c) You become eligible for Medicare; or

   (d) Your Dependent child no longer qualifies as a Dependent under the terms of the Plan.

   Coverage terminates at the end of the month in which the event occurs. You or your Dependent must notify the Third Party Administrator in writing in the event of a legal separation, divorce or a child losing Dependent status within 60 days of the date coverage terminates. If you do not provide the notice to the Third Party Administrator within 60 days of the loss of coverage, the Dependent will not be eligible for COBRA Continuation Coverage.

C. COBRA Premiums, Payments and Due Dates

The standard COBRA premium is determined by the Trustees and adjusted from time to time; however, this adjustment will occur no more than once during the Plan's fiscal year unless there is a substantial change in the Plan.

COBRA premium payments must be made monthly to the Third Party Administrator. The initial COBRA premium payment is due 45 days after the date the COBRA election is made. Each subsequent payment is due on or before the first day of each month, but will be considered timely if the payment is received within 30 days of the due date.

If a COBRA premium payment is not received by the Third Party Administrator within the time limits specified above, COBRA Continuation Coverage will be terminated retroactive to the last day of the

month in which a timely COBRA premium payment was made. Once this coverage is terminated due to a missed payment, no benefits will be reinstated under COBRA Continuation Coverage.

D. The Notification Responsibilities of the Third Party Administrator

When coverage terminates due to an Employee's death, termination or eligibility for Medicare, the Employer has 30 days in which to notify the Third Party Administrator of the Qualifying Event. When the Third Party Administrator is notified of a Qualifying Event, the Third Party Administrator will send a COBRA Election Notice and COBRA Election Form to you and your Dependents who would lose coverage due to the Qualifying Event. The Third Party Administrator will send the notice within 14 days of the time it receives notice of a Qualifying Event. The Election Notice tells you about your right to elect COBRA Continuation Coverage, the due dates for returning the election form, the amount of the payment for COBRA Continuation Coverage and the due dates for COBRA payments.

In order to protect your Dependents' rights, you should keep the Third Party Administrator informed of any change in your address or in the addresses of Dependents.

E. Electing Continuation Coverage

You or your Dependents must complete the COBRA Election Form and send it back to the Third Party Administrator in order to elect COBRA Continuation Coverage. The following rules apply to the election of COBRA Continuation Coverage:

1. Each member of your family who would lose coverage because of a Qualifying Event is entitled to make a separate election of COBRA Continuation Coverage.

2. If you elect COBRA Continuation Coverage for yourself and your Dependents, your election is binding on your Dependents. However, your Dependents have the right to revoke that election before the end of the election period.

3. If you do not elect COBRA Continuation Coverage for your Dependents when they are entitled to Continuation Coverage, your Dependents have the right to elect COBRA Continuation Coverage for themselves. Your spouse may elect COBRA Continuation Coverage for herself or himself and any minor children who were covered by the Plan on the date of the Qualifying Event.

4. The person electing Continuation Coverage has 60 days after the COBRA Election Notice is sent or 60 days after coverage would terminate, whichever is later, to send back the completed Election Form. An election of Continuation Coverage is considered to be made on the date the COBRA Election Form is postmarked.

5. If the COBRA Election Form is not mailed back to the Third Party Administrator within the allowable period, you and/or your Dependents will be considered to have waived your right to COBRA Continuation Coverage.

F. When the COBRA Continuation Coverage Period Begins

If you properly elect COBRA Continuation Coverage, the period of COBRA Continuation Coverage (18, 29 or 36 months, as applicable) begins on the date your eligibility or your Dependents' eligibility for coverage otherwise terminated under the Plan.

G. When COBRA Continuation Coverage Ends

1. COBRA Continuation Coverage may end for any of the following reasons:

   (a) You or your Dependent were covered under another group health plan. However, coverage will continue if you or an eligible Dependent was covered under another group health plan prior to the COBRA election or if you or the eligible Dependent have a health problem for which coverage is excluded or limited under the other group health plan;

   (b) The required premium is not timely paid;

   (c) The Trustees terminate the Welfare Plan;

   (d) You or your Dependent reaches the end of the 18-month, 29-month or 36-month Continuation Coverage period;

   (e) Your coverage under the Plan ends and you become enrolled in Medicare. However, if your eligible Dependents are entitled to COBRA Continuation Coverage, their maximum coverage period is 36 months from the initial Qualifying Event; or

   (f) Your Dependents become entitled to Medicare, unless they are entitled to COBRA Continuation Coverage due to your death.

2. When your COBRA Continuation Coverage ends, the Plan will provide you and your Dependents with certification of the length of coverage under this Plan, including the time you were covered under COBRA. This will help reduce or eliminate any pre-existing condition limitation under a new group health plan. However, please be aware that plans are prohibited from imposing pre-existing conditions for plan years beginning on or after January 1, 2014.

SECTION 3: DEATH BENEFITS

3.01 Death Benefit for Active Bargaining Unit & Non-Bargaining Unit Employees Only

If you are eligible for Active Benefits through Contributions or Self-Payments but not COBRA Continuation Coverage, your coverage includes a Death Benefit to be paid to your beneficiary in the event of your death. The amounts of the Death Benefits are provided in the Schedule of Benefits.

The Trustees contracted with an insurance carrier to provide this Death Benefit and this benefit will be paid in accordance with the terms of the policy. If you wish to receive a copy of the terms and limitations, please contact the Third Party Administrator.

3.02 Designating Your Beneficiary

To designate a beneficiary, you must complete a form supplied by the Third Party Administrator and return the form to the Third Party Administrator. You may name more than one beneficiary and indicate the percentage of the Death Benefit you want each beneficiary to receive. If you do not specify the percentage for each beneficiary, then your beneficiaries will share the benefit equally. If one of your beneficiaries dies before you, the benefit will be split equally among your surviving beneficiaries. You may change your beneficiary at any time by submitting a new form. Beneficiary designations are effective on the date you sign the form.

If there is no named beneficiary still surviving at the time of your death, your Death Benefit will be divided equally among the living members of the first surviving class listed below:

A. Your spouse;

B. Your children;

C. Your parents;

D. Your brothers and sisters; or

E. Your estate.

SECTION 4: ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

4.01 AD&D Benefits for Active Bargaining Unit & Non-Bargaining Unit Employees Only

If you are eligible for Active Benefits through Contributions or through Self-Payments but not COBRA Continuation Coverage, your coverage includes the Accidental Death and Dismemberment (AD&D) Benefit. The Trustees contracted with an insurance carrier to provide this AD&D Benefit and this benefit will be paid in accordance with the terms of the policy. If you wish to receive a copy of the terms and limitations, please contact the Third Party Administrator.

This benefit is payable to you if you sustain a Loss within 90 days of an Accident. For the purposes of this section, Loss means loss of a limb, sight or life.

You may find the types of losses covered under the AD&D Benefit and the benefit amounts that will be paid in the event of a Loss in the Schedule of Benefits. This amount is in addition to any other benefits you may receive under the Plan. If you die as a result of an Accident, the Benefit is paid to your beneficiary.

To qualify as a Loss, the severance of a limb must occur at or above the wrist joint or ankle joint. Loss of sight means the total and permanent loss of sight. If more than one of the above losses is sustained as the result of the same Accident, benefits are paid only for the loss that pays the greatest amount.

4.02 Limitations on AD&D Benefits

The benefits described above do not cover any loss that results from:

A. Bodily or Mental Illness or disease of any kind;

B. Ptomaine or bacterial infections caused by pyogenic organisms which occur with and through an accidental cut or wound;

C. Suicide or attempted suicide, unless suicide or attempt arises as a result of a physical or mental condition;

D. Intentional self-inflicted injuries;

E. Participation in the commission of an assault, felony, riot or a civil promotion;

F. War or act of war (declared or undeclared) or any act related to war or insurrection;

G. Service in the armed forces of any country while such country is engaged in war;

H. Police duty as a member of any military, naval or air organization;

I. Participation in flying, ballooning, parachuting, or other aeronautic activities, except as a passenger on a commercial aircraft;

J. Use of any drug, narcotic or hallucinogen not prescribed by a licensed Physician; or

K. Any of the circumstances listed under the General Plan Exclusions in Section 11.

SECTION 5: WEEKLY DISABILITY BENEFITS

5.01 Eligibility for Weekly Disability Benefits

If you are a Bargaining Unit Employee who is eligible for Active Benefits through Contributions or Self-Payments but not COBRA Continuation Coverage, you may be eligible for Weekly Disability Benefits.

However, in order to be eligible, you must be Disabled under the terms of the Plan and you must be covered under the Plan on the date your Disability begins.

5.02 Payment of Weekly Disability Benefits

The amount of the Weekly Disability Benefit payable is provided in the Schedule of Benefits. If you are Disabled for part of a week, you will receive one-seventh of the weekly benefit for each day of disability. The Plan will withhold your share of FICA tax from each weekly payment made to you and will send it to the government. You must include the weekly benefits you receive in your gross income and pay Federal Income Tax on them at the end of the tax year. If you have questions about how this works, you should consult a competent tax advisor or legal counsel.

Benefits will start on the 1st day of disability due to an Accident or on the eighth consecutive day of disability due to a Sickness. This Benefit is payable for up to 13 weeks for any one continuous period of disability.

If you have successive periods of disability that are the result from the same or related causes and the successive periods are separated by less than two weeks of full-time work in Covered Employment, they will be considered one continuous period of disability.

Alternatively, if the second period of disability is due to an Accident or Sickness entirely unrelated to the cause of the first disability and the second disability begins after you have returned to work in Covered Employment for at least one full day, then the second disability will be considered as a new period of disability and you will be eligible for a new 13-week period of Weekly Disability Benefits.

5.03 Weekly Disability Benefits during a Course of Treatment for Chemical Dependency

If you are eligible for Weekly Disability Benefits and participate in a course of treatment for Chemical Dependency, you may receive Weekly Disability Benefits once your Physician has certified your Disabled status as well as your status as a patient in a treatment program. Weekly Disability Benefits during a course of treatment for Chemical Dependency are limited to the period of time in which you are in the treatment program and the two weeks following your discharge from the program. However, Benefits will not be payable beyond the date on which you have already received weekly benefits for the maximum 13-week period for any one period of disability. Further, benefits will be paid for no more than two periods of disability due to Chemical Dependency during any 60-month period.

5.04 Limitations on Your Weekly Accident and Sickness Disability Benefits

No Weekly Disability Benefits will be paid (1) For any period for which your disability is not certified by a Physician and you are not under the care of a Physician; or (2) if your loss is caused by any of the items listed in the General Plan Exclusions in Section 11.

SECTION 6: MAJOR MEDICAL EXPENSE BENEFIT FOR ACTIVE EMPLOYEES AND RETIREES NOT YET ELIGIBLE FOR MEDICARE

6.01 The Deductible

The Deductible is the amount of Covered Medical Expenses that you and each of your eligible Dependents pay each calendar year before Plan benefits are paid. The amounts of the individual and family Deductibles are listed in the Schedule of Benefits of this booklet.

Please be aware that once you meet the family Deductible, no further Deductible will be applied to any eligible member of your family during the remainder of the calendar year.

6.02 Percentage of Benefits Payable

Once you pay the annual Deductible, the Plan will pay the percentage of your Covered Medical Expenses listed in the Schedule of Benefits up to the negotiated rate or UCR Charges and up to any Plan maximums.

6.03 Out-of-Pocket Maximum

After satisfying your individual and/or family Deductible, the maximum amount you pay for Covered Medical Expenses each calendar year is the out-of-pocket maximum listed in the Schedule of Benefits. The amounts excluded from the maximum out-of-pocket expense are also provided in the Schedule of Benefits.

6.04 Preferred Provider Organization (PPO)

The Welfare Fund contracts with Preferred Provider Organizations ("PPO") to help control medical costs. A PPO is a group of Hospitals and providers that agree to provide services at fees that are generally lower as a result of our participation in the PPO.

To minimize your out-of-pocket costs, contact the Third Party Administrator for information about which Hospitals and providers are in the Plan's PPO network. Although you are not required to use the PPO Hospitals and providers, when you use PPO Hospitals and providers rather than non-PPO Hospitals and providers, you can reduce costs for both you and the Fund. To receive a list of PPO Hospitals and providers free of charge, please contact the Third Party Administrator. In the event there is no PPO network provider in your area, the Plan will treat the out-out-network provider as if the provider was an in-network PPO provider.

6.05 The Pre-Certification/Utilization Review Program

If you are expecting to incur expenses for the following types of treatment, you, someone on your behalf or your Physician must contact the Plan's UR company to obtain Pre-Certification prior to incurring the expenses, or in the case of an Emergency, within 48 hours of the Emergency.

If your request for Pre-Certification is denied, you may appeal that denial under the Plan's Claims and Appeals procedures.

A. Scheduled Hospital and Inpatient Admissions.

Once you provide the necessary information, the UR company will evaluate the proposed admission based on your individual treatment needs and the standards in the community. When the Plan and your Physician reach an agreement on your treatment plan, the UR company will notify you, your Physician, the Hospital and the Third Party Administrator of the number of Hospital days authorized for coverage under the Plan. If you have not received a written authorization before your admission date, call the Third Party Administrator or the UR Company for the number of days authorized.

