PIPE TRADES INDUSTRY
HEALTH AND WELFARE PLAN

RESTATED PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

EFFECTIVE JUNE 1, 2018

Important!

There are several significant events that may occur while you are covered under the Plan. Please contact the Plan Office, in writing, if any of the following occurs:

- **YOUR ADDRESS OR TELEPHONE NUMBER CHANGES**
- **YOU MARRY, DIVORCE OR OBTAIN A LEGAL SEPARATION FROM YOUR SPOUSE -** You must also submit the appropriate legal documents (for example: marriage certificate, legal separation order, divorce decree, property settlement agreement, or custody agreement).
- **THE STATUS OF A DEPENDENT CHANGES -** Your Eligible Dependent(s) no longer meet the definition of Eligible Dependent.
- **YOU ACQUIRE A NEW DEPENDENT -** You must also submit the child's state-certified birth certificate, decree of adoption or a Qualified Medical Child Support Order.
- **YOU GO INTO MILITARY SERVICE**
- **YOU RETURN FROM MILITARY SERVICE**
- **YOU ARE ELIGIBLE TO RECEIVE WORKERS' COMPENSATION BENEFITS**
- **YOU BECOME DISABLED** - You must furnish the Plan Office with evidence of your disability and both beginning and ending dates of the disability.
- **YOU BECOME ELIGIBLE FOR MEDICARE**
- **YOU RETIRE**

You may contact the Plan Office at:

Pipe Trades Industry Health and Welfare Plan
Post Office Box 3040
Terre Haute, IN 47803-0040
(812) 877-2581
www.pthwplan.org

PROVISIONS FOR FILING FOR BENEFITS MAY AFFECT YOUR ELIGIBILITY FOR BENEFITS. PLEASE READ THE REQUIREMENTS REGARDING THE FILING OF CLAIMS SO THAT YOU WILL NOT LOSE ANY BENEFITS TO WHICH YOU MAY BE ENTITLED.

THIS BOOKLET DESCRIBES THE BENEFITS PROVIDED BY THE PLAN. POSSESSION OF THIS BOOKLET IS NOT A GUARANTEE OF ELIGIBILITY FOR BENEFITS. THE TRUSTEES RESERVE THE RIGHT TO CHANGE OR TERMINATE THE BENEFITS AT ANY TIME. THE PLAN IS NOT UNDERWRITTEN BY AN INSURANCE COMPANY; THEREFORE, NO POLICY IS ISSUED. THE BENEFITS ARE PROVIDED ON A FULLY SELF-FUNDED BASIS.

EVERY EFFORT HAS BEEN MADE TO SEE THAT THE INFORMATION CONTAINED IN THIS BOOKLET IS ACCURATE AND UP TO DATE AT THE TIME OF ITS PRINTING.

A WORD OF CAUTION: NO ONE HAS THE AUTHORITY TO SPEAK FOR THE BOARD OF TRUSTEES IN INTERPRETING THE RULES OF ELIGIBILITY OR BENEFITS PROVIDED BY THE PLAN, EXCEPT THE FULL BOARD OF TRUSTEES AND/OR THE PLAN ADMINISTRATIVE MANAGER TO WHOM SAID AUTHORITY HAS BEEN DELEGATED.

PIPE TRADES INDUSTRY HEALTH AND WELFARE PLAN
Post Office Box 3040
Terre Haute, IN 47803-0040
www.pthwplan.org

June 1, 2018

Dear Participant:

Enclosed is a copy of the booklet which contains a description and explanation of the benefits provided under the Pipe Trades Industry Health and Welfare Plan ("the Plan") effective June 1, 2018. The contents of the booklet are similar to what was in your prior January 1, 2013 Plan Document and Summary Plan Description and have been updated to incorporate any changes made since that time.

Your Trustees feel that this is an excellent Plan which will meet the medical needs of the covered Employees and Eligible Dependents. You are sincerely urged to help us operate the Plan as efficiently as possible. Remember, it is **your** Plan and that every dollar saved on unnecessary medical expenses helps the Plan remain financially sound.

We appreciate your support and cooperation in the past and look forward to serving you in the future.

Very truly yours,

Board of Trustees

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CLAIM AND OTHER FORMS

Two (2) types of claim forms are available from the Plan Office: **MEDICAL CLAIM FORM** which enables you to apply for medical care benefits and the **WEEKLY DISABILITY CLAIM FORM** which enables you to apply for the Weekly Disability Benefit.

Medical Claim Form

A claim form is **not** needed to file prescription drugs, hospital bills or Physician bills for those Physicians who provide their own claim forms. When using those claim forms, they **must** contain: the **member's name and social security number or unique ID number, the patient's name and the dependent's relationship to the Participant**.

Advise the Plan Office **immediately** if you or any of your dependents become insured under another health insurance plan.

If you have coverage under another health or insurance plan, be sure that this Plan Office receives copies of all bills submitted to the other plan within **one (1) year** of the service date.

ALL CLAIMS MUST BE SUBMITTED WITHIN ONE (1) YEAR OF THE SERVICE DATE.

Weekly Disability Claim Form

In the case of a claim for the Weekly Disability Benefit, the weeks for which you are claiming benefits must have passed. Multiple weeks may be included on a single claim form only when properly certified by the attending Physician for a period prior to the date signed by the Physician.

Benefits are payable on the basis of seven (7) **day periods.** In the case of Sickness, you **WILL NOT** be paid for the first seven (7) days; however, a form properly certifying that you were under the care of a Physician during that week **must be filed.** Each form **must** be signed by the Physician who verifies that you were unable to work during the period for which you are claiming benefits. **ALL CLAIMS MUST BE FILED WITHIN ONE (1) YEAR OF THE FIRST DAY OF DISABILITY.**

Dependent Form

This form needs to be completed when you become covered under this Plan or when there is a change in status (**i.e., marriage, divorce, legal separation, remarriage, death, adding a dependent or a loss of Eligible Dependent status**).

Beneficiary Form

In order to name the Beneficiary(ies) to receive your Death Benefit, the Plan's Beneficiary Form needs to be completed when you become covered under this Plan. You will need to complete a new Beneficiary Form in order to change a Beneficiary.

Opting-Out of Coverage

A spouse of a participant may opt out of the Plan's coverage due to eligibility under a high deductible healthcare plan (such as a Health Savings Account) through the spouse's employer, by completing the Plan's appropriate form with proof that the spouse has a high deductible healthcare plan. A spouse of a participant may rejoin this Plan by completing the Plan's appropriate form with proof that the spouse is no longer being covered under the high deductible healthcare plan and that the participant is still eligible under this Plan. Eligibility will commence on the first day of termination under the high deductible plan.

PREAMBLE

The Pipe Trades Industry Health and Welfare Plan was established July 1, 1961 pursuant to an Agreement and Declaration of Trust. The purpose of the Plan is to provide benefits for eligible Employees and their Eligible Dependents on a self-funded basis.

This Welfare Plan Document and Summary Plan Description is restated as one (1) combined document effective June 1, 2018 in accordance with the provisions of the Agreement and Declaration of Trust. For coverage prior to this Restatement date, please refer to the Welfare Plan Document and Summary Plan Description effective for the period in which you are interested.

DEFINITIONS

Whenever used in this Plan, the following terms shall have the respective meanings set forth below unless otherwise expressly provided herein.

Except where otherwise indicated by the context, any masculine terminology herein shall also include the feminine, and the definition of any term herein in the singular shall also include the plural.

Section 1.01 - Accident
"Accident" means a sudden unexpected event or Injury occurring without forewarning or developing in the course of a Sickness.

Section 1.02 - Act
"Act" means the Employee Retirement Income Security Act of 1974, as amended.

Section 1.03 - Alternate Recipient
"Alternate Recipient" means any child of a participant who is recognized under a Qualified Medical Child Support Order as having a right to benefits under this Plan.

Section 1.04 - Associations
"Associations" means the Associations of participating Employers who are parties to the Trust Agreement which funds the Plan.

Section 1.05 - Beneficiary
"Beneficiary" means a person designated by a participant or by the terms of the Plan who is or may be entitled to a benefit.

Section 1.06 - Board Of Trustees or Trustees
"Board of Trustees" or "Trustees " means the Employer Trustees and the Employee Trustees who are designated and appointed in accordance with the terms of the Trust Agreement, and who, collectively, shall be the "Plan Administrator" of the Trust Fund as that term is used in the Act.

Section 1.07 - Coinsurance
"Coinsurance" means the percentage of the total covered medical expense paid by the Plan.

Section 1.08 - Co-Payment
"Co-Payment" means the portion of an expense the Employee or Eligible Dependent pays before the Plan pays its portion of the benefit.