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

B. Emergency Hospitalization.

If you seek treatment in an Emergency and are admitted, you must notify the UR company no later than the next business day following admission. The UR company will work with your Physician to determine the length of stay necessary based on your individual treatment needs and the standards in the community. The UR company will notify you, your Physician, the Hospital and the Third Party Administrator of the number of Hospital days authorized for coverage under the Plan.

C. Continued Stay Review.

If your Hospital stay must be extended beyond the days initially authorized, the UR company will work with your Physician to process an extension of stay authorization. The UR company will contact your Physician 24 hours before the scheduled discharge date to confirm discharge or authorize additional days for the stay. This continued stay review also applies to newborn infants who need additional Hospital stays beyond the length of the mother's stay.

D. Home Nursing Care, Hospice Care and Skilled Nursing Facility Care.

E. Durable Medical Equipment.

If your Physician orders or prescribes Durable Medical Equipment costing over $500, the UR company will review such order for medical necessity under the Plan. If determined Medically Necessary, the UR company will authorize rental of such Durable Medical Equipment unless the rental price exceeds the purchase price.

F. Outpatient Surgical Procedures.

The UR company will review certain outpatient surgical procedures as approved by the Board to determine the appropriateness of the admission and of the facility based on your individual treatment needs and the standards in the community. Accordingly, you should contact the UR company at the number listed on the back of your ID card if your Physician recommends you undergo an outpatient surgical procedure.

G. Genetic Testing.

H. Treatment for Obesity.

Please also remember that Pre-Certification does not verify eligibility for benefits or guarantee benefit payments under the Plan. Additionally, Pre-Certification does not constitute a guarantee or warranty of the quality of treatment you receive. All Covered Expenses under the Plan are subject to the Plan's Deductibles, Co-Payments and maximums. **Additionally, please remember that if you fail to Pre-Certify the above listed expenses, all charges incurred will be subject to an additional $250 Deductible before any payment is made by the Plan.**

6.06 Covered Medical Expenses and Exclusions

A. Expenses Covered Under the Plan

The Plan covers the negotiated rate or Usual, Customary and Reasonable Charges ("UCR Charges"), subject to the Plan maximums and limitations provided in the Schedules of Benefits for the following services and supplies (Covered Medical Expenses) provided or ordered by a Physician (except as specifically provided otherwise) that you receive for the treatment of a non-occupational Accident or Sickness when Medically Necessary:

1. Hospital services and supplies for:

   (a) Room and board fees up to:

      (1) The Hospital's regular daily semi-private room rate for wards, intensive care, coronary care, neonatal care, nurseries and other special units;

      (2) The Hospital's regular daily rate for a private room when required for contagious or communicable diseases or where the Hospital only has private rooms; or

      (3) 85% of the Hospital's private room charges where there are only private rooms available for in-network providers and 65% for out-of-network providers.

   (b) Drugs, medicines and other Hospital services for medical care and treatment, exclusive of professional services, while hospitalized.

2. Outpatient services at a Hospital, licensed birthing center or licensed Free Standing Surgical Center, including fees incurred for:

   (a) Outpatient surgical procedures; and

(b) Emergency treatment for an Accident or Sickness.

3. Medical care and treatment (including surgery) that is listed as a covered expense under the Plan and is provided by a legally qualified Physician or other qualified health care professional acting within the scope of their licensure as defined by state law.

4. Pre-admission tests performed on an outpatient basis at a Hospital performed prior to and in connection with Inpatient or outpatient surgery.

5. Private duty professional nursing services.

6. Second surgical opinions, plus x-rays and tests related to such opinion, but only if:

   (a) The opinion is given by a board certified specialist in the specialty of the proposed surgery, and;

   (b) The surgeon giving the second opinion has a separate practice from the surgeon who first recommended the surgery.

7. Physical therapy administered in accordance with a Physician's instructions as to the type and duration of the therapy.

8. Speech therapy, provided that the therapy is required as a direct result of an Accident or Sickness and is ordered by a Physician with specific instructions as to the type and duration of the therapy.

9. Occupational therapy, provided that the therapy is required as a direct result of an Accident or Sickness and is ordered by a Physician with specific instructions as to the type and duration of the therapy.

10. Physician and Hospital services and supplies required to correct damage caused to the eyes solely by Accident or Sickness within one year of the Accident or Sickness.

11. Routine physical exams are covered as Preventive Services in accordance with federal law. However, if such an exam reveals symptoms or conditions that require further testing or treatment, benefits for the additional tests and/or treatment are paid the same as any other Accident or Sickness.

12. Well Child Exams and routine immunizations for eligible Dependents are covered as Preventive Services in accordance with federal law. However, if such an exam reveals symptoms or conditions that require further testing or treatment, benefits for the additional tests and/or treatment are paid the same as any other Accident or Sickness.

13. Convalescent Care provided in a Skilled Nursing Facility.

14. Transfer by local ambulance to:

   (a) The nearest metropolitan Hospital, limited to the first trip to the Hospital for any one Sickness or for all injuries sustained in any one Accident;

(b) The nearest metropolitan Hospital where suitable treatment is available if such treatment is not available in the Hospital where the covered person is located, provided that such transfer is necessary and approved in advance by the Fund; and

(c) Local ambulance service for transportation of the covered person from the Hospital to his/her home upon discharge if approved in advance by the Fund.

15. Hospital services and supplies provided for outpatient kidney dialysis.

16. Diagnostic x-ray and laboratory services, including CAT scans, on an outpatient basis.

17. Diagnostic infertility testing for Active Bargaining Unit and Non-Bargaining Unit Employees and their Dependent spouses, if such tests are performed for the Physician to make an initial diagnosis.

18. Radiation therapy and chemotherapy provided in connection with the administration of x-ray, radium or radioactive isotope therapy or chemotherapy by a Physician.

19. Hospital charges for room and board, nursing care and miscellaneous fees while in a Hospital as an Inpatient solely for dental care treatment as a result of damage to natural teeth caused solely by an Accident within one year after the Accident's occurrence.

20. Home health care services and supplies where the home health care is provided by or through a Home Health Agency in lieu of Hospital confinement if such services cost less to the Plan than they would if they were provided by a Hospital. Covered Medical Expenses for home health care services include charges incurred for the following services and supplies:

    (a) Part-time or intermittent nursing care provided by or under the supervision of a registered nurse (R.N).;

    (b) Part-time or intermittent home health aide services under the supervision of a R.N.;

    (c) Medical social services provided under a Physician's direction;

    (d) Medical supplies (other than drugs and biologicals) and the use of medical appliances;

    (e) Physical, respiratory, occupational or speech therapy; and

    (f) Nutritional counseling.

21. Treatment of chronic pain by a pain control center where the center is operated by and under the control of a Hospital and provided the treatment is approved before it starts.

22. Chiropractic care up to Plan maximums as provided in the Schedule of Benefits.

23. Treatment or surgery for one occurrence of Morbid Obesity, subject to the Plan's Pre-Certification Program, for covered Participants and Dependents over 18 years of age where an evaluation has been conducted by a licensed professional counselor, psychologist or psychiatrist who specializes in obesity issues.

24. Whole blood or blood plasma and the cost of its administration.

25. Casts, splints, trusses, braces (except dental braces), crutches and prosthesis.

26. The initial cost of artificial limbs and/or artificial eyes and replacements once every 60 months.

27. Purchase and/or rental of Durable Medical Equipment. The Fund reserves the right to purchase the equipment instead of paying for rental, if purchase would cost less than the reasonable and customary rental amount.

    Durable Medical Equipment means equipment, recognized as such by Medicare Part B, that (1) can withstand repeated use; (2) is primarily and customarily used to serve a medical purpose related to the person's physical disorder; (3) generally is not useful in the absence of illness or injury; and (4) is appropriate for use in the home.

    Examples of Durable Medical Equipment include: wheel chairs, Hospital beds and equipment for giving oxygen.

    Coverage for Durable Medical Equipment is not provided for (1) equipment that serves as a comfort or convenience item or (2) equipment used for environmental control or to enhance the environmental setting or surroundings of an individual.

    Examples of equipment that are not covered include, but are not limited to, the following: exercise equipment, elevators, posture chairs, air conditioners, heaters, humidifiers, dehumidifiers, air filters, whirlpool tubs and portable jacuzzi pumps.

28. Medical and surgical benefits for mastectomies, as required by federal law under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"), including the following, when requested by the patient in consultation with her Physician:

    (a) Reconstruction of the breast on which the mastectomy has been performed;

    (b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

    (c) Prostheses and physical complications of all stages of mastectomy including lymphedemas, then the cost of two brassieres.

29. Charges for oxygen and its administration.

30. Allergy serums.

31. Surgical stockings.

32. Licensed ambulatory surgery center services.

33. Wigs under $150.00, if necessary, due to hair loss as a result of radiation therapy or chemotherapy.

34. Examinations and eyeglasses required to correct impairment caused by an ocular Accident or by intra-ocular surgery where such expenses are incurred no later than twelve months after the injury is sustained or the surgery is performed.

35. Non-experimental or non-investigative organ or tissue transplants including, cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or

pancreas/kidney transplants performed at a Blue Distinction Center for Specialty Care® or a facility approved by the Plan prior to the operation. Benefits are available to both the recipient and donor as follows:

(a) If both the donor and the recipient have BlueCross and BlueShield coverage, each will have their benefits paid by their own program.

(b) If you are a recipient covered under the Plan and the donor has no coverage from any other source, the benefits under this Plan will be provided for both you and the donor.

(c) If you are a donor covered under the Plan and no coverage is available to you from any other source, the benefits under the Plan will be paid on your behalf. However, no benefits will be provided for the recipient.

(d) Subject to the above limitations, covered expenses will include:

(1) Inpatient and Outpatient covered expenses related to the transplant surgery.

(2) The evaluation, preparation and delivery of the donor organ.

(3) The removal of the organ from the donor.

(4) The transportation within the United States or to/from Canada of the donor organ to the location of the transplant surgery.

(5) If the covered person is the recipient and their place of residency is more than 50 miles from the Hospital where the transplant will be performed, benefits will be provided for the covered person and one companion (two companions if the recipient is a Dependent child), including transportation by automobile, train or coach air fare, lodging and meals.

The total combined maximum covered expenses for lodging and meals is $200 per day and the total combined maximum covered expenses for transportation, lodging and meals is $10,000.

36. Treatment of Mental/Nervous Disorders. Treatment also includes family or group therapy where the patient is a covered person and is a Participant in the therapy session.

37. Treatment of Chemical Dependency:

(a) Inpatient treatment provided by a Hospital or Chemical Dependency treatment facility where the treatment is Pre-Certified;

(b) Outpatient treatment; and

(c) Family or group therapy where the patient is a covered person and is a participant in the therapy session.

A course of treatment may be for one or more types of dependency. If the patient is discharged from an Inpatient program into an outpatient program, the entire program of treatment will count as one course of treatment.

38. Acupuncture.

39. Removal of impacted teeth, including anesthesia for such services. However, benefits under this Section will be paid only after benefits under the Plan's Dental Benefit have been exhausted.

40. Charges incurred for covered pregnancy expenses provided by a licensed midwife, if the birth occurs in a Hospital. In the event that a Physician's services are also needed, the maximum Allowable Expense under the Plan for the midwife and the Physician will not exceed the charges that would have been incurred if the entire maternity process had been handled by a Physician.

41. Abortion procedures if the life of the mother would have been in danger if the fetus were carried to term.

42. Medical complications arising from an abortion procedure.

43. Treatments for temporomandibular jaw joint (TMJ) after the dental benefits under the Plan have been exhausted.

44. Intrauterine devices (IUDs).

45. Voluntary sterilization procedures for Participants and their Dependent spouses.

46. The UCR allowance for secondary surgical procedure performed during the same operative session as a primary procedure is 50% of the amount allowed for each secondary procedure if performed alone, under the following criteria:

    (a) The secondary procedure is to correct a separate pathological condition;

    (b) The pathological condition would have required surgical intervention had an incision not already been present; and

    (c) The degree of difficulty, operative time, and risk are significantly increased by the secondary procedure.

    Each additional covered procedure is covered at 25% of the amount allowed.

47. One annual Influenza virus immunization (flu shot).

48. Preventive Services.

49. Provided there is an appropriate Medically Necessary reason for conducting the test and subject to the Plan's Pre-Certification Program, genetic testing is covered for determining the existence of inherited mutations which creates a susceptibility to (1) medullary carcinoma of the thyroid, (2) colon cancer and (3) breast or ovarian cancer (inherited BRCA1 or BRCA2 mutations).

    The determination of whether genetic testing is Medically Necessary is subject to the following requirements and restrictions:

    (a) The initial consultation and follow up consultation must be performed by a genetic counselor certified by the accrediting agency of the state in which the services are provided.

    (b) For medullary carcinoma of the thyroid, genetic testing for RET proto-oncogene point mutations will be eligible for coverage in family members who are:

(1) Symptomatic patients with defined RET gene mutations;

(2) Patients known to be affected by inherited medullary thyroid cancer or to multiple endocrine neoplasia type 2, but not previously evaluated for RET mutations; and

(3) Patients with medullary thyroid cancer with no family history of such cancer (sporadic incidence).

(c) For colon cancer, the determination of whether genetic testing is Medically Necessary is subject to the following requirements and restrictions:

(1) Genetic testing to determine carrier status of the adenosis polyposis coli gene (APC) is eligible for coverage in:

i. Patients with greater than 20 colonic polyps; or

ii. First-degree relatives (i.e., siblings, off-spring, or parents) of patients diagnosed with familial adenomatous polyposis (FAP).