Section 1.09 - Cosmetic
"Cosmetic" means any Surgical Procedure, procedure or treatment performed primarily:

(A) to improve the physical appearance or to change or restore bodily form without materially correcting a bodily malfunction; or

(B) to prevent or treat a mental or nervous disorder through a change in bodily form.

Section 1.10 - Custodial Care
"Custodial Care" means services or supplies, regardless of where or by whom they are provided which:

(A) a person without medical skills or background could provide or could be trained to provide; or

(B) are provided mainly to help the covered individual with daily living activities, including (but not limited to):

  (1) walking, getting in and/or out of bed, exercising, and moving the covered individual;

  (2) bathing, using the toilet, administering enemas, dressing, and assisting with any other physical or oral hygiene needs;

  (3) assistance with eating by utensil, tube, or gastrostomy;

  (4) homemaking, such as preparation of meals or special diets, and house cleaning;

  (5) acting as a companion or sitter; or

  (6) supervising the administration of medications which can usually be self-administered, including reminders of when to take such medications; or

(C) provide a protective environment; or

(D) are part of a maintenance treatment plan or are not part of an active treatment plan intended to or reasonably expected to improve Injury, Sickness, or functional ability; or

(E) are provided for convenience or are provided because arrangements are not appropriate or adequate.

Section 1.11 - Deductible Amount
"Deductible Amount" means a specified dollar amount of eligible medical expenses which have previously been paid individually by the participant or his Eligible Dependents during the calendar year before the Coinsurance is applicable. The annual Deductible Amount of Seven Hundred Dollars ($700.00) must be paid by each participant and Eligible Dependent (or a maximum annual Two Thousand One Hundred Dollars ($2,100.00) Family Unit Deductible Amount must be satisfied) before any benefits are payable.

Section 1.12 - Developmental Care
"Developmental Care" means services or supplies, regardless of where or by whom provided which:

(A) are provided to a covered individual who has not previously reached the level of development expected for his age in the following areas of major life activity:

(1) intellectual;

(2) receptive and expressive language;

(3) learning;

(4) mobility;

(5) self-direction;

(6) capacity for independent living;

(7) economic self-sufficiency; or

(B) are not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to Injury or Sickness); or

(C) are educational in nature.

Section 1.13 - Disability Or Disabled
"Disability" or **"Disabled"** means a physical or mental condition which, on the basis of medical evidence satisfactory to the Board of Trustees, prevents an eligible Employee from engaging in almost or substantially all of the customary duties and activities of any occupation for which he is qualified by reason of education, training or experience.

Section 1.14 - Durable Medical Equipment
"Durable Medical Equipment" means equipment which:

(A) can withstand repeated use;

(B) is mainly and customarily used for a medical purpose;

(C) is not generally useful to a person in the absence of an Injury or Sickness; and

(D) is suited for use in the home.

Section 1.15 - Eligible Dependent
"Eligible Dependent" means:

(A) the legal spouse of the eligible Employee;

(B) a child, adopted child, stepchild or legal ward of the eligible Employee from birth until the end of the month the child turns age twenty-six (26);

As used herein "adopted child" shall also include a child placed for adoption and means an individual who has not reached age twenty-six (26) as of the date of the assumption and retention by an eligible Employee of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with the eligible Employee terminates upon the termination of the legal obligation set forth above; or

(C) an unmarried child, adopted child, stepchild or legal ward of the eligible Employee over age twenty-six (26) who is incapable of self-sustaining employment due to mental or physical handicap, who is dependent upon the eligible Employee for primary support and maintenance, and whose mental or physical handicap commenced prior to his attaining age twenty-one (21). In order for said individual to remain eligible, notification of such handicap must be given to the Plan Office prior to said child's attaining age twenty-one (21) and a determination made by the Board of Trustees of continuing eligibility;

(D) a child for whom an eligible Employee is ordered by a United States court of competent jurisdiction to provide medical coverage in accordance with the provisions of a Qualified Medical Child Support Order.

"Eligible Dependent" shall NOT include an individual who is in military service.

Notwithstanding the foregoing, a child shall be eligible to participate until the end of the month the child turns 26 at which time the child’s coverage shall terminate.

Section 1.16 - Emergency
"Emergency" means a severe condition which:

(A) results from symptoms which occur suddenly and unexpectedly; and

(B) requires immediate Physician's care to prevent death or serious impairment of health; or

(C) poses an imminent serious threat to the covered individual or to others.

Section 1.17 - Employee
"Employee" means any person who is employed by an Employer. The term also means those individuals who are temporarily unemployed as a result of a reduction in force or who have retired from active employment but who are considered active due to Reserve Credit.

Employee also means members of affiliated local Unions, travel card members and office employees of affiliated local Unions, employees of the Plan Office, any employee of the Trustees, any Welfare, Apprenticeship or related fund and office employees of Employers covered by a non-bargaining participation agreement. As of May 1, 2003, no new non-bargaining personnel are allowed in the Plan.

Section 1.18 - Employer
"Employer" means:

(A) an employer who is a member of, or is represented by, the Associations, and who is bound by a collective bargaining agreement with a local Union providing for the establishment and maintenance of a Trust Fund and for the payment of contributions to such Trust Fund.

(B) an employer who is not a member of the Associations but whose Employees are represented by a local Union and who satisfies the requirements for participation in the Plan as established by the Board of Trustees. Such employer shall, by the making of a payment to the Trust Fund on behalf of any Employee, be deemed to have become a party to any agreement between the Union and the Associations.

(C) a local Union, which shall be considered as the employer of the Employees of said local Union on whose behalf said local Union makes contributions to the Trust Fund.

(D) the Board of Trustees, which shall be considered as the employer of the Employees of the Welfare Plan on whose behalf the Board of Trustees make contributions to the Trust Fund.

(E) any Welfare, Pension, Apprenticeship or related fund.

Section 1.19 - Expense
"Expense" means the cost incurred for a covered service or supply and which is ordered by a Physician. An expense shall be considered incurred on the date the service or supply was rendered or ordered.

Section 1.20 - Experimental
"Experimental" means a service or supply that the Board of Trustees determines meets one (1) or more of the following criteria:

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

(B) a drug, device, treatment, or procedure which was reviewed and approved (or which is required by federal law to be reviewed and approved) by the treating facility's institutional review board or other body serving a similar function, or a drug, device, treatment or procedure which is used with a patient informed consent document which

was reviewed and approved (or which is required by federal law to be reviewed and approved) by the treating facility's institutional review board or other body serving a similar function;

(C) a drug or device which Reliable Evidence shows is the subject of on-going FDA Phase I, II or III clinical trials or is 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

(D) a drug, device, treatment, or procedure for which the prevailing opinion among experts, as shown by Reliable Evidence, is that further studies or clinical trials are necessary 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.

(E) A drug, device, treatment, or procedure for a condition or treatment not specifically approved by the FDA unless it is determined by the Plan's medical professionals to be an appropriate standard of care specifically for that condition or treatment.

If a procedure is Experimental, any part of said procedure shall be considered Experimental.

For purposes of this definition **"Reliable Evidence"** means only published reports and articles in the authoritative medical and scientific literature; the written protocol(s) used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, treatment or procedure. For purposes of this paragraph, **"authoritative"** means that the prevailing opinion with the appropriate specialty of the United States medical profession is that the medical and scientific literature is entitled to credit and acceptance, as is, for example, *The New England Journal of Medicine*.

Section 1.21 - Family Unit
"Family Unit" means the eligible Employee and all of his Eligible Dependents. If both the Employee and legal Spouse are eligible Employees under the Plan, their eligible children shall be considered Eligible Dependents. Benefits shall be coordinated so that one hundred percent (100%) of the Usual, Customary and Reasonable Charge shall be compensated.

A dependent legal spouse who is also an eligible Employee shall receive benefits first as an eligible Employee and then as an Eligible Dependent. Benefits will be coordinated so that one hundred percent (100%) of the eligible Expense shall be compensated.

"Family Unit" also means an eligible Employee without dependents.

Section 1.22 - Hospital
"Hospital" means an institution which is licensed as a hospital and operated pursuant to law, and is primarily and continuously engaged in providing or operating, either on its premises or in facilities controlled by the hospital, under the supervision of a staff of Physicians, medical,

diagnostic, and major surgery for the medical care and treatment of sick and injured persons on an inpatient basis for which a charge is made, with twenty-four (24) hour nursing service by or under the supervision of registered graduate professional nurses (RNs).