(2) Genetic testing is considered Investigative and is not eligible for coverage for the following:

i. Identification specifically for I1307K mutation; and

ii. Identifying which patients should undergo HNPCC genetic testing by using the replication error (RER) phenotype test, also referred to as the micro-satellite instability (MSI) test.

(d) For breast or ovarian cancer, the determination of whether genetic testing is Medically Necessary is subject to the following requirements and restrictions:

(1) Genetic testing is eligible for coverage for:

i. Individuals who have breast or ovarian cancer and are from families with a high risk of BRCA1 or BRCA2 mutations.

ii. Unaffected individuals (male or female) who come from families with a known BRCA1 or BRCA2 mutation.

(2) Genetic testing is Investigative and not eligible for coverage for:

i. Unaffected family members in the absence of a known BRCA1 or BRCA2 mutation in the family, unless the family history reveals at least four first and/or second-degree relatives with breast, ovarian or colon cancer and there is no affected family member available for testing;

ii. Unaffected individuals of potentially high-risk populations (e.g., Ashkenazi Jewish descent) with no significant family history; and

iii. Minors for BRCA1 or BRCA2 mutations.

50. Any procedures or services covered under the Plan as listed above that is rendered by a qualified Physician or other qualified health professional acting within the scope of his or her licensure as defined by state law.

B. Medical Expenses Not Covered

Specifically, the Major Medical Benefit does not cover the following:

1. Services or supplies that are not Medically Necessary, as determined by the Plan Administrator.

2. Services or supplies in excess of any maximum benefit or limitation specified in the Plan.

3. Services or supplies that are not specifically listed as a covered expense under the Major Medical Benefit.

4. Services or supplies received by a person, facility or organization acting outside the scope of the applicable license.

5. Services, supplies, treatments or procedures which are not rendered for the treatment or correction of, or in connection with, a specific non-occupational accidental bodily injury or Sickness, unless specifically identified as being covered under the Plan.

6. A pregnancy or pregnancy related condition other than for a Participant or Dependent spouse.

7. Abortion procedures unless the life of the Participant or Dependent spouse is endangered or there is a medical complication.

8. Any type of drugs or medications, procedures, tests, examination, treatments or care provided for or in connection with infertility, or any direct attempt to induce or facilitate fertility or conception, including, but not limited to:

   (a) Hormone therapy;

   (b) Surgically induced fertility;

   (c) Artificial insemination or any related procedure such as in vitro or in vivo fertilization and egg implantation; or

   (d) Any treatment, counseling for infertility or therapy.

9. With respect to Hospital and Skilled Nursing Facilities services and supplies, any items such as a telephone, a TV, cosmetics, guests trays, magazines or beds or cots for guests or other family members or any other personal comfort items.

10. Home health care except as provided in the Plan.

11. Immunizations, x-rays or tests not related to an Accident or Sickness and not considered Preventive Services.

12. Non-Emergency plastic or cosmetic surgery, except to correct damage caused by an Accident or Sickness or congenital deformities of a Dependent child.

13. Radial keratotomy, Lasik, refractions, eye examinations and eyeglasses unless specifically covered under the Plan and not covered under the Plan's Vision Benefit.

14. Any care or treatment of teeth, gums or the alveolar process except as specifically covered under the Plan and not covered under the Plan's Dental Benefit.

15. Reversal or attempted reversal of vasectomies or other sterilization procedures.

16. Treatment or removal, in whole or in part, of corns, callosities, hypertrophy or hyperplasia of the skin or any subcutaneous tissue, or for the cutting or trimming of toenails unless Medically Necessary.

17. Travel or transportation except as specifically provided.

18. Orthopedic shoes or orthopedic prescription devices to be attached to shoes unless the shoe is an integral part of a brace required by the patient's condition.

19. Air conditioners, air-purification units, humidifiers, allergy-free pillows, blankets, mattress covers, electric heating units, swimming pools, orthopedic mattresses, exercising equipment, vibratory equipment, elevators or stair lifts, blood pressure instruments, stethoscopes, clinical thermometers, scales, elastic bandages or stockings, wigs or devices or surgical implantations for simulating natural male or female body contours except as specifically provided.

20. Services that are in the nature of education or vocational testing and training.

21. Education, training or room and board while a person is confined in an institution which is primarily a school or other institution for training.

22. Any type of rest cure or custodial care (care that is designed primarily to assist a person in meeting the activities of daily living, (i.e. milieu therapy)), regardless of what the care is called.

23. Care, treatment, services or supplies provided in a nursing home, rest home, home for the aged, convalescent home or similar establishment or facility unless it is a facility that meets the Plan's definition of Skilled Nursing Facility and such services are pre-certified.

24. Treatment, care, services, supplies or procedures while a person is confined in a Hospital operated by the U.S. government or its agency unless the charges are made by a Veteran's Administration (V.A.) Hospital which claims reimbursement for the "reasonable cost" of care furnished by the V.A. for a non-service related disability, to the extent required by law, such charges will be considered Covered Medical Expenses had the V.A. not been involved.

25. The completing of claim forms (or other forms required by the Plan for the processing of claims) by a Physician or other provider of medical services or supplies.

26. Any charges incurred for treatment or consultation with a marriage counselor, pastor, rabbi or priest.

27. Exercise equipment or membership fees in a health club facility.

28. Any operations, treatment or hormone therapy in connection with sex transformations, implantation of any sex organ or any type of sexual dysfunction or inadequacies, including complications arising from such conditions.

29. Hearing aids or related exams or fittings.

30. The following expenses related to a human organ or tissue transplant:

    (a) Cardiac rehabilitation services where not provided to the transplant recipient immediately following discharge from a Hospital after transplant surgery.

    (b) Travel time and related expenses incurred by a Physician or provider.

    (c) Storage fees.

    (d) Expenses incurred on behalf of any individual who is not the recipient or donor, unless specifically covered under Section 6.06(A).

31. Expenses covered under the Plan's Dental Benefit, Vision Benefit or Prescription Drug Benefit.

32. Services or supplies which are not recognized as payable (in whole or in part) by Medicare, including services and supplies that are in excess of the maximum number of such services/supplies allowed by Medicare where the covered individaul is eligible for Medicare.

33. Charges for any of the circumstances listed under the General Plan Exclusions in Section 11.

SECTION 7: PRESCRIPTION DRUG BENEFITS

7.01 Eligibility

If you meet the Plan's eligibility requirements, you and your Dependents are eligible for the Prescription Drug Benefit. The benefit amounts and applicable Co-Payments are shown in the Schedule of Benefits.

7.02 General Information

The Prescription Drug Benefit covers Prescription Drugs and is administered by a prescription benefit manager ("PBM"). Accordingly, this Benefit is subject to the contractual agreements between the Plan and the PBM.

7.03 The Drug Card Program

You should have already received a packet of materials regarding the Prescription Drug Card Program and the Mail Order Program. The packet includes a list of participating pharmacies, details about how to use the programs and prescription drug I.D. cards. If you have not received those materials, please contact the Third Party Administrator.

When you or your Dependents need to have a prescription filled or refilled you should:

A. Go to a participating pharmacy;

B. Show the pharmacist your prescription drug I.D. card; and

C. Pay the pharmacist the applicable Deductible and/or copayment per prescription.

7.04 The Mail Order Program

You may use the Mail Order Program to order up to a 90-day supply of any covered medication that your Physician prescribes for you or your eligible Dependent. You are encouraged to use this service for maintenance medications. Maintenance medications are medications you or your Dependents take for long periods of time for chronic conditions such as high blood pressure, heart condition, diabetes, asthma and arthritis.

If your Physician prescribes a long-term medication and/or maintenance medication that you need right away, ask the Physician to write two prescriptions — one prescription to be filled at a participating pharmacy using the Drug Card Program, and one prescription for the remainder of the medication to be submitted to the Mail Order Program.

For more information on the Mail Order Program, please contact the Third Party Administrator or PBM.

7.05 Excluded Drugs

The following medications are not covered under the Plan:

A. Patient medicines or drugs which can be obtained without a Physician's prescription;

B. Dietary or nutritional supplements, dental vitamins or wellness vitamins, except as required under federal law;

C. Prescription Drugs with a generic or over-the counter equivalent;

D. Infertility or impotence drugs, including but not limited to, Clomid, Pergonal and Viagra;

E. Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original order;

F. Any drug or medication obtained or prescribed in connection with a condition or treatment not covered under the Plan;

G. Allergens or antigens, Methadone, Minoxidil, Rogaine and other hair growth agents;

H. Injectable or intravenous medications, other than insulin which are not provided through the Plan's Specialty Drug Program; and

I. Medications that are not considered Medically Necessary, as determined by the Plan Administrator.

7.06 Preferred Drugs, Non-Preferred Drugs and the Specialty Drug Program

The amount of your Prescription Drug Co-Payment will depend on whether the drug is Preferred, Non-Preferred or Specialty as listed in the Schedule of Benefits.

A. Preferred and Non-Preferred Drugs

Preferred Drugs are brand drugs which are considered formulary. Non-Preferred Drugs are brand drugs which are considered non-formulary.

Please note that Prescription Drugs may change from Preferred and Non-Preferred (and vice versa) over time. For more information about which drugs are Preferred or Non-Preferred, please contact the PBM at the telephone number provided on your ID card.

B. Specialty Drug Program

Specialty Drugs are medications created to target and treat complex medical conditions and rare diseases. The Plan covers Specialty Drugs that are self-administered under the Prescription Drug Benefit. To receive coverage for Specialty Drugs, they must be received through the Plan's Specialty Drug Program. When you are prescribed a Specialty Drug, call the number listed under the PBM's Specialty Drug Administrator to enroll in the Specialty Drug Program. Once you enroll in the program, your medications will be sent directly to your home or work address via safe, temperature controlled and tested packaging at no additional cost. If you are currently taking or are prescribed a Specialty Drug, you should contact the PBM's Specialty Drug Administrator or the Third Party Administrator for more information on the program.

7.07 Penalty for Brand Drug Chosen when Generic Drug Available

If you have a prescription filled (even if your Physician checks dispense as written) with a brand drug when a generic is available, your Co-Payment and cost difference will apply as follows:

- You will pay the cost difference between the brand drug and generic drug
- You will pay the applicable brand drug Co-Payment (Preferred or Non-Preferred)

The generic name of a drug is its chemical name and the brand name is the trade name under which the drug is advertised and sold. Both generic and brand name drugs must meet the same federal requirements for safety, purity and strength.

If your Physician prescribes a brand name drug with a generic equivalent, ask if you can use the generic version instead. If you are unsure if there is a generic equivalent for a brand drug, please contact your Physician, pharmacist or the PBM.

7.08 Pre-Authorizations and Step-Therapy

To ensure the safety and efficacy of the medications prescribed to you, a prior authorization program has been added in which certain drugs will be reviewed by the PBM and approved according to established clinical criteria. If prior authorization or step therapy is required, a message will be sent to the pharmacy and the PBM will work with you, your Physician and the pharmacy to obtain the appropriate information to complete the process. Please be sure to allow adequate time for this process prior to filling your prescription.

Step-Therapy is a program in which a patient with a chronic condition first tries a less costly medication (first-line drug) before using a more expensive drug (second-line drug). The goal of Step-Therapy is to ensure that the patient receives an appropriate medication for a condition.

Certain generics that exist within a family of drugs (aka drug class) work in a similar manner as the brand drug equivalent. For select classes of drugs, a trial of the generic will be required before gaining access to the more expensive second line, branded (Preferred and Non-Preferred) drugs. The categories of drugs requiring Step-Therapy are listed below:

- Selective Serotonin Reuptake Inhibitor (SSRI) Antidepressants
- Asthma -Singulair
- Nasal Steroids/Nasal Allergy Products
- Cox-2 Inhibitors (Anti-inflammatory)

For a complete and updated listing of all drugs subject to the quantity limit, prior authorization and Step Therapy process, please contact the PBM.

7.09 Medicare Prescription Drug Plan

Medicare eligible Retirees and Medicare eligible Dependents are automatically enrolled in the Plan's Medicare Prescription Drug Plan (PDP). The drug plan administrator processes benefits through both the group Medicare Part D Prescription Drug Plan and the Fund's Plan. The first part of the PDP coverage is

paid under the Medicare Part D Prescription Drug Plan. The remaining coverage is paid by the Fund through what is known as a "wrap around plan."

PDP ID cards are automatically provided by the PDP if you are eligible for the Medicare Prescription Drug Plan and enrollees in the PDP may receive prescription benefits through the retail pharmacy or through mail order.

SECTION 8: DENTAL BENEFIT FOR ACTIVE BARGAINING UNIT EMPLOYEES

8.01 Eligibility

You and your Dependents are eligible for the Plan's Dental Benefit if you are an Active Bargaining Unit Employee and you are eligible for Active Benefits.

8.02 Three Tier PPO Network and Payment of Benefits

To provide you the greatest access to the Dentist of your choice, you may seek care from a (1) Delta Dental PPO Dentist, (2) Delta Dental Premier Dentist, or (3) Nonparticipating Dentist.

A. Preferred Provider Network.

You and your eligible Dependents will receive the highest calendar year maximums, greatest discounts and benefit levels if you choose a Dentist in the PPO network. This is because the Dentists in the PPO network agree to provide services at fees that are generally lower than those of non-participating Dentists.

To minimize your out-of-pocket costs, contact Delta Dental or the Third Party Administrator for information about Dentists in the Plan's PPO network. Although you are not required to use the PPO Dentists, when you use PPO Dentists, you will reduce costs for both you and the Fund. To receive a list of PPO Dentists free of charge, please contact the Third Party Administrator or the Dental PPO administrator.

B. Non-Preferred Provider Premier Network

It is recommended that you select a Dentist within the Dental PPO network, but the second most favorable option is to choose a Dentist in the Non-PPO Premier network. The Premier network is much larger, giving you more Dentists to choose from, but has lower discounts. Although a Premier Dentist is considered a Non-PPO provider, the Premier Dentist receives the total of the reimbursement from the Plan and your copayment, if any, as full reimbursement for covered services.

C. Non-PPO Providers

If you and your Dependents choose a Dentist who is not in the Plan's PPO or Non-PPO Premier network, this Dentist may balance bill you for services. Balance billing would mean you pay the difference between what the health insurance chooses to reimburse and what the provider chooses to charge. Both PPO and Premier Dentists are prohibited from balance billing you for services. You will incur more out-of-pocket costs if you choose a Non-PPO Dentist.

D. Payment of Benefits

The Plan will pay benefits, up to the UCR charges pursuant to the Schedule of Benefits. Although you are not required to choose a PPO Dentist, you and your eligible Dependents will have the most benefits and lowest out-of-pocket costs if you do choose a Dentist in the PPO network. An example of how choosing a PPO or Non-Preferred Premier Dentist will save you money is provided on the following page.

For Example:

John is choosing a new Dentist and is considering a Dentist in each network tier. In the upcoming year, he knows he will need three fillings and a root canal in addition to X-rays and his usual twice a year preventive visits (cleanings and exams). Below is an example of what John will pay for each Dentist:

	PPO	***Non-PPO Premier***	***Non-PPO***
Billed Cost	$2,000	$2,000	$2,000
Negotiated Rate	$1,500	$1,750	N/A
UCR	N/A	N/A	$1,750
What Plan Pays	$1,200	$1,000 (calendar year maximum)	$1,000 (calendar year maximum)
What John Pays	20% of $1,500	(20% of $1,750) + (Difference between 80% of $1,750 and the $1,000 calendar year maximum)	Difference between billed amount ($2,000 and What Plan Pays ($1,000))
Total Amount John Pays	**$300**	**$750**	**$1,000***

*If you seek care from a nonparticipating Dentist and that Dentist charges more than Delta Dental's Nonparticipating Dentist Fee, you must pay the difference from your own pocket. In the above example, the difference (and subsequent out-of-pocket expense) is $250.00. When you add the difference to the amount owed by John ($750) after the Calendar Year Maximum is paid, you arrive at $1,000.

8.03 Covered Dental Expenses

Covered dental expenses shall be the UCR Charges incurred for the following services and supplies provided by a Dentist in accordance with accepted standards of dental practice (cleaning and fluoride application may be provided by a licensed dental hygienist):

A. Diagnostic and Preventative Expenses

1. Oral Exams (including evaluations by a specialist) and Prophylaxes cleanings are payable twice per calendar year.

2. Fluoride treatments are payable once per calendar year for individuals up to age 19.

3. Space maintainers are payable once per area per lifetime for individuals up to age 19.

4. Emergency Palliative Treatment to temporarily relieve pain.

5. Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period.

B. Basic Services

1. Fillings and Crown repair.

2. Endodontic Services including root canals.

3. Non-Surgical Periodontic Services (non-surgical services to treat gum disease).

4. Oral Surgery Services including extractions and dental surgery.

5. Other basic, miscellaneous services.

6. Relines and repairs to bridges, dentures and implants.

7. Composite resin (white) restorations are Covered Services on posterior teeth.

8. Porcelain facings on crowns are Covered Services on posterior teeth.

9. Porcelain and resin facings on bridges are Covered Services on posterior teeth.

C. Major Services

1. Surgical Periodontic Services (surgical services to treat gum disease).

2. Major Restorative Services (crowns).

3. Prosthodontic Services (bridges and dentures).

4. Inlays of any material are Covered Services.

5. Veneers are payable on incisors, cuspids, and bicuspids once per tooth per five-year period.

D. Orthodontic Care

1. Orthodontic Services including initial and subsequent installations of orthodontic appliances (braces).

2. The age limit for Dependent children is 19.

3. Benefits are subject to Plan maximums.

8.04 Exclusions and Limitations to Covered Services

1. Implants and related services

2. Occlusal guards.

8.05 Extension of Dental Benefits

If your eligibility is terminated, you may not continue group coverage except as required by the continuation coverage provisions of the Consolidated Budget Reconciliation Act of 1985 (COBRA) or comparable, non-preempted state law. An affiliate of Delta Dental may also offer you coverage under an individual direct payment policy if your eligibility is terminated. If your eligibility for Dental Benefits terminates while you are receiving dental treatment that started while you were eligible, Dental Benefits shall continue to be paid for your treatment for 30 days after the date of the covered individual's eligibility terminates.

SECTION 9: VISION EXPENSE BENEFIT FOR ACTIVE BARGAINING UNIT EMPLOYEES

9.01 Eligibility

Benefits are payable under this Article for covered vision expenses incurred by eligible Active Bargaining Unit Employees and their eligible Dependents.

9.02 Covered Vision Expenses

The Plan has contracted with a Vision Preferred Provider Organization (PPO), a network of vision care professionals, to provide you with services and supplies at discounted prices. Plan benefits and maximums are listed in the Schedule of Benefits. Your out-of-pocket costs depend on the service or supply rendered and whether it is received in network through a Vision PPO provider or from a provider who is not in the network.

9.03 Using a Vision PPO Provider

It is always your decision to use or not to use a Vision PPO provider, but keep in mind that when you utilize a PPO provider, you will gain the following advantages:

- You will have greater coverage and less out-of-pocket costs.
- You will receive discount prices on all your vision care needs, including some procedures that are not covered under the Plan.
- You do not need to file a claim because the PPO providers file them directly with the Vision PPO administrator.

9.04 If You Use a Non-Network Provider

If you receive services or supplies from a vision professional who is not in the Plan's Vision PPO network, you pay the full cost of the services or supplies you receive and then submit a completed claim form to the Vision PPO network administrator for reimbursement, along with proof of payment for examinations and supplies. The Plan pays up to a specific dollar amount per covered person toward the cost of covered vision care expenses, as shown in the Schedule of Benefits and you are responsible for paying amounts in excess of Plan payments.

9.05 Exclusions and Limitations

Benefits shall not be paid by this Plan for any of the following services or supplies:

A. Visual analysis which does not include eye refraction.

B. Examination or service rendered by anyone other than a licensed ophthalmologist or optometrist.

C. Supplies, materials, lenses or frames that are not prescribed by a licensed ophthalmologist or optometrist.

D. Medical or surgical treatment of the eye.

E. Special procedures, including but not limited to, orthoptics, visual training or subnormal visual aids.

F. Plan or prescription sunglasses or other special purpose vision aids.

G. Aniseikonic lenses, non-prescription lenses, eyeglasses obtained when there is no prescription change or two pairs of glasses in lieu of bifocals.

H. Scratch resistant coating.

I. Eye examinations required by an employer or as a condition for employment or which may be required as a result of any labor agreement or by any governmental body or as part of any physical examination, such as a school examination.

J. Vision care expenses which are excluded under the Plan's General Plan Exclusions.

SECTION 10: HOSPICE BENEFIT

10.01 Eligibility

You and your Dependents are eligible for the Hospice Benefit if you are eligible for Active Benefits or Retiree Benefits.

10.02 Hospice Benefit

The Fund provides you and your Dependents with Hospice Benefits, up to the maximums shown in the applicable Schedule of Benefits when you have a terminal condition (life expectancy of six months or less). To be eligible for Hospice Benefits, the Hospice care must be rendered as part of a Hospice Care Program by a licensed Hospice Care Agency. Remember that before you enroll in a Hospice Care Program, you must Pre-Certify the treatment with the Pre-Certification organization.

Since the Hospice Care Program provides certain services and supplies which are not Covered Medical Expenses under the Plan, a covered person must elect to use the Hospice Care Program for most of the care for a terminal condition instead of receiving benefits for that care under the regular Covered Medical Expense provisions. A covered person will receive any and all palliative care (care focused on relieving the pain, symptoms and stress of serious illness) for the terminal condition under the Hospice Care Program. A person may revoke this election at any time and any benefits provided at that time will be payable for Covered Medical Expenses.

The following services are covered under the Hospice Benefit and are subject to the maximum limits in the applicable Schedule of Benefits:

A. Home Care

Home care allows a patient to receive care in his or her own home. Services and equipment covered include:

1. Physician services;
2. Physical, respiratory and occupational therapies;
3. Drugs, medications and medical supplies when provided under the Hospice Care Program through a Hospice Care Agency;
4. Private duty nursing services by a R.N. or L.P.N., if certified by a Physician;
5. Rental of Durable Medical Equipment; and
6. Oxygen and its administration.

B. Outpatient Care

Outpatient care is care that you receive in a licensed medical facility. Services covered include:

1. Physician services;

2. Laboratory, x-ray and diagnostic testing; and

3. Transportation in an Emergency situation.

C. Inpatient Care

Inpatient care is care that you receive while you are an admitted patient in a Hospital or Hospice facility. Covered services include:

1. Room and board in a crisis period which may include overnight visits by family;

2. Nursing services;

3. All other related Hospital expenses;

4. Physician services; and

5. Ambulance service or alternative types of transportation.

D. Other Services

In addition to the services outlined above, certain other services for you and your family are also covered. Other covered services include, but are not limited to:

1. Visits by a licensed social worker to evaluate the social, psychological and family problems related to the terminal illness. In addition, this professional will help develop a plan to assist in resolving these problems; and

2. Emotional support services to help relieve stress, cope with the anticipated loss, complete unfinished family business and maintain the patient in the most appropriate environment.

E. Exclusions and Limitations

The following services and supplies incurred through a Hospice Care Program are not covered under the Plan:

1. Bereavement counseling provided to a terminally ill person's family after his or her death;

2. Long-term Inpatient care;

3. Administrative services;

4. Child care and/or housekeeping services; and

5. Transportation, except in Emergency situations as specifically provided.

SECTION 11: GENERAL PLAN EXCLUSIONS

11.01 Exclusions

The following list of specific exclusions is not an all-inclusive listing of the Plan's limitations and excluded procedures, services, supplies and types of treatment. It is only representative of the types of services and supplies for which charges may be incurred which are not payable by the Plan.

A. Accidents, Sicknesses or dental treatments for which you are entitled to benefits under a workers' compensation or occupational disease law. However, this exclusion does not apply to the Death or Accidental Death and Dismemberment Benefits.

B. Care, treatment, procedures, services or supplies provided to a person who is not covered and/or eligible under the Plan.

C. Any expenses or charges for services or supplies that are provided by Hospitals or medical institutions owned or operated by a federal, state or local government, or their medical practitioners, unless you are required to pay such charges.

D. Any expenses or charges caused by your voluntary participation in a riot.

E. Any expenses or charges caused by war or any act of war, whether declared or undeclared.

F. Any expenses or charges incurred during the commission of a felony or involvement in a criminal enterprise.

G. Any expenses or charges incurred while in the military service of any country, or civilian non-combatant unit serving with such forces. However, the Plan will cover expenses as required under USERRA.

H. Any expenses or charges for which you do not have to pay.

I. Any expenses or charges for services or supplies not prescribed by a Physician or Dentist, unless such services or supplies are provided under the supervision of a Physician or Dentist.

J. Any expenses or charges for services or supplies:

   1. Not provided in accord with generally accepted professional medical standards;

   2. Not Medically Necessary; or

   3. For drug therapy programs not available in the United States or available in the United States only under special license by the federal government for practitioners engaged in research.

K. Any expense or charge for Experimental or Investigative Treatments and Procedures.

L. Any expenses or charges for services and supplies that exceed the UCR Charges.

M. Any expenses, charges or treatments received in any penal facility or jail or equivalent institution.

N. Any treatments, services or supplies furnished by a person who resides in your home, or who is a member of your immediate family (i.e., your spouse, child, brother, sister or parent).

O. Any expenses or charges for third party ordered care, such as a pre-employment physical or school physical.

P. Any expenses or charges (1) for failure to keep scheduled visits; (2) for completion of claim forms or (3) for reports or medical requests not requested by the Fund; and

Q. Charges that would not have been made if this Plan did not exist.

SECTION 12: COORDINATION OF BENEFITS

12.01 Benefits Are Coordinated

Under the Welfare Plan, your medical benefits may be coordinated if another group plan or source is obligated to make benefit payments for you or your Dependents. Benefits are coordinated so that no more than 100% of your expenses are paid through the combined coverage of the plans.

The coordination of benefits applies only to Medical, Prescription, Vision and Dental Benefits provided under this Plan. It does not apply to Death, AD&D or Weekly Disability Benefits.