For the purpose of paying benefits for mental/nervous disorders, drug and alcohol treatment, "**Hospital**" also means confinement in either:

(A) a hospital licensed by the Department of Health or Department of Mental Health, or

(B) a hospital owned or operated by a state, which is especially intended for the use in the diagnosis, care, and treatment for psychiatric, mental/nervous disorders, drug and alcohol treatment.

(C) a facility which is certified by the State of Indiana Department of Mental Health under Indiana Administrative Code 440 IAC 7.5-1 through 440 IAC 7.5-6 or a similar facility that meets the similar statutory and regulatory requirements for such facilities in the State in which the services were performed.

"Hospital" does NOT include any military or veteran's hospital or soldier's home unless there is a legal requirement to pay.

"Hospital" also does NOT include a hospital or institution or part of a hospital or institution which is licensed or used primarily as a clinic, convalescent home, rest home, nursing home, home for the aged, halfway house or board and care facility, or primarily affording Custodial or educational care.

Section 1.23 - Incurred Date Of Claim
"Incurred Date of Claim" means the first date on which an eligible Employee or Eligible Dependent is under the care of a Physician and/or has incurred Expense which is payable by the Plan.

Section 1.24 - Injury
"Injury" means any accidental bodily injury which requires treatment by a Physician and which results in loss independent of Sickness or other causes.

Section 1.25 - Maternity
"Maternity" means expenses related to pregnancy and childbirth.

Section 1.26 - Medical Condition
"Medical Condition" shall mean any condition, whether physical or mental, including, but not limited to, any condition resulting from Sickness, Injury (whether or not the Injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a Medical Condition.

Section 1.27 - Medically Necessary
"Medically Necessary" means a service or supply which is ordered by a Physician and which is:

(A) provided for the diagnosis or direct treatment of an Injury or Sickness;

(B) appropriate and consistent with the symptoms and findings or diagnosis and treatment of the covered individual's Injury or Sickness;

(C) provided in accordance with generally accepted medical practice on a national basis; and

(D) the most appropriate supply or level of service which can be provided on a cost effective basis (including, but not limited to, inpatient versus outpatient care, electric versus manual wheelchair, surgical versus medical or other types of care).

The fact that a Physician prescribes services or supplies does NOT automatically mean that such services or supplies are Medically Necessary and covered by the Plan. Whether a particular service or supply is Medically Necessary shall be determined by the Board of Trustees.

Section 1.28 - Medicare
"Medicare" means the federally sponsored health insurance program for aged and disabled individuals, as set forth in Title XVIII of the Social Security Act, as amended.

Section 1.29 - Organ
"Organ" shall mean a somewhat independent part of the body that is arranged according to a characteristic structural plan, performs a special function or functions and is composed of various tissues, one of which is primary in function.

Section 1.30 - Out-Of-Pocket Limit
"Out-of-Pocket Limit" means a specific dollar amount of eligible medical Expenses which have been individually paid by an eligible Employee or Eligible Dependent during the calendar year before the Coinsurance increases to one hundred percent (100%).

The following shall NOT be counted towards the Out-of-Pocket Limit:

(A) any Expenses not covered by the Plan;

(B) Expenses arising from weekend (Friday, Saturday or Sunday) Hospital admissions not covered by the Plan;

(C) any Expenses incurred by an eligible Employee or an Eligible Dependent which exceed the Maximum Annual Benefit or other Plan maximums.

Section 1.31 - Physician
"Physician" means any of the following licensed practitioners who is acting within the scope of his license and who performs a service payable under the Plan:

(A) a doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC); or

(B) where required to be covered by law, a licensed doctoral clinical psychologist, and a licensed or certified social worker (LCSW or CCSW), a licensed physician's assistant (PA), or any other licensed practitioner who:

   (1) is acting under the supervision of a doctor of medicine (MD); and

   (2) performs a service which is payable under the Plan when performed by a doctor of medicine (MD).

"Physician" does not include a person who:

(A) lives in the eligible Employee's home; or

(B) is a member of the eligible Employee's family.

Section 1.32 - Plan
"Plan" means the Pipe Trades Industry Health and Welfare Plan as described herein and as hereafter amended.

Section 1.33 - Plan Year
"Plan Year" means the twelve (12) month period beginning on July 1 of each year and ending on June 30 of the following year.

Section 1.34 - Qualified Medical Child Support Order
"Qualified Medical Child Support Order" means a Medical Child Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits as an Eligible Dependent under the Plan, provided:

(A) The Medical Child Support Order clearly specifies:

   (1) the name and last known mailing address, if any, of the eligible Employee and the name and mailing address of each Alternate Recipient covered by the order;

   (2) a reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;

   (3) the period to which such order applies; and

   (4) the Plan to which such order applies.

(B) The Medical Child Support Order does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to satisfy the requirements of law relating to medical child support pertaining to Medicaid eligible children as described in Section 1908 of the Social Security Act, as added by Section 13623 of OBRA 1993.

(C) Benefits paid to an Alternate Recipient shall be at the level of benefits available under the Plan at the time the Expense is incurred.

(D) An Alternate Recipient shall be eligible for benefits only if the Employee is eligible for benefits.

(E) In the event that the Employee loses eligibility and later becomes re-eligible for benefits, any previous Qualified Medical Child Support Order, which according to its terms is still in effect, will automatically be renewed.

Section 1.35 - Sickness

"Sickness" means a disease, disorder or condition which requires treatment by a Physician. For a female Employee or legal Spouse, "Sickness" includes childbirth, pregnancy or related conditions.

Section 1.36 - Substance Abuse Treatment Center

"Substance Abuse Treatment Center" means a Hospital or clinic licensed for inpatient or outpatient drug or alcohol abuse treatment. Facilities providing inpatient substance abuse service must be licensed for the level of care, have a Physician on staff and have registered nurses on staff 24/7. Facilities providing outpatient services must be licensed for the level of care and services being performed and must be supervised by a Physician, as defined under the Plan.

Section 1.37 - Surgical Procedure

"Surgical Procedure" means only the following:

(A) a cutting procedure;

(B) suturing of a wound;

(C) treatment of a fracture;

(D) reduction of a dislocation;

(E) radiotherapy (including radioactive isotope that is used in lieu of a cutting operation for removal of a tumor);

(F) electrocauterization;

(G) diagnostic and therapeutic endoscopic procedures; or

(H) injection treatment of hemorrhoids, varicose veins, joint, tendon sheath, ligament or trigger points.

Section 1.38 - Trust Agreement

"Trust Agreement" means the Agreement and Declaration of Trust establishing the Pipe Trades Industry Health and Welfare Plan, effective July 1, 1961, and that instrument as amended from time to time.

Section 1.39 - Trust Fund Or Fund
"Trust Fund" or "Fund" means all of the assets which are held by the Trustees for the purpose of maintaining the Plan.

Section 1.40 - Union Or Unions
"Union" or **"Unions"** means the local unions of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the U.S. and Canada, AFL-CIO, who represent its employees and members.

Section 1.41 - Usual, Customary And Reasonable Charge (UCR)
"Usual, Customary and Reasonable Charge (UCR)" means that the charge by any provider for the services or procedures rendered and the supplies furnished must be similar to all other like providers of the same service in the same geographical area, as determined by the Board of Trustees based upon data collected from the health plans, insurance carriers and third party administrators. The "geographical area" reference is the zip code for the general level of charges being made by a Physician of similar training and experience.

Provided further, in some situations, the covered medical expenses will be limited to a specific percentage of the Usual, Customary and Reasonable Charge. These situations include, but are not limited to, the following:

(A) for multiple or bilateral surgeries performed during the same operative session which are not incidental, or not part of some other procedure, and which add significant time or complexity (all as determined by the Trustees) to the complete procedure, the covered medical expense will be:

(1) one hundred percent (100%) of the Usual, Customary and Reasonable Charge for the primary procedure;

(2) fifty percent (50%) of the Usual, Customary and Reasonable Charge for the secondary procedure, including any bilateral procedure; and

(3) twenty-five percent (25%) of the Usual, Customary and Reasonable Charge for each additional covered procedure. This applies to all Surgical Procedures except as determined by the Trustees.

(B) for surgical assistance by a Physician, the covered medical expense will be twenty percent (20%) of the Usual, Customary and Reasonable Charge for the corresponding surgery;

(C) for non-surgical treatments performed during an office visit, the covered medical expense will be limited to the Usual, Customary and Reasonable Charge for the non-surgical treatment alone.

For all services provided by an In-Network provider, the Usual, Customary and Reasonable Charge will be the allowed amount as negotiated by the Plan's PPO network.

If the primary PPO Network has contracted with other affiliated networks (i.e. the “Blues” in other states), the Usual, Customary and Reasonable charge will be the PPO Network’s discounted charge under that arrangement.

SCHEDULE OF BENEFITS

Section 2.01 - Eligible Employees And Eligible Dependents Not Entitled To Medicare

ELIGIBLE EMPLOYEE ONLY

BENEFIT	AMOUNT PAYABLE
Death	$11,500.00
Accidental Death and Dismemberment (Non-occupational Only) *Loss*: Life	$11,500.00
Both Hands, Feet, Eyes or combination of any two (2)	$11,500.00
One (1) Hand, Foot or Eye	$5,750.00
Weekly Disability Weekly Benefit (subject to Social Security taxes)	$500.00
Maximum Benefit	15 weeks per calendar year

ELIGIBLE EMPLOYEE AND ELIGIBLE DEPENDENTS

HEALTH CARE BENEFITS

MEDICAL

(The maximum annual benefit, Deductible Amount, Out-of-Pocket Limit and Coinsurance amounts below apply to all medical benefits)

Maximum Annual Benefit	No Maximum
Deductible Amount	$700.00 per person per calendar year $2,100.00 per Family Unit per calendar year
Out-of-Pocket Limit	$4,000.00 per person

per calendar year

$8,000.00
per Family Unit
per calendar year

Coinsurance **(UNLESS OTHERWISE STATED)** ....80% of UCR*

The following benefits are paid at 80% UCR* **(UNLESS OTHERWISE SPECIFICALLY STATED)**

BENEFIT

- Hospital Room and Board (Average Semi-Private Room)
- Intensive Care, Coronary Care and Constant Care Unit Benefit
- Hospital Miscellaneous
- Physician's Visits (In Hospital)
- Surgery (In/Outpatient)
- Anesthesia
- Maternity Benefits (Eligible Female Employee or Dependent Spouse Only)
- Physician's Visits (In Office)
- X-Ray and Laboratory
- Durable Medical Equipment
- Wheelchair or Motorized Scooter Benefit
- Private Duty Nursing and Rehabilitative Services
- Enteral or Parenteral Nutrition Therapy
- Organ Transplant Benefit
- Alcohol and Drug Related Illnesses Treatment Benefit (Out-of-Network Inpatient Services are not covered)
- Nervous, Mental or Psychiatric Disorder Treatment Benefit

Chiropractic ....80% of UCR*
Annual Maximum .... $1,000.00 per person

LiveHealth Online Doctor Visit Benefit

The Annual Deductible Amount does not apply to this Benefit.
In-Network Benefits through LiveHealth Online Only
No Employee Co-Payment, Coinsurance or Deductible.

In-Network Only 100%

Prescription Drugs

Retail (up to 34 day supply)
Out-of-Network .... 50% of charge
after the medical Deductible Amount
In-Network.. 100% of charge
after $38 per prescription
Co-Payment for brand name drugs
and $20 per prescription
Co-Payment for generic drugs

Retail (up to 60 day supply)
In-Network.. 100% of charge
after $70 per prescription
Co-Payment for brand name drugs
and $40 per prescription
Co-Payment for generic drugs

Retail (up to 90 day supply)
In-Network.. 100% of charge
after $105 per prescription
Co-Payment for brand name drugs
and $60 per prescription
Co-Payment for generic drugs

Mail Order (Maintenance drugs - up to 90 day supply)
In-Network .... 100% of charge
after $77 per prescription
Co-Payment for brand name drugs
and $38 per prescription
Co-Payment for generic drugs

Wellness Benefits...100% of UCR

- Routine Physical examination – one office call every year age two and over
- Cervical Cancer Screening (Pap Smear) – one every year
- PSA (Prostate Specific Antigen) test – one every year
- Mammogram – one every year age 40 and over
- Sigmoidoscopy – one every five years age 50 and over
- Colonoscopy – one every five years age 50 and over
- Well-child visits and routine immunizations through age 24 months
- Routine Adult and Childhood Immunizations (age two and over)

*** After the Deductible Amount is met. Applies only to eligible Expenses. Noncovered charges DO NOT apply to the Deductible Amount or the Out-of-Pocket Limit.**

Section 2.02 - Retired Or Disabled Individuals And Eligible Dependents Not Entitled To Medicare

RETIRED OR DISABLED INDIVIDUAL ONLY

BENEFIT	**AMOUNT PAYABLE**
Death	$4,500.00

Accidental Death and Dismemberment
(Non-occupational Only)

Loss:

Life	$4,500.00
Both Hands, Feet, Eyes or combination of any two (2)	$4,500.00
One (1) Hand, Foot or Eye	$2,250.00

RETIRED OR DISABLED INDIVIDUAL AND ELIGIBLE DEPENDENTS (NOT ENTITLED TO MEDICARE)

HEALTH CARE BENEFITS

MEDICAL

(The maximum annual benefit, Deductible Amount, Out-of-Pocket Limit and Coinsurance amounts below apply to all medical benefits)

Maximum Annual Benefit	No Maximum
Deductible Amount	$700.00 per person per calendar year $2,100.00 per Family Unit per calendar year
Coinsurance **(UNLESS OTHERWISE STATED)**	80% of UCR*

Out-of-Pocket Limit $4,000.00
per person
per calendar year

$8,000.00
per Family Unit
per calendar year

<u>The following benefits are paid at 80% UCR*</u> **(UNLESS OTHERWISE SPECIFICALLY STATED)**

<u>BENEFIT</u>

- Hospital Room and Board (Average Semi-Private Room)
- Intensive Care, Coronary Care and Constant Care Unit Benefit
- Hospital Miscellaneous
- Physician's Visits (In Hospital)
- Surgery (In/Outpatient)
- Anesthesia
- Maternity Benefits (Eligible Female Employee or Dependent Spouse Only)
- Physician's Visits (In Office)
- X-Ray and Laboratory
- Durable Medical Equipment
- Wheelchair or Motorized Scooter Benefit
- Private Duty Nursing and Rehabilitative Services
- Enteral or Parenteral Nutrition Therapy
- Organ Transplant Benefit
- Alcohol and Drug Related Illnesses Treatment Benefit (Out-of-Network Inpatient Services are not covered)
- Nervous, Mental or Psychiatric Disorder Treatment Benefit

<u>Chiropractic</u> ....80% of UCR*
Annual Maximum .... $1,000.00 per person

<u>LiveHealth Online Doctor Visit Benefit</u>
The Annual Deductible Amount does not apply to this Benefit.
In-Network Benefits through LiveHealth Online Only
No Employee Co-Payment, Coinsurance or Deductible.

In-Network Only 100%

Prescription Drugs

Retail (up to 34 day supply)
Out-of-Network .... 50% of charge
after the medical Deductible Amount

In-Network 100% of charge
after $32 per prescription
Co-Payment for brand name drugs
and $15 per prescription
Co-Payment for generic drugs

Retail (31 to 60 day supply)
In-Network.. 100% of charge
after $60 per prescription
Co-Payment for brand name drugs
and $30 per prescription
Co-Payment for generic drugs

Retail (61 to 90 day supply)
In-Network.. 100% of charge
after $90 per prescription
Co-Payment for brand name drugs
and $45 per prescription
Co-Payment for generic drugs

Mail Order (Maintenance drugs - up to 90 day supply)
In-Network .... 100% of charge
after $64 per prescription
Co-Payment for brand name drugs
and $25 per prescription
Co-Payment for generic drugs

Wellness Benefits..100% of UCR

- Routine Physical examination – one office call every year age two and over
- Cervical Cancer Screening (Pap Smear) – one every year
- PSA (Prostate Specific Antigen) test – one every year
- Mammogram – one every year age 40 and over
- Sigmoidoscopy – one every five years age 50 and over
- Colonoscopy – one every five years age 50 and over
- Well-child visits and routine immunizations through age 24 months
- Routine Adult and Childhood Immunizations (age two and over)

***After the Deductible Amount is met. Applies only to eligible Expenses. Noncovered charges DO NOT apply to the Deductible Amount or the Out-of-Pocket Limit.**

Section 2.03 - Retired or Disabled Individuals And Eligible Dependents Entitled To Medicare

RETIRED OR DISABLED INDIVIDUAL ONLY

BENEFIT	AMOUNT PAYABLE
Death	$4,500.00

Accidental Death and Dismemberment
(Non-occupational Only)
Loss:

Life	$4,500.00
Both Hands, Feet, Eyes or combination of any two (2)	$4,500.00
One (1) Hand, Foot or Eye	$2,250.00

RETIRED OR DISABLED INDIVIDUAL AND ELIGIBLE DEPENDENTS (ENTITLED TO MEDICARE)