12.02 Another Group Plan Defined

Another group plan or source refers to any plan providing benefits or services and includes:

A. Group blanket or franchise insurance coverage (such as coverage provided to college students);

B. Group Blue Cross or group Blue Shield coverage and other group prepayment coverage;

C. Any coverage under labor-management trustees plans, union welfare plans, employer organization plans, employee benefits organization plans or any other arrangement of benefits or individuals of a group;

D. Any coverage under governmental programs;

E. Any coverage required or provided by statute; and

F. This Plan when you are covered as:

    1. An Employee and as a Dependent; or

    2. A Dependent child of more than one Employee.

12.03 How Benefits are Paid

Benefits coordination ensures that you receive maximum benefits and that benefits are not paid for more than 100% of the actual charges incurred.

When health care coverage is available from more than one group plan, the primary plan pays benefits first. Your primary plan determines benefits as if that plan was the only coverage available. Then the secondary plan pays according to their coordination of benefits rules. When this Plan is secondary, it will pay the difference between your Allowable Expenses and what your primary plan paid.

This Plan defines Allowable Expenses as any necessary, reasonable and customary item of expense for medical care or treatment that is covered under at least one of the plans by which you are covered. If a plan provides benefits in the form of service rather than cash payments, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. Allowable Expenses do not include any portion of a charge that is not considered a Covered Medical Expense under this Plan.

The combined payments of both plans will not be more than the primary plan's contract calls for if the primary plan has a contract with the provider through an HMO or PPO arrangement. Moreover, if this Plan and the other plan have a contract with the same provider, the Allowable Expense will be the lower of the two contracted or negotiated fees.

If you or a Dependent is covered by another group plan or source in addition to this Plan, the order of benefit payment will be determined according to the Plan's coordination of benefits rules.

For prescription drug benefits, if you have secondary coverage through another prescription drug plan and you choose to use that plan as primary coverage for prescriptions, you may submit a claim for your Co-Payment amount to this Plan and it may be used to satisfy any of the individual and family Deductibles under the Plan.

12.04 Order of Benefit Payment

For coordination with other plans the following rules apply:

A. A plan without coordination of benefits rules will be primary and will pay benefits before this Plan.

B. A plan that covers a person other than as a Dependent is primary and pays benefits before a plan that covers the person as a Dependent.

C. For claims on behalf of Dependent children whose parents are not divorced or separated or for claims on behalf of Dependent children whose parents share custody, the plan that covers the parent whose birthday (month and day) falls first in the calendar year is primary and will pay benefits first. If both parents have the same birthday, the plan covering the parent for the longer period of time will be primary and pay benefits first.

D. For claims on behalf of Dependent children whose parents are divorced or separated, whether or not they have ever been married, the following rules apply:

    1. If there is a court decree that establishes financial responsibility for medical expenses, the plan covering the parent who has such financial responsibility will be primary.

    2. If there is no court decree and the parent with custody has not remarried, the plan that covers the parent with custody will be primary.

    3. If there is no such court decree and the parent with custody has remarried, the order of benefit coordination will be as follows:

        (a) The plan of the parent with custody is primary and pays benefits first;

        (b) The plan of the step-parent with custody pays benefits second;

        (c) The plan of the parent without custody pays benefits third; and

        (d) The plan of the step-parent without custody, if any, pays benefits fourth.

E. For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the spouse's plan will be primary and the parent's plan will be secondary.

F. A plan that covers you as an employee who is not laid off or retired is primary and pays benefits before a plan that covers you as a laid-off employee or retired employee.

G. A plan that covers you as a current full-time employee or as a dependent of that current full-time employee is primary and pays benefits before a plan that covers you as a part-time or seasonal employee or as an employee who is eligible because of contributions or payroll deductions previously made to the plan.

H. If a person is covered under the Plan as both an Employee and a Dependent spouse, the Plan will coordinate benefits and will pay primary employee benefits and secondary Dependent benefits, up to the maximums provided in the Schedule of Benefits.

I. If a person who has COBRA Continuation Coverage is also covered under another plan as an employee, Retiree or Dependent, the COBRA Continuation Coverage is secondary.

J. If none of the above rules apply, the plan that has covered the claimant for the longer period of time will be primary and pay benefits first.

12.05 Coordination of Benefits Implementation Rules

The Trustees, without the consent of any person, have the following rights to implement the coordination of benefits rules:

A. Release or obtain information considered necessary;

B. Authorize payment directly to another group plan or source that paid claims which should have been paid by this Plan; and

C. Recover payments in excess of the amount that should have been paid by this Plan.

12.06 Coordination of Benefits with Medicare

A. When you are an Active Employee or Entitled to Medicare due to Disability

If you are covered under Active Benefits or are entitled to Medicare due to disability but are not yet entitled to Medicare due to age, the Plan will be primary and pay benefits first. If you are an Active Employee whose eligible Dependent is entitled to Medicare, the Plan will be primary to Medicare for that Dependent.

B. When you are entitled to Medicare due to Age and are not an Active Employee

If you are entitled to Medicare due to your age, Medicare will have primary responsibility and the Plan will pay second. Where the Plan pays second to Medicare, all claims incurred will be covered the same as PPO charges and you will be subject to the Plan's PPO Plan Deductibles and Co-Payments as stated in the Schedule of Benefits.

If you or your Dependents are eligible for Medicare and have not enrolled in Medicare Part A and Medicare Part B, the Plan will assume that you have enrolled and will coordinate benefits under Medicare Part A and Part B. This means that this Plan will only pay benefits equal to what it would have paid if you were enrolled in Medicare Part A and Part B and you will be responsible for any difference.

C. End Stage Renal Disease (ESRD)

There are special rules that apply to the first 30 months of ESRD (the initial 30-month period). The primary/secondary rules depend on whether the covered person is eligible for Medicare due to age or disability at the beginning of the initial 30-month period. After the 30-month period, Medicare is always primary.

1. Eligibility because of the Employee's active status:

   If you are eligible for benefits because of the Employee's active status and become entitled to Medicare solely because of ESRD, this Plan will have primary responsibility for your claims during the initial 30-month period and Medicare pays second.

   If during the initial 30-month period the Employee becomes eligible for Retiree Benefits, the Plan will continue to pay primary during the balance of the 30-month period.

   After the initial 30-month period, Medicare has primary responsibility and this Plan will pay second.

2. Eligibility because of the Employee's retired status:

   If you are retired and not otherwise eligible for Medicare at the time you become entitled to Medicare ESRD benefits, the Plan will have primary responsibility for ESRD during the initial 30-month period and Medicare will pay second.

   If you are retired and already eligible for Medicare at the time you become entitled to Medicare ESRD benefits, Medicare will have primary responsibility for ESRD during the initial 30-month period and this Plan will pay second.

   After the initial 30-month period, Medicare continues to pay primary and the Plan pays second.

SECTION 13: SUBROGATION AND REIMBURSEMENT

13.01 Reimbursement to the Plan

Subrogation or reimbursement rules apply if the Fund pays any benefits that arise out of an Accident or Sickness which results in a claim against a third party. By accepting benefits under the Plan you are agreeing to reimburse the Fund for all such expenses paid on your behalf.

Under these circumstances, the Fund is entitled to full and total reimbursement of its expenditures from all third party recoveries and as such, you shall be deemed to hold the right to recovery against such party in trust for the Plan.

13.02 Third Parties Defined

Other sources may include, but are not limited:

A. Any person or entity legally responsible for your injury;

B. Other benefit plans;

C. An insurance company;

D. Workers' compensation; or

E. Any other person or entity that is obligated to make payments which the Fund would otherwise be obligated to make.

13.03 Your Responsibilities

A. You and/or your Dependent must immediately notify the Third Party Administrator whenever a claim against a third party is made for yourself and/or your Dependent regarding any loss for which benefits are received from the Fund.

B. You and/or your Dependent must cooperate with the Fund by providing information requested by the Fund concerning subrogation or reimbursement. You must provide the Third Party Administrator with:

   1. A signed Subrogation and Reimbursement Agreement;

   2. The names and addresses of all potential third parties and their insurer, adjusters and claim numbers;

   3. Accident reports; and

   4. Any other information the Plan Administrator requests.

C. If you fail to meet your responsibilities, the Plan Administrator may withhold future benefit payments until you comply with these requirements.

D. By accepting benefits under the Plan for these expenses, you and/or your Dependent agree to give the Plan Administrator the right to prosecute your claim and maintain an action against the third party on your behalf (subrogation).

13.04 If You Are Reimbursed by a Third Party

The Fund is entitled to 100% reimbursement of all medical and short term disability claims paid on your behalf and/or your Dependent's behalf, related to the injury or illness, from all third party recoveries.

The Fund's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of you and/or your Dependent, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Therefore, if you and/or your Dependent receive payment from or on behalf of a third party for claims paid by the Fund, you must reimburse the Fund for 100% of benefits paid under the Plan. The proceeds from the settlement or judgment must be divided as follows:

A. First, the Plan has priority over all monies recovered. Accordingly, you or your representative must pay a sum sufficient to fully reimburse the Fund for 100% of benefits paid related to the injury or illness. You must pay your own legal fees and other costs of litigation in connection with the recovery from a Third Party. No reductions or deductions are allowed for litigation costs, court costs, or attorneys' fees (i.e. a common fund doctrine, make whole doctrine, and/or any other state law affecting these rights are preempted by this Plan provision under ERISA); then

B. Any remainder may be paid to you and/or your Dependent.

The proceeds of any claim against a third party must be divided as stated above even if you and/or your Dependent are not fully compensated for the loss. However, the Fund is not entitled to receive reimbursement in excess of the amount you and/or your Dependent receive from all third parties.

You and your Dependents (if applicable) shall be responsible for compliance with these provisions and the provisions of any subrogation/reimbursement agreement. You will also be responsible for compliance by your or your Dependents' agents and attorneys.

Furthermore, if you and/or your Dependent receive payment from a third party for Plan benefits already received and you do not reimburse the Fund as stated above, the Fund may take any action to recover the benefits paid. Such action includes, but is not limited to:

A. Initiating a claim to compel compliance with these terms or the terms of the subrogation/reimbursement agreement;

B. Withholding benefits payable to you or your Dependents until you or your Dependent(s) complies; or

C. Initiating such other equitable or legal action it deems appropriate (the Fund reserves the right to be reimbursed for its court costs and attorney's fees necessary to recover payment).

SECTION 14: CLAIMS AND APPEALS

14.01 General Information

A. Exhaustion of Remedies

You must exhaust all of the claims and appeals procedures of the Plan before you bring any action in court or administrative action for benefits. After you have exhausted all of the procedures in this Section and if you are dissatisfied with the written decision of the Board of Trustees on review, you may institute legal action.

If your appeal is denied, no legal action can be brought with respect to a claim under the Plan after 90 days from the decision on external appeal.

B. Discretionary Decision Making Authority of the Trustees

Subject to the provisions of the Trust Agreement, the Trustees have full and exclusive authority to determine all questions of coverage and eligibility, methods of providing or arranging for benefits and all other related matters. They have full power to construe the provisions of this Summary Plan Description/Plan Document and the terms used in this booklet. Any such determination and any such construction adopted by the Trustees will be binding upon all of the parties and beneficiaries of this Plan.

No determinations involved in or arising under the Trust Agreement or this Summary Plan Description/Plan Document will be subject to the grievance or arbitration procedure established in any collective bargaining agreement between the Association and the Union. However, this provision will not affect the rights and liabilities of any of the parties under any of such collective bargaining agreements.
In carrying out their respective responsibilities under the Fund, the Trustees and/or their delegates have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to benefits in accordance with the terms of the Plan.

Benefits under this Plan will be paid only if the Trustees and/or their delegates decide in their discretion that the applicant is entitled to them. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

14.02 Filing Your Initial Claim for Benefits

A. What is a Claim?

A claim for benefits is a request for Plan benefits that you make in accordance with the Fund's reasonable claims procedures.

If you make an inquiry about the Plan's provisions without a claim form, the Fund will not treat your inquiry as claim for benefits. In addition, if you request prior approval for a benefit that does not require prior approval by the Fund, that will not be treated as a claim for benefits. A claim may fall into one of the following categories:

1. Post-service claim – a claim for payment is requested for a treatment or supply that has already been received;

2. Disability claim – a claim for Weekly Disability Benefits;

3. Pre-service claim – a claim for Pre-Certification for a treatment or supply that requires approval in advance of obtaining care;

4. Urgent care claim – a pre-service claim where the application of time periods for making non-urgent care determinations could seriously jeopardize the claimant's life, health or ability to regain maximum function, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim; or

5. Concurrent care claim – a pre-service claim where a request is made to extend a course of treatment beyond the period of time or number of treatments previously approved. When you present a prescription to a participating pharmacy to be filled out under the terms of this Plan, that request is not a claim under these procedures. However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal regarding the denial by using these procedures.

B. How to File a Claim

To file a claim for benefits offered under this Plan, you must submit a completed claim form within 365 days from the date that the service for the charge is rendered.

You may obtain a claim form by calling the Third Party Administrator. A claim may be filed by a Participant, covered Dependent, an authorized representative or by a network provider. If you use the services of a PPO or other network provider, the provider will generally file your claims for you. If a claim is filed by a provider, the provider will not automatically be considered a claimant's authorized representative.