HEALTH CARE BENEFITS

MEDICAL

(The maximum annual benefit, Deductible Amount, Out-of Pocket Limit and Coinsurance amounts below apply to all medical benefits)

Deductible Amount	$700.00 per person per calendar year $2,100.00 per Family Unit per calendar year

Prescription Drugs

Retail (up to 34 day supply)

In-Network	100% of charge after $32 per prescription Co-Payment for brand name drugs and $15 per prescription Co-Payment for generic drugs

Retail (35 to 60 day supply)

In-Network	100% of charge after $50 per prescription Co-Payment for brand name drugs and $20 per prescription Co-Payment for generic drugs

Retail (61 to 90 day supply)
In-Network.. 100% of charge
after $75 per prescription
Co-Payment for brand name drugs
and $30 per prescription
Co-Payment for generic drugs

Mail Order (Maintenance drugs - up to 90 day supply)
In-Network.. 100% of charge
after $64 per prescription
Co-Payment for brand name drugs
and $25 per prescription
Co-Payment for generic drugs

Wellness Benefits...100% of UCR

- Routine Physical examination – one office call every year age two and over
- Cervical Cancer Screening (Pap Smear) – one every year
- PSA (Prostate Specific Antigen) test – one every year
- Mammogram – one every year age 40 and over
- Sigmoidoscopy – one every five years age 50 and over
- Colonoscopy – one every five years age 50 and over
- Well-child visits and routine immunizations through age 24 months
- Routine Adult and Childhood Immunizations (age two and over)

*** After the Deductible Amount is met. Applies only to eligible Expenses. Noncovered charges DO NOT apply to the Deductible Amount or the Out-of-Pocket Limit.**

All coverage except Death, Accidental Death and Dismemberment, Prescription Drug Benefits and Medicare Supplemental Benefits shall cease as of the date an Eligible Employee or Dependent becomes eligible for hospital and medical insurance under Social Security Medicare whether or not the individual is enrolled in the program. **(This provision applies only to expenses incurred on or after the date the person becomes eligible for Medicare).**

Medicare has three relevant parts - Hospital Insurance (Part A), Medical Insurance (Part B) and Prescription Drug Coverage (Part D). Part A covers Inpatient Hospital care and generally is available to all individuals over age 65 at no cost. Part B covers Physician services, Outpatient Hospital services and other medical supplies and is optional. Part D covers prescription drugs and is covered by this Plan. Generally, a Medicare participant must pay a monthly premium for Parts B and D, however, this Plan pays the Part D premium on behalf of the Medicare participant. The Plan coordinates expenses covered under Medicare Parts A, B and D. If a Medicare participant or beneficiary opts out of this Plan's Part D coverage and enrolls in a different Part D Plan the supplemental coverage for Part D under this Plan will be discontinued and the participant will still pay the same amount for the Plan's supplement to Parts A and B.

When you become entitled to Medicare, all medical coverage will be coordinated with Medicare Parts A and B whether or not the individual is enrolled in the Medicare program. (This provision applies only to expenses incurred on or after the date the person becomes eligible for Medicare).

The Plan will automatically enroll the participant under Medicare Part D for Prescription benefits and will automatically coordinate with Part D without having to submit a claim.

For purposes of making it clear what this means, if the individual qualifies for Medicare coverage for either Hospital (Part A) or Physician services (Part B), and the individual does not enroll in Medicare, the claims under this Plan shall be calculated as if the individual had enrolled in both Part A and B of Medicare and benefits shall be reduced by any payments which would have been made by Medicare regardless of the fact that the individual is not enrolled in the program. While the Plan will automatically enroll everyone in Part D, you may opt out of that coverage. Be aware that if you opt out of this Plan's Part D coverage, you will no longer be eligible for prescription drug coverage through the Plan.

Typically, after Medicare pays their portion of your claim, Medicare will electronically submit your remaining balance to the Plan Office for payment. When this occurs, you will not need to submit anything to the Plan Office for payment. However, if this does not occur, the Explanation of Medicare Benefits (EOMB) must be sent to the Plan Office along with the expenses before any payment will be made by the Plan. For Medicare Part D services, the Plan will automatically coordinate with Part D at the time you receive your medication. **Medicare Coordination of Benefits shall apply to retired and disabled eligible Employees and SHALL NOT apply to a working, active Employee who maintains eligibility based upon employer contributions even though eligible for Medicare.** In the case of a retired or Disabled member who remains eligible under the Plan based upon Reserve credits and who is also eligible for Medicare, the Plan will be primary and Medicare will be secondary.

The Plan shall pay only what Medicare does not pay only after the Plan Deductible Amount is met, only if the expenses are covered under the Plan and provided further; that no more shall be payable than the covered services described in the Plan for eligible Employees and Eligible Dependents eligible for Medicare. The Plan shall pay all deductible amounts required by Medicare when the eligible Employee or Eligible Dependent is initially hospitalized and after the Plan Deductible Amount has been met. **The Plan shall pay no benefits for charges incurred over or above the prevailing reserve days established by Medicare.**

ELIGIBILITY RULES

Section 3.01 - Initial Eligibility
Initial Eligibility shall begin on the first day of the second month following any calendar quarter during which an Employee works and is credited with three hundred (300) hours or more of covered employment for an Employer or Employers and payment for the same at the applicable rate is received from said Employer or Employers by the Plan Office.

In the event that an Employee works less than three hundred (300) hours in his initial calendar quarter or his Employer(s) make(s) payment for less than three hundred (300) hours, the Employee may pay the difference in order to meet the Initial Eligibility requirements. Payment shall be in an amount equal to the difference in the hours reported and three hundred (300) multiplied by the applicable Employer contribution rate and may only be made at the beginning of the initial Benefit Quarter.

Section 3.02 - Continuation Of Eligibility
Once having become eligible, an Employee shall continue to be eligible as long as he is working for a contributing Employer or Employers and on whose behalf at least three hundred (300) hours of contributions at the applicable Employer contribution rate have been received for each appropriate calendar quarter in accordance with the following schedule:

CALENDAR QUARTER	BENEFIT QUARTER
Hours Worked In: January, February, March	Gives Eligibility In: May, June, July
Hours Worked In: April, May, June	Gives Eligibility In: August, September, October
Hours Worked In: July, August, September	Gives Eligibility In: November, December, January
Hours Worked In: October, November, December	Gives Eligibility In: February, March, April

If the Employee's Union withdraws from the Plan, such withdrawal shall terminate the eligibility for benefits of all Employees, participants and their Beneficiaries represented by such withdrawing Union as of the effective date of such withdrawal as well as terminate the right, title or interest in or to any balance in the Employee's Reserve Credit. Notwithstanding such withdrawal, no payments whatsoever shall be made from or out of the Plan to or for the benefit of the Employees represented by such withdrawing Union or to any other trust fund or entity created for the purpose of providing health and welfare benefits to the Employees represented by such withdrawing Union and, by such withdrawal, the withdrawing Union and the Employees, participants and their Beneficiaries, represented by it, or any person claiming by or through or

under any of them, shall have no further right, title or interest in or to the Plan, or any part thereof, excepting, only, that the balance of any authorized regular benefits payable to individual Employees and their Beneficiaries under bona fide claims accruing prior to the effective date of such withdrawal may continue to be paid after such withdrawal or as otherwise provided by law.

Section 3.03 - Reserve Credit
Hours worked at the applicable rate in excess of three hundred (300) in each calendar quarter shall be considered Reserve Credit and shall be used to continue eligibility during periods of unemployment or under-employment. The maximum amount of Reserve Credit which shall be credited to any Employee's account shall be equal to one (1) quarter of coverage.

Reserve Credit shall be used to provide continuous eligibility only and shall not be used to establish or reestablish Initial Eligibility. If eligibility ceases as a result of an individual's failure to make a timely self-contribution payment, reserve hours shall not be applied to any subsequent Benefit Quarter. When using the Reserve Credit, the Plan shall reduce the Employee's accumulated balance by the self-contribution rate in effect for active members or in a manner otherwise determined by the Trustees.

If the Employee's Union withdraws from the Plan, such withdrawal shall terminate the right, title or interest in or to any balance in the Employee's Reserve Credit as well as terminate the eligibility for benefits of all Employees, participants and their Beneficiaries represented by such withdrawing Union as of the effective date of such withdrawal.

Section 3.04 - Self-Contribution Payments
After once having become eligible, if an Employee is in danger of losing eligibility due to a period of unemployment or under-employment and that Employee is available for employment in the jurisdiction of an affiliated local Union, the Employee shall be permitted to make self-contribution payments to the Fund in an amount equal to the difference between the credited hours for the calendar quarter and the required three hundred (300) hours multiplied by the applicable hourly Employer contribution rate.

The self-contribution payment must be made quarterly and received by the Plan Office on or before the tenth day of the first month of the Benefit Quarter. Payment may also be made on a monthly basis provided that it is received by the Plan Office on or before the tenth day of the month for which coverage is being requested.

Self-contribution payments for the full 300 hours can be made for no more than 24 consecutive months unless the Employee has applied for Social Security Disability and is in the waiting period before Medicare starts.

Failure to make a timely or making an incorrect self-contribution payment shall result in a loss of eligibility, the forfeiture of all unused Reserve Credit hours earned prior to that point and the right to make future self-contribution payments.

Section 3.05 - Reinstatement Of Eligibility
An Employee who loses his eligibility shall become eligible again on the first day of a Benefit Quarter following receipt of Employer contributions in the amount of three hundred (300) hours at the applicable rate for the applicable calendar quarter. If the Employee works at least two

hundred (200) hours but less than three hundred (300) hours, the Employee may pay the difference in order to reinstate eligibility. Payment shall be in an amount equal to the difference in the hours reported and three hundred (300) multiplied by the applicable Employer contribution rate and may only be made at the beginning of the reinstated Benefit Quarter.

Section 3.06 - Employment Outside Of Jurisdiction

An Employee represented by an affiliated local Union and who is working in covered employment outside the jurisdiction of the local Union may maintain eligibility by making self-contribution payments at the beginning of each Benefit Quarter in an amount equal to three hundred (300) times the applicable hourly contribution rate.

The self-contribution payment must be made quarterly and received by the Plan Office on or before the tenth day of the first month of the Benefit Quarter. Payment may also be made on a monthly basis provided that it is received by the Plan Office on or before the tenth day of the month for which coverage is being requested.

Failure to make a timely or making an incorrect self-contribution payment shall result in a loss of eligibility and the right to make future self-contribution payments.

Section 3.07 - Eligibility For Employees Entering Military Service Under The Uniformed Services Employment and Reemployment Rights Act (USERRA)

(A) ***Effective Date:***

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") was signed into law on October 13, 1994 to protect the eligibility of an Employee and to offer continuation of coverage to the Employee and his Eligible Dependents after the Employee enters into military service.

(B) ***Provisions:***

(1) ***Return to Work Coverage Guaranteed:***

If an Employee enters the Uniformed Services, as defined in USERRA, for active military duty or training, inactive duty or training, full-time National Guard or Public Health Service duty, or fitness-for-duty examination, coverage for the Employee and his Eligible Dependents will terminate when he no longer meets the continuation of eligibility requirements (up to one (1) additional Benefit Quarter). If an Employee is discharged from the Uniformed Services, except for a dishonorable discharge, the Employee and his Eligible Dependents will also receive up to one (1) additional quarter of coverage at no cost on the day he begins work with an Employer participating in this Fund, until continuation of eligibility requirements are met. To protect his rights to reinstatement with his Employer prior to Uniformed Service, the Employee must present himself to that Employer within a time frame established by law as listed in Subsection (3) below.

(2) ***Continuation of Coverage While in the Military:***

USERRA requires a group health care plan to offer identical health care coverage for **up to twenty-four (24) months** to persons who have coverage in connection with their employment but who are absent from such employment due to military service. In effect, military service is treated as if it is a "qualifying event" for COBRA purposes.

The Employee must notify the Plan Office immediately when the Employee knows he is entering Military Service.

If notification of the Plan Office is delayed for several months, the extension of coverage for a maximum of twenty-four (24) months begins with the initial date of entry into military service and a retroactive payment to that date may be charged. The Employee has an obligation to notify the Plan Office as soon as the Employee knows he is entering military service **if the Employee wishes to take advantage of continuation coverage. Failure to notify the Plan Office may be taken as an indication that the Employee does not wish to purchase coverage.**

(3) ***Reemployment Requirements When Returning from Service:***

Under the law, the application period for re-employment is based on a restrictive time schedule keyed to the length of time spent in military service.

For service of less than thirty-one (31) days, a service member must apply for re-employment with a signatory Employer at the beginning of the next regular scheduled work period on the first day after an honorable discharge from service, taking into account safe transportation plus an eight (8) hour rest period.

For military service of thirty-one (31) days or more but less than one hundred eighty-one (181) days, an application for re-employment must be filed within fourteen (14) days (calendar days not work days) after the service member's honorable discharge from the service.

For service over one hundred eighty-one (181) days, an application for re-employment must be submitted within ninety (90) days (calendar days not work days) after an honorable discharge.

Section 3.08 - Eligibility For Employees/Members Of Nonaffiliated Local Unions

Contributions made on behalf of Employees represented by Local Unions with which the Plan has reciprocal agreements shall be returned to the appropriate home fund pursuant to the terms of the reciprocal agreement and no eligibility for benefits shall be established under this Plan.

Section 3.09 - Eligibility For Shop Owners and Self Employed Members
Participation and eligibility for shop owners and self employed members shall be based upon the reporting and payment of forty (40) hours per week (thirteen (13) weeks per calendar quarter) or the actual number of hours worked in the case of a bargaining unit individual, whichever is greater. Failure to report the minimum of one hundred sixty (160) or two hundred (200) hours per month in a calendar quarter shall result in a failure to establish initial eligibility or to maintain eligibility. Such shop owners or self employed members must be signatory to either a collective bargaining agreement with the Union or have signed a participation agreement.

Section 3.10 - Eligibility For Non-Bargained Employees of Employers
Participation and eligibility for non-bargained employees of Employers shall be based upon the reporting and payment of forty (40) hours per week (thirteen (13) weeks per calendar quarter). Failure to report the minimum of one hundred sixty (160) or two hundred (200) hours per month in a calendar quarter shall result in a failure to establish initial eligibility or to maintain eligibility. An Employer may participate under this Section only if it covers all non-bargaining employees, and if it signs a Participation Agreement. As of May 1, 2003, no new non-bargaining personnel are allowed in the Plan.

Section 3.11 - Eligibility Under The Family And Medical Leave Act Of 1993
When an eligible active Employee qualifies in all respects for a leave under the Family and Medical Leave Act of 1993 (FMLA), any accumulated eligibility to the credit of the Employee, at the time the leave commences, shall be kept on the records of the Plan and shall be available to the Employee upon return from such leave. During the period of the leave, continuation of health benefits shall be maintained at no cost to the Employee. If the Employee fails to return to work after an approved leave, the accumulated eligibility shall revert back to the time the leave commenced and the period of absence shall be treated as if no work was performed in covered employment.

Section 3.12 - Continuation Coverage Under COBRA
In compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan offers certain Employees, spouses and/or dependent children the opportunity to continue the health benefits by making self-payments in certain instances where the eligibility for said benefits would otherwise terminate. This coverage shall be known as COBRA and shall apply to the health benefits only.

Proof of good health shall not be required to obtain COBRA coverage if the Employee, spouse and/or dependent child meet the qualifications. The Employee, spouse and/or dependent child must take certain actions within specified time periods in order to initiate and maintain COBRA coverage.

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

(A) **<u>Eligibility For COBRA Coverage</u>**

An Employee, dependent spouse and/or dependent child who becomes eligible for COBRA coverage shall be known as a Qualified Beneficiary. An event which causes an Employee, spouse and/or dependent child to become a Qualified Beneficiary to become eligible for COBRA shall be known as a Qualifying Event. In order for a Qualified Beneficiary to become eligible for COBRA coverage, the individual must be eligible for benefits from the Plan on the date the Qualifying Event occurs.

An employee shall become a Qualified Beneficiary on the date his eligibility for benefits from the Plan terminates due to the occurrence of any of the following Qualifying Events:

(1) a reduction in hours worked; or

(2) a termination of employment for any reason other than gross misconduct.

A spouse and/or dependent child shall become a Qualified Beneficiary on the date his eligibility for benefits from the Plan terminates due to the occurrence of any of the following Qualifying Events:

(1) the Employee's death;

(2) a reduction in the hours worked by the Employee;

(3) a termination of the Employee's employment for any reason other than gross misconduct;

(4) the Employee's divorce or legal separation;

(5) the Employee's entitlement to Medicare; or

(6) the loss of Eligible Dependent status as defined in this Plan.

(B) **<u>Benefits Available</u>**

Only the health care benefits shall be available under the COBRA coverage. COBRA coverage does not apply to the Death Benefit, Accidental Death and Dismemberment Benefit and Weekly Disability Benefit.