1. Hospital, Physician and Medical Claims

   The following information must be completed by you and the provider in order for your request for medical benefits to be a claim and for the Fund Office to be able to decide your claim:

   (a) Employee's name;

   (b) Patient's name;

   (c) Patient's date of birth;

   (d) Social Security number of Employee or Retiree;

   (e) Date of service;

   (f) CPT-4 (the code for Physician services and other health care services found in the *Current Procedural Terminology, Fourth Edition*, as maintained and distributed by the American Medical Association);

   (g) The appropriate ICD (the diagnosis code found in the *International Classification of Diseases, Clinical Modification* as maintained and distributed by the U.S. Department of Health and Human Services);

(h) Billed charge;

(i) Number of units (for anesthesia and certain other claims);

(j) National Provider Identifier (NPI) of the provider; and

(k) Billing name and address.

2. All other Benefits

You should contact the Third Party Administrator about how to file a claim for Dental, Weekly Sickness and Disability, Prescription Drugs, Hospice, Dollar Bank Account reimbursements, Death or AD&D Benefits.

C. Where to File a Claim

1. Hospital, Physician & Medical Claims

All Hospital, Physician and medical claims in general, (both PPO and non-PPO providers) should be filed electronically with Anthem Blue Cross Blue Shield ("Anthem"). The Fund will consider your claim to have been filed as soon as it is received at Stewart C. Miller & Co., Inc. Both PPO and non-PPO providers should complete the claim form for you and send it electronically to Anthem.

2. Prescription Drugs

You can avoid the need for filing direct claims by presenting your identification card to the pharmacy when you have your prescription filled. If you need to file a claim form, you may send or fax it and any accompanying receipts to the Catamaran Claims Department at the following address:

Catamaran Claims Department
P.O. Box 1170
Port Washington, NY 11050
Fax: (516) 605-6980
Toll Free Telephone Number: (800) 800-1188

3. Dental Claims

All dental claims should be filed with Delta Dental ("Delta"). The Fund will consider your claim to have been filed as soon as it is received by Delta. Either your provider or you should complete the claim form and send it to following address:

Delta Dental
PO Box 9085
Farmington Hills, MI 48333

4. Vision Claims

   Vision claims from a PPO provider will be automatically filed by the provider. If you incur claims from a non-PPO vision provider, you are responsible for submitting the claims for reimbursement to the following address:

   VSP
   P.O. Box 997105
   Sacramento, CA 95899-7105

5. Life, AD&D and Disability Claims

   To request a claim form and to submit claims for all benefits, please contact the Third Party Administrator.

   Stewart C. Miller & Co., Inc.
   2111 West Lincoln Highway
   Merrillville, IN 46410
   Telephone: (219) 769-6944
   Toll Free Telephone Number: (800) 759-6944
   www.scmiller.com

14.03 Initial Claim Determination Timeframes

A. Claim Filing Deadline

You must file your claim for benefits as soon as possible following the date you incurred the charges. A claim is considered to have been filed on the day it is received by the correct claims office, even if it is incomplete.

If you fail to file your claim as soon as possible, it will not invalidate or reduce your claim if it was not reasonably possible for you to file the claim within a reasonable time. However, you must submit your claim no later than 12 months from the date you incurred the charges unless you can show good cause for filing a claim beyond the 12-month deadline. The Board of Trustees will determine whether you have shown good cause.

B. Claim Processing Timeframes

The time period for making an initial decision on a claim starts as soon as the claim is filed in accordance with the Plan's filing procedures, regardless of whether the Fund has all of the information necessary to decide the claim.

The amount of time the Plan can take to process a claim depends on the type of claim.

1. Post-service claims

   (a) Ordinarily, the Plan will notify you of the decision on your claim within 30 days from the Plan's receipt of the claim.

(b) The Plan may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, the Plan will notify you before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(c) If an extension is needed because the Plan needs additional information from you to process your claim, the extension notice will specify the information needed. In that case you will have 45 days from the time you receive the notification to supply the additional information. If you do not provide the information within that time, your claim will be decided on the basis of the information that the Plan has at that time and your claim may be denied. During the period in which you are allowed to supply additional information, the normal time period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The Plan then has 15 days to make a decision and notify you of the determination.

2. Weekly Disability Claims

(a) The Plan will make a decision on your Weekly Disability claim and notify you of the decision within 45 days.

(b) If the Plan requires an extension of time due to matters beyond the control of the Plan, the Plan will notify you (within the 45-day period) of the reason for the delay and the time when the decision will be made. The Plan will make its decision within 30 days of the time the Plan notifies you of the delay.

The Plan may delay the period for making a decision for an additional 30 days, provided the Plan Administrator notifies you of the circumstances requiring the extension and the date as of which the Plan expects to render a decision, before the expiration of the first 30-day extension period.

(c) If an extension is needed because the Plan needs additional information from you to process your claim, the extension notice will specify the information needed. In that case you will have 45 days from the time you receive the notification to supply the additional information. If you do not provide the information within that time, your claim will be decided on the basis of the information that the Plan has at the time and your claim may be denied.

During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). Once you respond to the Plan's request for the information or at the expiration of the 45 days if you do not respond, the Plan will make its decision on the claim and notify you within 30 days.

3. Pre-Service Claims

(a) Ordinarily, the Plan will notify you of the decision on your claim within 15 days from the Plan's receipt of the claim.

(b) The Plan may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, the Plan will notify

you before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(c) If an extension is needed because the Plan needs additional information from you to process your claim, the extension notice will specify the information needed. In that case you will have 45 days from the time you receive the notification to supply the additional information. If you do not provide the information within that time, your claim will be decided on the basis of the information that the Plan has at the time and your claim may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The Plan then has 15 days to make a decision and notify you of the determination.

4. Urgent Care Claims

(a) Ordinarily, the Plan will notify you of the decision on your claim within 72 hours from the Plan's receipt of the claim.

(b) If an extension is needed because the Plan needs additional information from you to process your claim, the Plan will notify you of such extension within 24 hours. In that case you will have 48 hours from the time you receive the notification to supply the additional information. If you do not provide the information within that time, your claim will be decided on the basis of the information that the Plan has at the time and your claim may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 48 hours or until you respond to the request (whichever is earlier). The Plan then has 48 hours to make a decision and notify you of the determination.

5. Concurrent Care Claims

(a) If the concurrent care claim is urgent and made 24 hours prior to the end of the already authorized treatment, the Plan will notify you of its decision within 24 hours.

(b) If the concurrent care claim is not an urgent claim, then the pre-service limits apply.

14.04 Notice of Initial Decision

You must be provided with a notice of the initial determination about your claim within certain timeframes after your claim is received. The notice must provide the following information:

A. Sufficient information to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable). Upon request, the Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

B. The specific reason(s) for the denial of benefits or other Adverse Benefit Determination;

C. A specific reference to the pertinent provision(s) of the Plan upon which the decision is based;

D. A description of any additional material or information that is needed to process your claim and an explanation of why the information is needed;

E. A copy of the review procedures and time periods to appeal your claim, a statement of your right to bring a civil action under ERISA following an Adverse Benefit Determination on review;

F. If an internal rule, guideline, protocol, or similar criteria was relied on in the process of making a decision on your claim, a copy of that internal rule, guideline, protocol, or similar criteria, or a statement that a copy is available to you at no cost upon request; and

G. If your health or Weekly Disability claim was denied on the basis of medical necessity, Experimental or Investigative Treatment or similar exclusion, a copy of the scientific or clinical judgment that was relied on in the process of making a decision on your claim or a statement that it is available to you at no cost upon request.

15.05 Internal Appeal Procedures

A. Internal Appeal Filing Deadline

You have the right to a full and fair review if your claim for benefits is denied by the Plan. You must file your appeal in writing, unless your appeal is of an urgent care claim, which may be submitted orally by telephone. You must make your request to the Third Party Administrator within 180 days after receiving notice of denial, except with respect to Death Benefit and AD&D claims. You must file a request for an appeal of the denial of a Death Benefit or AD&D claim within 60 days after receiving notice of the denial. Your appeal application must be in writing and it must include the specific reasons you feel the denial was improper. You may submit any document you feel appropriate, as well as submitting your written statement.

B. Internal Appeal Process

The appeal process works as follows:

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

   (a) it was relied upon by the Plan in making the decision;

   (b) it was submitted, considered or generated in the course of making the decision (regardless of whether it was relied upon);

   (c) it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or

   (d) it constitutes a statement of Plan policy regarding the denied treatment or service.

2. Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Plan on your claim, without regard to whether their advice was relied upon in deciding your claim.

3. Before the Plan can issue a final internal Adverse Benefit Determination based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must

be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is required to be provided to give you a reasonable opportunity to respond prior to that date.

4. A different person will review your claim than the one who originally denied the claim. The reviewer will not give deference to the initial Adverse Benefit Determination. You have the right to present evidence and testimony as part of your appeal. The decision will be made on the basis of a full and fair review of the record, including such additional evidence and testimony that you may submit.

5. If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was Experimental or Investigational Treatment), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

C. Timing of Notice of Decision on Internal Appeal

1. Urgent Care Claims

   If the appeal is for an urgent care claim, you will be notified of the decision on appeal as soon as possible, but not later than 72 hours after the receipt of the request for appeal.

2. All Non-Urgent Pre-Service Care Claims

   If the appeal is for a non-urgent pre-service claim, you will be notified no later than 30 days after receipt of the request for appeal.

3. Weekly Disability Claims and Post-Service Care Claims

   Ordinarily, decisions on appeals will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. The Plan will advise you in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than five (5) days after the decision has been reached.

4. Death Benefit and AD&D Claims

   The Plan will send you a notice of the Board of Trustees' decision on appeal within 60 days of the receipt of the appeal by the Plan Office.

14.06 Notice of Decision on Internal Appeal

The Plan will provide you with a written decision, in a culturally and linguistically appropriate manner, on any internal appeal of your claim. However, if your claim is an urgent care claim, the Plan may notify you of the decision in writing, via fax or orally via telephone. The notice of a denial of a claim on appeal will state:

A. Sufficient information to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable). Upon request, the Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

B. The specific reason(s) for the determination;

C. Reference to the specific Plan provision(s) on which the determination is based;

D. A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge;

E. A statement of your external appeal rights, an explanation regarding how to initiate those rights, and your right to bring a civil action under ERISA following an Adverse Benefit Determination on internal appeal;

F. The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman to assist individuals with the internal claims and appeals and external review processes; and

G. If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge. If the determination was based on medical necessity or because the treatment was Experimental or Investigational Treatment or other similar exclusion, the Plan will provide you with an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

14.07 External Review Procedures

A. External Review Filing Deadline

If your claim was not a claim for Disability or Death benefits under the Plan and was denied under the internal appeals procedures, resulting in an Adverse Benefit Determination, you have the right to file a request for an external review by an independent review organization with the Fund Office within four months of the date of the internal appeal decision. However, a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that you or your Dependent fails to meet the requirements for eligibility under the terms of the Plan is not eligible for the external review process.

B. External Review Process

The external review process works as follows:

1. Request for External Review

   Within five days of the Plan's receipt of the written request for external review, the Plan must determine whether:

   (a) You are or were covered under the Plan at the time of service or requested service,

(b) The Adverse Benefit Determination relates to a medical necessity determination or rescission of coverage;

(c) You exhausted or are deemed to have exhausted the Plan's internal appeal process; and

(d) You have provided all information and forms required to process an external review.

2. Determination of Eligibility for External Review

Within one business day after the completion of this review, the Plan must notify you (or your authorized representative) whether the request is complete and is eligible for review. If the request is not complete, the Plan must provide notice of what information or materials are needed and allow you to perfect the request within the four-month filing period or 48 hours following receipt of the notification, whichever is later. If the request is not eligible for external review, the notice must include the reason(s) for ineligibility and contact information for the Employee Benefits Security Administration.

3. Referral to an Independent Review Organization (IRO)

If your request is eligible for review, the Plan will utilize an unbiased method to assign the external review to one of its three IRO's. The timeline for completion of the external review is as follows:

(a) The IRO will timely notify you of receipt of assignment of the external review and such notice will inform you that you may provide additional information within ten business days following receipt of the notice. The IRO is not required, but may, accept and consider additional information submitted after ten business days.

(b) The Plan must provide the claim file and any information considered in making the Adverse Benefit Determination within five business days after the date of assignment to the IRO. Failure by the Plan to submit the information to the IRO may result in an immediate reversal of the Adverse Benefit Determination. The IRO must send notice of such to you and the Plan within one business day.

(c) The IRO must forward any additional information received from you to the Plan within one day of receipt and the Plan may reconsider and reverse its decision, terminating the external review. The Plan must provide notice within one business day of such a decision to you and the IRO.

(d) The IRO will review all information received de novo. In addition to all information provided, the IRO may consider the following information, if the IRO deems it appropriate:

(1) The claimant's medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the Plan, claimant or treating provider;

(4) The terms of the Plan;

(5) Appropriate practice guidelines, which must include all evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

(6) Any applicable clinical review criteria developed and used by the Plan, unless the criteria is inconsistent with the terms of the Plan or applicable law; and

(7) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider it appropriate.

4. Request for an Expedited External Review

You may make a request for an expedited external review if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal or standard external review as described above would seriously jeopardize the life or health of the claimant or would jeopardize the ability to regain maximum function or if the final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received Emergency Services, but has not been discharged from a facility.