<u>Procedure for Obtaining COBRA Coverage</u>

When the Plan administrative manager determines that a Qualifying Event has occurred, he shall send an election notice to the Qualified Beneficiary within fourteen (14) days of the date on which he determines that the Qualifying Event occurred. The election notice shall inform the Qualified Beneficiary what coverage may be continued, the cost of said coverage and what the Qualified Beneficiary must do in order to obtain the COBRA coverage. The election notice shall also contain an application form for the COBRA coverage which must be completed and returned, along with the proper payment, to the Plan Office within the time period set forth therein.

The election notice shall be sent, by first class mail, to the Qualified Beneficiary's last known address on file in the Plan Office. In the case of multiple Qualified Beneficiaries of the same family, a single election notice shall be sent to all Qualified Beneficiaries at that address. It shall be the responsibility of each Qualified Beneficiary to read the election notice and take the required action(s). The parent or guardian of a Qualified Beneficiary who is a minor child may read the election notice for said child and take action on said child's behalf.

Each Qualified Beneficiary shall be entitled to individually elect the COBRA coverage if the Employee or spouse rejects coverage for the entire family. If the Qualified Beneficiary or a parent or guardian, acting on behalf of a minor Qualified Beneficiary, elects COBRA coverage, he shall make sure that a completed and signed application form is returned to the Plan Office within sixty (60) days of the date on the election notice. Each Qualified Beneficiary who elects COBRA coverage must be named on the application form or a separate application form must be submitted for any person not named therein. If, for any reason, the Plan Office does not receive the completed application for any Qualified Beneficiary within the sixty (60) day period that Qualified Beneficiary's eligibility for COBRA shall expire and his health care benefits shall terminate as of the date he first became a Qualified Beneficiary. The Plan shall not be liable and shall be held harmless in the event that a parent or guardian, acting on behalf of a Qualified Beneficiary who is a minor child, fails to inform the minor Qualified Beneficiary of his right to elect COBRA coverage and/or fails to elect COBRA coverage for said minor Qualified Beneficiary within the sixty (60) day period.

Each spouse and/or dependent child shall be responsible for notifying the Plan administrative manager whenever any of the following Qualifying Events occur:

(1) divorce from the Employee;

(2) legal separation from the Employee; or

(3) loss of status as an Eligible Dependent as defined in Article 1, Section 1.15.

The notification shall take place immediately after any of the Qualifying Events occur. If a Qualifying Event listed in (1) through (3) above is not reported to the Plan administrative manager within sixty (60) days after it occurs, COBRA coverage shall NOT be provided.

The monthly self-payment rate for COBRA coverage shall be determined periodically by the Trustees and shall be based upon the cost of the coverage provided by the Plan. The monthly self-payment rate and frequency of payment shall be indicated on the Election Notice at the time it is sent to the Qualified Beneficiary. The self-payment rate may change due to changes in the benefits offered by the Plan and, in certain cases, to reflect changes in the cost of the coverage.

The first self-payment shall be due on the first day of the calendar month next following the date on which the Qualifying Event occurs. The first self-payment shall cover the Qualified Beneficiary from the date of the Qualifying Event through the last day of the next following calendar month and shall be in an amount prorated to reflect the actual number of days of coverage during the period. Subsequent self-payments shall be due on the first day of each calendar month in an amount equal to the monthly self-payment rate, except that the last self-payment due shall be prorated to reflect the actual number of days of coverage up to the date COBRA coverage terminates.

When the Plan administrative manager is properly notified of an election to purchase COBRA coverage, he shall send a bill to the Qualified Beneficiary showing the self-payment due from the date of the Qualifying Event through the last day of the calendar month in which the election notice was received. The entire amount shown on the bill must be received within forty-five (45) days of the due date as stated on the bill. COBRA coverage shall not be effective and no medical expenses incurred after the Qualifying Event shall be paid unless and until the full bill is paid.

It shall be the absolute responsibility of each Qualified Beneficiary or person acting on behalf of a Qualified Beneficiary to ensure that the Plan administrative manager receives the correct payment on a timely basis. The Plan shall not be liable and shall be held harmless by the Qualified Beneficiary in the event that a parent or guardian, acting on behalf of a Qualified Beneficiary who is a minor, causes said Qualified Beneficiary to lose COBRA coverage through a failure to submit correct payment in a timely fashion.

(C) **Maximum Periods of COBRA Coverage**

An Employee, spouse or dependent child who becomes a Qualified Beneficiary due to the Employee's reduction in hours worked or termination of employment (for reasons other than gross misconduct) may elect to make self-payments for COBRA coverage for a maximum period of eighteen (18) months from the date of the Qualifying Event.

An Employee, spouse or dependent child who becomes disabled as determined by Medicare when he suffered a Qualifying Event may elect to make self-payments for COBRA coverage for a maximum period of twenty-nine (29) months from the date of the Qualifying Event.

A spouse or dependent child who becomes a Qualified Beneficiary due to reasons other than the Employee's reduction in hours worked or termination of employment (for reasons other than gross misconduct) may elect to make self-payments for COBRA coverage for a maximum period of thirty-six (36) months from the date of the Qualifying Event.

A spouse or dependent child who qualifies for eighteen (18) months of COBRA coverage, as provided above, may qualify for an additional eighteen (18) months of COBRA coverage if, following the first Qualifying Event and while COBRA coverage is in effect, the spouse or dependent child suffers a second Qualifying Event which, in the absence of the first Qualifying Event, would have entitled the Qualified Beneficiary to thirty-six (36) months of COBRA. The thirty-six (36) month period of COBRA due to the occurrence of the second Qualifying Event shall be applied retroactively to the date on which the first Qualifying Event occurred and shall run concurrently with the eighteen (18) month period of COBRA coverage attributable to the first Qualifying Event.

In the event that an Employee becomes a Qualified Beneficiary and subsequently is reemployed with an Employer within eighteen (18) months from the date he became a Qualified Beneficiary, his eligibility for further COBRA coverage shall terminate on the last day of the calendar month in which he is reemployed and said individual's rights to future benefits shall be determined in accordance with the general provisions of the Plan as it exists at that time. The COBRA coverage of a spouse or dependent child of a reemployed Employee shall also terminate on the last day of the calendar month in which the Employee is reemployed and their rights to future benefits shall be determined in accordance with the general provisions of the Plan as it exists at that time.

(D) **<u>Termination of COBRA Coverage</u>**

COBRA coverage shall terminate on the first date any one (1) of the following events occur:

(1) the date on which a Qualified Beneficiary completes the maximum period of COBRA coverage for which he is eligible; or

(2) the date on which a self-payment for COBRA coverage is not made in a timely manner; or

(3) the date, after the election of COBRA coverage, on which a Qualified Beneficiary becomes covered under any other group health care plan, including a Blue Cross Blue Shield program or Medicare; or

(4) the date on which an Employee's divorced spouse remarries and becomes eligible for coverage as set forth in (3) above; or

(5) the date the Plan terminates.

Section 3.13 - Qualified Medical Child Support Orders

An Alternate Recipient under a Qualified Medical Child Support Order (QMCSO) shall be eligible for benefits from the Plan only if the Employee, retired or Disabled individual, widow or widower is eligible.

Benefits paid to an Alternate Recipient shall be at the level of benefits available under the Plan at the time the Expense was incurred.

In the event that the Employee, retired or Disabled individual, widow or widower loses eligibility and later regains eligibility, the eligibility of an Alternate Recipient under an unexpired QMCSO will automatically be reinstated.

The Plan has adopted procedures to determine if a medical child support order is a Qualified Medical Support Order which are stated at Sections 1.33 and 5.26 herein.

Section 3.14 - Termination Of Coverage

Benefits for eligible Employees and Eligible Dependents shall terminate when they can no longer fulfill the eligibility requirements of the Plan as set forth herein or if the Plan is terminated. In the event the Plan is terminated, pending claims as of the date of termination will be paid in accordance with the terms of the Plan then in effect. The eligibility of a child shall terminate on the later of the date of his reaching his age twenty-six (26) or the date he becomes eligible to enroll in an eligible employer-sponsored health plan through his employer or his spouse's employer, if married (except as defined under Eligible Dependent). The eligibility for a spouse shall terminate on the effective date of a divorce except as provided under the Continuation of Coverage under COBRA provisions. The eligibility of an Alternate Recipient who is receiving benefits pursuant to a Qualified Medical Child Support Order (QMCSO) shall terminate on the earlier of the date the Employee loses his eligibility or the date specified in the QMCSO. Termination of coverage also occurs on the effective date of the withdrawal of a participating local Union from the Plan.