An expedited external review will occur in accordance with the procedures stated above for a standard external review, except that each step must be performed in the most expeditious method and the IRO must provide the claimant notice of its decision as expeditiously as the circumstances require, but no more than 72 hours after the IRO receives the request for an expedited external review. If the decision is not communicated in writing, the notice must provide written confirmation to you and the Plan within 48 hours after notice is provided.

C. Timing of Notice of Decision on External Review

The assigned IRO must provide written notice of the final external review to the claimant and the Plan within 45 days after the IRO first receives the request for review.

D. Content of Notice of Decision on External Review

The IRO will provide you and the Plan with a written decision. The notice of the decision will contain all of the following:

1. A general description of the reason for the request for external review including sufficient information to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning and the reason for the previous denial.

2. The date the IRO received the assignment and the date of the IRO decision.

3. Reference to the evidence or documentation, including the specific coverage provisions and evidence-based standards that were relied on in making its decision.

4. A discussion of the principal reason(s) for the IRO's decision, including the rationale for the decision and any evidence-based standards that were relied on in making its decision.

5. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or the claimant.

6. A statement that judicial review may be available to the claimant.

7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsmen established under PHS Act section 2793.

E. Guidance under the Patient Protection and Affordable Care Act of 2010

These external review procedures apply to health care claims (i.e. health, dental and vision claims) that are denied on appeal by the Trustees. They are intended to comply with the interim safe harbor provisions contained in the U.S. Department of Labor Technical Release 2010-01. As such time as the guidance is revised or replaced by the DOL, the new guidance shall be incorporated by reference herein and these procedures will be superseded by such new guidance to the extent necessary to comply with the Patient Protection and Affordable Care Act of 2010.

14.08 Physical Examination

The Trustees have the right and opportunity, at the Plan's expense, to have a Physician they designate examine you or your Dependent as often as is reasonable while your claim for Plan benefits is pending.

14.09 Payment of Claims

The Plan will make payments due immediately upon receipt by the Third Party Administrator of proper written proof of loss.

The Plan may pay all or a portion of any benefits provided for health care services to the provider, unless you direct otherwise in writing at the time you file your claim. The Plan does not require that the services be rendered by a particular provider.

Upon your death, benefits accrued on your behalf will be paid at the Plan's option to the first surviving class of the following:

A. Your spouse;

B. Your Dependent children, including legally adopted children;

C. Your parents;

D. Your brothers and sisters; or

E. Any person the Trustees determine is entitled to payment.

The Fund will rely upon an affidavit to determine benefit payments, unless it receives written notice of a valid claim before payment is made. The affidavit will release the Fund from further liability.

Any payment made by the Fund in good faith will fully discharge it to the extent of such payment.

14.10 Authorized Representatives

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

14.11 Benefit Payment to an Incompetent Person

Benefit payments under the Plan may become payable to a person who is adjudicated incompetent or to a person who in the opinion of the Trustees is unable to administer such payments properly because of mental or physical disability. The Trustees may make payments for the benefit of the incompetent person as they deem best. The Trustees will have no duty or obligation to see that the funds are used or applied for the purpose(s) for which paid if they are paid:

A. Directly to such person;

B. To the legally appointed guardian or conservator of such person;

C. To any spouse, child, parent, brother or sister of such person for the welfare, support and maintenance of that person; or

D. By the Trustees directly for the support, maintenance and welfare of such person.

If any question or dispute arises concerning the proper person or persons to whom any payment will be made under the Fund, the Trustees may withhold payment until a binding adjudication of the question or dispute is made. The resolution must be satisfactory to the Trustees in their sole discretion. Alternatively, the Trustees may pay the benefits if they have been adequately indemnified to their satisfaction against any resulting loss.

14.12 Misstatement by Plan Participant

If you make a misstatement in any application or claim for benefits, the misstatement (except for a fraudulent misstatement) may not be used in any legal contest unless the Plan furnishes you with a copy of the document containing the misstatement.

SECTION 15: DEFINITIONS

This section contains definitions of terms used throughout this booklet. The terms are listed in alphabetical order.

A. **Accident** means an injury caused by a sudden unforeseen event. Such injury must be the result of an external source.

B. **Active Bargaining Unit Employee** means a person who is a member of the collective bargaining unit represented by the Union on whose account the Contributing Employer is or has been required to make Contributions into the Fund and who is eligible to participate in and receive benefits in accordance with this Plan. Active Bargaining Unit Employee shall also include alumni of the bargaining unit.

C. **Active Benefits** mean benefits offered by the Fund that may be available to Participants who are either Active Bargaining Unit Employees or Active Non-Bargaining Unit Employees.

D. **Active Non-Bargaining Unit Employee** means a full-time (more than 30 hours per week) office or Non-Bargaining Unit Supervisory Personnel employee of a Contributing Employer.

E. **Adverse Benefit Determination** means a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on:

   1. A determination of an individual's eligibility to participate in the Plan;

   2. A determination that a benefit is not a covered benefit;

   3. The imposition of a source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or

   4. T determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

F. **Board of Trustees and/or Trustees** means the Trustees and Board of Trustees designated in the Trust Agreement, together with their successors designated and appointed in accordance with the terms of the Trust Agreement for the Plumbers and Pipefitters Local No. 172 Welfare Plan. The Board of Trustees is the administrator of this Plan as that term is used in the Employee Retirement Income Security Act of 1974.

G. **Chemical Dependency/Substance Abuse** means any abuse of, addiction to or dependency on the use of drugs, narcotics, alcohol or any other chemical (except nicotine).

H. **Contributions** are payments made by Contributing Employers to the Fund on behalf of their Active Bargaining Unit and Non-Bargaining Unit Employees.

I. **Contributing Employer** means any person, firm, association, partnership or corporation which is signatory to a collective bargaining agreement which requires Contributions to this Fund. Contributing Employer also means the Union and any other entity that has entered into a participation

agreement with the consent of the Trustees and which does in fact make Contributions to the Fund as provided for in the Fund's Trust Agreement and has agreed in writing to be bound by such Trust Agreement.

J. **Co-Payment** means the fixed dollar amount you are required to pay for services at the time you receive services.

K. **Covered Employment** means employment of a Bargaining Unit Employee by a Contributing Employer for which Contributions to this Fund are required.

L. **Covered Medical Expenses** means the negotiated rate or UCR Charges for expenses ordered by a Physician and incurred by a covered person for Medically Necessary services and supplies required for the treatment of a non-occupational Accident or Sickness. The Plan covers the negotiated rate or UCR Charges subject to the Plan maximums and limitations provided in the Schedules of Benefits.

M. **Creditable Coverage** means coverage under any of the following: (1) a group health plan; (2) health insurance coverage; (3) Medicare Part A or Part B or (4) any other plan where there was not a break in coverage of 63 or more consecutive days between your coverage under the prior plan and this Plan.

N. **Death Benefits** mean benefits offered by the Fund that may be available to Participants who are either Bargaining Unit Retirees or Non-Bargaining Unit Retirees.

O. **Dentist** means a legally qualified Dentist practicing within the scope of his or her license or a legally qualified Physician authorized by his or her license to perform the particular dental service rendered.

P. **Dependent** means any one of the following individuals:

1. A Participant's spouse (marriage license required).

2. Each child of a Participant from the date he or she first becomes a child of the Participant to the end of the month in which such child attains age 26 (birth certificate required).

3. An unmarried child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, provided:

    a. Such incapacity began before the end of the month such child attains age 26;

    b. Such child is chiefly dependent upon the Employee for financial support and maintenance; and

    c. Proof of such incapacity is submitted to the Trustees within 31 days of the date such Dependent's eligibility would otherwise terminate.

4. A Participant's child includes natural and legally adopted children, children placed in the Participant's home for adoption and step children. A Dependent child will also include a child of an eligible Participant who has been appointed legal guardian by a court of competent jurisdiction. Proof of such guardianship may be required.

Q. **Disabled**

1. **Bargaining Unit and Non-Bargaining Unit Employee** – if, as result of an Accident or Sickness, he is completely unable to perform each and every duty associated with his occupation or employment.

2. **Retiree or Dependent** – if, as result of Accident or Sickness, he is completely unable to perform the normal activities of a person of like age or sex.

R. **Emergency** is the sudden and unexpected onset of a medical condition requiring immediate medical attention. A condition will be an Emergency only if:

1. Severe symptoms occur suddenly and unexpectedly;

2. Immediate care is secured; and

3. The Sickness or condition as finally diagnosed is one that would normally require immediate medical care.

S. **Experimental or Investigative Treatments and Procedures** applies to a service, procedure, drug, device or treatment modality for a specific diagnosis (referred to herein as such treatment or procedure) that meets one of the following criteria:

1. Such treatment or procedure has failed to obtain final approval for a specific diagnosis from the appropriate governmental body;

2. Reliable evidence does not establish a consensus conclusion among experts recognizing the safety and effectiveness of such treatment or procedure on health outcomes for a specific diagnosis;

3. Such treatment or procedure, or the patient-informed consent document utilized with such treatment or procedure was reviewed and approved by the treating facility "institutional review board" or other body serving a similar function, or if federal law requires such review or approval;

4. Reliable evidence shows that such treatment or procedure is (1) the subject of ongoing phase I or phase II clinical trials; (2) the subject of on-going phase III clinical trials; or (3) otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

5. Reliable evidence shows that the prevailing opinion among experts regarding such treatment or procedure is that further studies or clinical trials are needed to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

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

Note: The Trustees have the authority to determine whether a service, procedure, drug, device or treatment modality is Experimental or Investigative. The fact that a Physician has prescribed, ordered, recommended or approved the service, procedure, drug, device or treatment does not, in itself, make it eligible for payment.

T. **Free Standing Surgical Center** means a health care facility licensed as a free standing or ambulatory surgical center in which surgery is performed on patients on an outpatient basis.

U. **Fund and/or Welfare Fund** means the Plumbers and Pipefitters Local No. 172 Welfare Fund.

V. **Plan Administrator** means the Board of Trustees of the Plumbers and Pipefitters Local No. 172 Welfare Fund.

W. **Home Health Agency** is a public or private agency or organization that meets all of the following requirements:

1. It is primarily engaged in providing skilled nursing services and other therapeutic services in the homes or places of residence of its patients;

2. It has established policies for governing the services that it provides, such policies being established by a group of professional personnel associated with the agency or organization, including one or more Physicians and one or more registered professional nurses;

3. It provides for the supervision of its services by a Physician or registered professional nurse;

4. It is licensed according to all the applicable laws of the state in which it is located; and

5. It is eligible to participate in Medicare.

X. **Hospice** is a public or private agency or organization primarily engaged in providing a coordinated set of services at home or in an outpatient or institutional setting to persons suffering from a terminal medical condition. The agency or organization must:

1. Be eligible to participate in Medicare;

2. Have an interdisciplinary group of personnel that includes the services of at least one Physician and one registered nurse (R.N.);

3. Maintain clerical records on all of its patients;

4. Meet the standards of the National Hospice Organization; and

5. Provide either directly or indirectly or by another arrangement, the "core service" listed as Covered Expenses.

Y. **Hospital** means a lawfully operating institution accredited by the American Hospital Association for the care and treatment of sick and injured persons with organized facilities for diagnosis and treatment, medical supervision, 24-hour nursing service by registered nurses and surgery (or provides for surgical facilities on a formal arrangement). In no event, however, does the term Hospital include any institution or part of an institution which is used principally as a rest facility or facility for the aged, nor does it include a Hospital operated by the United States Government, unless the claimant is required to pay such expense.

Z. **Inpatient** means a person who, while confined in a Hospital or Skilled Nursing Facility, is assigned a bed in any department of a Hospital or Skilled Nursing Facility other than in its outpatient department and for whom a charge for room and board is made by a Hospital or Skilled Nursing Facility.

AA. **Medically Necessary** means a service or supply that:

1. Is consistent with the symptoms of diagnosis and treatment of the person's injury or Sickness;

2. Is appropriate with regard to standards of good medical practice and recognized by an established medical society in the United States; and

3. Could not have been omitted without adversely affecting the person's condition or the quality of medical care.

BB. **Medicare** means the Hospital and Supplementary Medicare Insurance Plans established by Title XVIII of the Social Security Act of 1965, as then constituted or as later amended.

CC. **Mental Illness** means those illnesses classified as a disorder in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

DD. **Mental or Nervous Disorder** means (1) a Mental Illness or (2) a neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind, regardless of whether such disease or disorder has causes or origins which are organic, physiological, traumatic or functional.

EE. **Morbid Obesity** means:

1. A body mass index (BMI) of greater than or equal to 40 kg/meter squared or a BMI greater than or equal to 35 kg/meters squared with at least two of the following co-morbid conditions which have not responded to maximum medical management and which are generally expected to be reversed or improved by bariatric treatment: (1) Hypertension, (2) Dyslipidemia, (3) Diabetes Mellitus, (4) Coronary heart disease and (5) Sleep apnea; or

2. Evidence is present that a comprehensive non-surgical treatment has been attempted prior to surgical treatment, including, but not limited to, participation in a non-surgical weight reduction program (which includes nutritional therapy, behavior modification or health interventions, counseling and instruction on physical activity, ongoing support for lifestyle changes) for at least three months within the 24-month period prior to the proposed surgery.

FF. **Participant** means a Bargaining Unit Employee, Non-Bargaining Unit Employee and/or Retiree who is eligible and covered under the Plan.

GG. **Pension Plan or Pension Fund** means the Plumbers and Pipefitters Local No. 172 Pension Fund.

HH. **Physician** means a person licensed as a medical doctor (MD) or doctor of osteopathy (DO) and authorized to practice medicine, to perform surgery and to administer drugs under the laws of the state or jurisdiction where the services are rendered and who is acting within the scope of such license.

II. **Plan and/or Welfare Plan** means this document as adopted by the Trustees and as amended by the Trustees.

JJ. **Prescription Drugs** means legal drugs and medicines approved by the United States Food and Drug Administration (FDA), dispensed by a pharmacist pursuant to the written prescription of a Physician. Also included under Prescription Drugs are charges for supplies required for treatment of diabetes such as insulin, clinistix, syringes and charges incurred for syringes that are necessary for the self-treatment of allergies.

KK. **Preventive Services** means:

(a) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved, except as provided in (d) below;

(b) Immunizations for routine use in children, adolescents, and adults that have a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

(c) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

(d) With respect to women, to the extent not described in paragraph (a) above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

LL. **Retiree** is a person who meets the applicable eligibility requirements for Retiree Benefits.

MM. **Self-Payments** are any payments made by Active Bargaining Unit and Non-Bargaining Unit Employees, Dependents or Retirees for the purpose of maintaining coverage under the Plan.

NN. **Skilled Nursing Facility/Convalescent Care** means a lawfully operated institution for the care and treatment of persons convalescing from a Sickness or Accident which provides room and board and 24-hour nursing service by registered licensed nurses and is under the full-time supervision of a legally qualified Physician or Surgeon or a registered nurse (R.N.).

OO. **Sickness** includes pregnancy, childbirth, abortion and related medical conditions among other illnesses.

PP. **Third Party Administrator** means the office of Stewart C. Miller & Co., Inc, the contracted third party administration organization.

QQ. **Usual, Customary and Reasonable (UCR) Charges** means the following:

1. For service or supply covered under a Plan PPO or similar organization contract, the fee shall be the amount the service provider has agreed to accept as payment in full under its contract with a Plan PPO or similar organization.

2. For service or supply where the fee is not determined under (1) above, the fee will be equal to the fee most often charged by the provider for the same service or supply; or the fee most often charged in the same area by providers with similar training and experience for a comparable service or supply. "Area" means metropolitan area or a county, or a greater area if needed to find a cross section of providers of a comparable service or supply.

The Board of Trustees reserves the right under extenuating circumstances to pay an amount greater than the fee determined under subsections (1) or (2) above.

RR. **Union** means Plumbers and Pipefitters Local Union No. 172.

Additional terms are defined in other Sections of this Plan as follows:

Terms	Section
1. Allowable Expenses	12.03
2. Basic Services	8.03
3. Benefit Month	2.01
4. Covered Medical Expense	6.06
5. Deductible	6.01
6. Dollar Bank Account	2.01
7. Durable Medical Equipment	6.06
8. Excess Eligibility Credit	2.01
9. Eligibility Month	2.01
10. Loss	4.01
11. Major Restorative	8.03
12. Orthodontic Care	8.03
13. Pre-Certification (Pre-Certified)	6.05
14. Preferred Provider Organization (PPO)	6.04
15. Qualifying Event	2.04

SECTION 16: ADDITIONAL PLAN INFORMATION

16.01 Plan Name

Plumbers and Pipefitters Local No. 172 Welfare Plan.

16.02 Board of Trustees

A Board of Trustees is responsible for the operation of this Plan. The Board of Trustees consists of an equal number of Employer and Union representatives, selected by the Employers and the Union that have entered into collective bargaining agreements relating to this Plan. If you wish to contact the Board of Trustees, you may use the addresses below.

As of the date of this Plan Restatement, the Trustees of this Plan are:

Union Trustees	Employer Trustees
Mr. Broc Buczolich Plumbers and Pipefitters Local Union No. 172 4172 Ralph Jones Ct. South Bend, IN 46628	Mr. Kevin Conery Dynamic Mechanical Services, Inc. 1606 Chestnut Street Mishawaka, IN 46545
Mr. Tim Freet Plumbers and Pipefitters Local Union No. 172 4172 Ralph Jones Ct. South Bend, IN 46628	Mr. David Niezgodski Niezgodski Plumbing & Heating P.O. Box 3906 South Bend, In 46619
Mr. Kurt Mead, Alternate Plumbers and Pipefitters Local Union No. 172 4172 Ralph Jones Ct. South Bend, IN 46628	Mr. David Dodd, Alternate DA Dodd, Inc. 14 E. Michigan Road P.O. Box 430 Rolling Prairie, IN 46371 South Bend, IN 46619

16.03 Plan Sponsor and Administrator

The Board of Trustees is the Plan Sponsor and Plan Administrator. The Board has contracted with Stewart C. Miller & Co., Inc. to provide administrative services, including the processing of claims as the Third Party Administrator. Stewart C. Miller & Co., Inc., may be contacted at 2111 West Lincoln Highway, Merrillville, Indiana 46410. The telephone number is (219) 769-6944, the toll-free number is (800) 759-6944 and the fax number is (219) 769-4834.

16.04 Plan Numbers

The Plan number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501.

The Employer Identification Number assigned to the Board of Trustees by the Internal Revenue Service is 35-6022383.

16.05 Agent for Service of Legal Process

Mr. Dennis R. Johnson
Johnson & Krol, LLC
300 S. Wacker Drive, Suite 1313
Chicago, IL 60606
(312) 372-8587

Service of legal process also may be made on the Board of Trustees or any individual Trustee at the addresses provide in Section 17.02.

16.06 Source of Contributions

The benefits described in this Welfare Fund booklet are provided through Employer Contributions and Self-Payments. The amount of Employer Contributions and the Employees on whose behalf Contributions are made are determined by the provisions of the collective bargaining agreements. The amount of Self-Payments is determined by the Trustees.

16.07 Collective Bargaining Agreement

The Plan is maintained in accordance with a collective bargaining agreement between the Plumbers and Pipefitters Local Union No. 172 and the St. Joseph Valley Association of Plumbing-Heating-Cooling Contractors, Inc. Other agreements may be in effect from time to time. The agreements specify the Contributions required.

The Third Party Administrator will provide you, upon written request, information as to whether a particular Employer is contributing to this Fund on behalf of Participants working under a collective bargaining agreement or a list of participating employers.

16.08 Trust Fund

All assets are held in a Trust Fund for the purpose of providing benefits to covered Participants and defraying reasonable administrative expenses. All of the benefits are provided on a self-funded basis.

However, the Plan has contracted with a stop-loss insurance carrier to cover its exposure in the event of large health claims. As of the date of this Summary Plan Description, the stop-loss insurance is issued by HCC Life Insurance Co. Please contact the Third Party Administrator with all questions regarding the stop-loss insurance policy and its administration.

The Plan's assets are managed by professional asset managers selected by the Board of Trustees.

16.09 Plan Year

The records of the Plan are kept separately for each Plan Year. The Plan Year is the same as the Plan's fiscal year which begins on March 1 of each year and ends on February 28.

16.10 Type of Plan

This Plan is maintained for the purpose of providing life, AD&D, disability, medical, dental, vision and prescription drug benefits to Participants in the event of death, Sickness or Accident. The Plan benefits are shown in the applicable Schedules of Benefits in Section 1 of this booklet.

16.11 Gender

Except as the context may specifically require otherwise, use of the masculine gender will be understood to include both masculine and feminine genders.

16.12 Assignment

Generally, benefits from the Plan belong to you. You may not sell, assign, transfer or garnish these benefits.

16.13 Amendment and Termination

Active Employees and Retirees do not earn a vested right to health benefits. The Trustees expressly reserve the right, in their sole discretion, acting in accordance with the provisions of the Trust Agreement regarding Trustee acts, to amend or terminate the Plan in whole or in part at any time.

The Plan may be terminated under circumstances allowed by ERISA and the terms of the governing Trust Agreement. If the Trustees amend or terminate the Plan, they will notify you in writing of the changes that are made to your coverage.

16.14 Discretionary Authority

In carrying out their respective responsibilities under the Fund, the Trustees and/or their delegates have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to benefits. Benefits under this Plan will be paid only if the Trustees and/or their delegates decide in their discretion that the applicant is entitled to them. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

16.15 Severability Clause

If a provision of the Trust Agreement or the Plan or any amendment made to the Trust Agreement or to the Plan is determined or judged to be unlawful or illegal, such illegality will apply only to the provision in question and will not apply to any other provisions of the Trust Agreement or the Plan.

16.16 Worker's Compensation Not Affected

The Plan is not in lieu of and does not affect any requirements for coverage by the applicable workers' compensation laws or occupational diseases laws of any state.

16.17 Recovery of Benefits Paid in Error

If for any reason, any benefit paid to a covered person under this Plan is determined to have been in error, or wholly or partially in excess of the amount to which such payee was entitled to receive under the Plan, the Trustees may collect such erroneous benefit payment or overpayment by any remedy as the law may provide.

16.18 Privacy Policy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of your private health information. A complete description of your rights under

HIPAA can be found in the Plan's privacy notice. The privacy notice will be available from the Fund Administrator.

This Plan and the Plan Sponsor will not use or further disclose information that is protected by HIPAA ("protected health information"), except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan. The Plan also hires professionals and other companies to assist it in providing health care benefits. The Plan will require all of its business associates to also observe HIPAA's privacy rules.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You will also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice that provides a complete description of your rights under HIPAA's privacy rules. Please contact the Third Party Administrator if:

A. You need a copy of the Privacy Notice;

B. You have questions about the privacy of your health information; or

C. You wish to file a complaint under HIPAA.

16.19 The Plan's Use and Disclosure of Your Protected Health Information (PHI)

A. How the Plan Uses and Discloses Your Protected Health Information

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

The Plan will use and disclose your PHI as required by law and as permitted by your authorization or the authorization of your beneficiary. With an authorization, the Plan will disclose PHI to the Retirement Fund, reciprocal benefit plans or workers' compensation insurers for purposes related to administration of those plans.

B. Definition of Payment

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

1. Determination of eligibility, coverage and cost sharing amounts (e.g. cost of a benefit, Plan maximums and Co-Payments as determined for an individual's claim);

2. Coordination of benefits;

3. Adjudication of health benefit claims (including appeals and other payment disputes);

4. Subrogation of health benefit claims;

5. Establishing Employee Contributions;

6. Risk adjusting amounts due based on enrollee health status and demographic characteristics;

7. Billing, collection activities and related health care data processing;

8. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant (and their authorized representatives) inquiries about payments;

9. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

10. Medical necessity reviews, or reviews of appropriateness of care or justification of charges;

11. Utilization review, including pre-certification, pre-authorization, concurrent review and retrospective review;

12. Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, social security number, payment history, account number, and name and address of the provider and/or health plan); and

13. Reimbursement to the Plan.

C. Definition of Health Care Operations

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

1. Quality assessment;

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

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

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

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

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

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

    a. management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;

    b. customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;

    c. resolution of internal grievances; and

    d. due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or following completion of the sale or transfer, will become a covered entity.

D. The Plan's Disclosure of Protected Health Information to the Board of Trustees

For purposes of this section the Board of Trustees is the Plan Sponsor. With respect to PHI, the Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by this Summary Plan Description/Plan Document or as required by law;

2. Ensure that any agents, including a subcontractor to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

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

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

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

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

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

8. Make the information available that is required to provide an accounting of disclosures;

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

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

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

1. The Plan Administrator; and

2. Staff designated by the Plan Administrator.

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

16.20 Statement of ERISA Rights

As a Participant in the Plumbers and Pipefitters Local Union No. 172 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 the following rights.

A. Receive Information about Your Plan and Benefits

You have the right to:

1. Examine, without charge, at the Third Party Administrator's office, all documents governing the Plan. These include insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

3. 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.

B. Continue Group Health Plan Coverage

You also have the right to:

1. Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

2. Reduce or eliminate exclusionary periods of coverage for Pre-Existing Conditions under your group health plan, if you have Creditable Coverage from another plan. You should be provided a certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when:

   a. You lose coverage under the Plan;

   b. You become entitled to elect COBRA Continuation Coverage; or

   c. Your COBRA Continuation Coverage ceases.

   You must request the certificate of Creditable Coverage before losing coverage or within 24 months after losing coverage. Without evidence of Creditable Coverage, for plans with plan years beginning before January 1, 2014, you may be subject to a Pre-Existing Condition Exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. To request a certificate of Creditable Coverage, please contact the Third Party Administrator.

Stewart C. Miller & Co., Inc.
2111 West Lincoln Highway
Merrillville, IN 46410
Telephone: (219) 769-6944
Toll Free number: (800) 759-6944
www.scmiller.com

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

D. Enforce Your Rights

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

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

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a lawsuit in a court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file a lawsuit in court. You must exhaust all of the Plan's claims and appeals procedures before filing a lawsuit. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file a lawsuit. The court will decide

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

E. Receive Assistance with Your Questions

If you have any questions about your Plan, you should contact the Third Party Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Third Party Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or:

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 find answers to your Plan questions, your rights and responsibilities under ERISA and a list of EBSA field offices by contacting the EBSA:

1. By calling (866) 444-3272;

2. Sending electronic inquires to www.askebsa.dol.gov; or

3. Visiting the EBSA web site at www.dol.gov/ebsa.