A spouse of an Employee may opt out of the Plan's coverage due to eligibility under a high deductible health plan (such as a Health Savings Account) through the spouse's employer, by completing the Plan's appropriate form with proof that the spouse has a high deductible healthcare plan. A spouse of an Employee may rejoin this Plan by completing the Plan's appropriate form with proof that the spouse is no longer being covered under the high deductible healthcare plan and that the Employee is still eligible under this Plan. Eligibility will commence on the first day of termination under the high deductible plan.

Section 3.15 - Eligibility For Retired Or Disabled Individuals

A retired or Disabled individual who has been employed under the jurisdiction of the Plan may become eligible for benefits for himself and his Eligible Dependents under the Retired and Disabled Employee Program if he meets all of the following terms and conditions:

(A) **Eligibility**

(1) The individual provides proof that he is receiving pension or disability benefit payments from a pension plan to which a local Union affiliated with the United Association of Plumbers and Pipefitters is a sponsor and has been eligible under the Plan under the active contribution rate for twelve (12) consecutive months immediately preceding the date of receiving the retiree contribution rate. In the event the individual is not eligible for one (1) of the aforementioned pensions plans, the individual must have been continuously eligible under the Plan for five (5) years immediately preceding the date of application to the Retiree and Disabled Employee Program.

(2) If retired, the individual is at least age fifty-five (55).

(3) If Disabled, the individual is receiving disability benefits from the Social Security Administration.

(4) If qualified, the initial eligibility date of coverage shall be the first day of the Benefit Quarter following the date the application is approved or proof of pension or disability payments is received and proper payment is received. Dependents must meet the definition of Eligible Dependent as set forth in Section 1.15.

Retired or Disabled Employees who fail to enroll within the time limits set forth herein shall forfeit all future rights to participate in the Retired and Disabled Employee Program for themselves and their Eligible Dependents.

(B) **Contribution Payments**

Contribution payments must be made on a monthly or quarterly basis and must be made by the tenth day of the eligibility month or the tenth day of the first month of the Benefit Quarter.

Effective with Retirees who retire on or after February 1, 2019, the base amount of monthly contribution payments will be set by the Board of Trustees. If a Retiree has at least 5 years of service with the Plumbers and Pipefitters National Pension Fund or this Plan the Retiree will be granted a 2.5% reduction in the contribution amount for each year of service. If a Retiree does not participate in the Plumbers and Pipefitters National Pension Fund, the initial eligibility date of coverage under the Pipe Trades Industry Health & Welfare Plan will be used to determine the years of service at retirement. The minimum contribution payment is $375 per month for pre-Medicare coverage and $302 per month for Medicare coverage.

Failure to make timely and continuous payments as described above shall terminate the individual's right to make further payments and be covered under this Plan. NO LATE PAYMENTS SHALL BE ACCEPTED.

(C) **Benefits**

Benefits payable under the Retired and Disabled Employee Program shall be the same as provided to active, eligible Employees with the exceptions that the Death and Accidental Death and Dismemberment Benefits shall be Four Thousand Five Hundred Dollars ($4,500) each and no Weekly Disability Benefits shall be paid. In addition, all benefits shall be coordinated with any other group health insurance plan, health and welfare program, Medicare or Medicaid program, including the Prescription Drug Benefit coordinating with Medicare Part D. The Plan provides its own Medicare Part D coverage, which is explained in Section 3.17.

(D) **Termination of Coverage**

Coverage under the Retired or Disabled Employee Program shall terminate on:

(1) the first day of any month for which no contribution is paid; or

(2) the last day of the month during which the covered person fails to meet the eligibility rules or fails to meet the definition of Eligible Dependent.

(3) the effective date of the withdrawal of the Employee's Union from the Plan.

The Trustees reserve the right to terminate benefits or to change the requirements for participation of retired or Disabled members.

Section 3.16 - Eligibility For Widows/Widowers Of Active Employees Or Retired Or Disabled Employees

The widow or widower of a deceased, active Employee or eligible retired or Disabled individual and his Eligible Dependents that were eligible under this Plan at the time of death may elect to maintain eligibility for benefits from the Plan by making self-payments in a timely manner as set by the Trustees provided the widow or widower meets all of the following terms and conditions:

(A) **Eligibility**

In order to be eligible for this program, the widow or widower:

(1) will become eligible upon the death of the active, eligible Employee or retired or Disabled individual and upon approval of the Plan.

(2) will become eligible no later than ninety (90) days after the expiration or cancellation of any other health care plan, program or policy in effect on the active, eligible Employee or retired or Disabled individual's date of death, which provided coverage to such widow or widower, including COBRA coverage and upon approval of the Plan.

(B) **Effective Date of Coverage**

The widow or widower's coverage under this program shall commence with the first day of the month following the receipt of the required self-payment and approval by the Trustees.

(C) **Contribution Payments**

Contribution payments must be made on a monthly or quarterly basis and must be made by the tenth day of the eligibility month or the tenth day of the first month of the Benefit Quarter.

Failure to make timely and continuous payments as described above shall terminate the individual's right to make further payments and be covered under this Plan. NO LATE PAYMENTS SHALL BE ACCEPTED.

(D) **Benefits**

Benefits payable under the Widow/Widower Program shall be the same as provided to the dependent spouse of active, eligible Employees or retired or Disabled individuals. In addition, all benefits shall be coordinated with Medicare or Medicaid program. **No Death, Accidental Death and Dismemberment or Weekly Disability Benefits shall** be payable.

(E) **Termination of Coverage**

Coverage under the Widow/Widower Program shall terminate on:

(1) the first day of any month for which no contribution is paid; or

(2) the first day of the Benefit Quarter following the Benefit Quarter in which the widow or widower remarries; or

(3) the first day of the Benefit Quarter in which the widow or widower is covered for benefits under another group health care or group insurance plan.

(4) the effective date of the withdrawal of the Employee's Union from the Plan.

The Trustees reserve the right to terminate benefits or to change the requirements for participation of widows or widowers.

Section 3.17 - Eligibility for Medicare Part D Coverage
The Plan has contracted with a Prescription Benefit Manager to provide Medicare eligible Participants with Medicare Part D coverage. This Plan also provides a supplement to Part D to cover certain things not covered under the Part D plan.

(A) Initial Enrollment
Effective January 2016 all current and future Medicare eligible participants in the Pipe Trades Industry Health and Welfare Plan will be automatically enrolled in Medicare Part D when the participant is first eligible to enroll.

(B) Annual Enrollment
Each year all Medicare eligible participants are allowed to disenroll in the Plan's Medicare Part D coverage. You will automatically continue to be covered unless you disenroll. (See Disenrollment information below) The annual enrollment period is October 15th through December 7th.

(C) Special Enrollment
If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for the other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends.

To request special enrollment or obtain more information, contact the Plan Office at (812) 877-2581.

(D) Disenrollment from Coverage (Opt Out) from Prescription Coverage
Each year during the open enrollment process, Medicare eligible participants will have an option to disenroll from the Plan's Part D coverage. If you choose to disenroll you will not be allowed to re-enroll in the future. Furthermore, if you disenroll from the Plan's Part D coverage, your monthly premium for the Supplemental coverage for Medicare Parts A & B will remain the same and the Plan will not supplement any other Medicare Part D program.

While you may drop the Medicare Part D coverage provided by the Plan, be aware you will never be able to reenroll, your monthly premium for the Supplement to Medicare coverage will remain the same, and the Plan will only coordinate with Medicare Parts A and B.

DESCRIPTION OF BENEFITS

Section 4.01 - Death Benefit
Upon the death of an eligible individual and receipt of proper proof of death, the Plan shall pay the Death Benefit as set forth in the Schedule of Benefits to the designated Beneficiary. In the event that the deceased Employee dies without designating a Beneficiary or in the event that the designated Beneficiary has predeceased the Employee, the amount of the Death Benefit shall be paid to the first applicable of the following surviving individuals in equal shares, in descending order:

> The deceased Employee's surviving Spouse; child or children; parents; siblings; or failing these, to the deceased Employee's estate.

Benefits payable to minor children may be paid to the minor's legal guardian.

Notwithstanding the foregoing, an Employee's designation of his spouse as Beneficiary shall become null and void automatically upon divorce. Should the Employee wish to maintain the Beneficiary designation of an ex-spouse, he must fill out a new beneficiary card after the divorce.

An eligible individual may designate a new Beneficiary at any time by filing a written request for a change on forms provided by the Plan. A change of Beneficiary shall NOT be effective until received by the Plan provided that said change is received prior to the eligible individual's death.

No Death Benefits shall be paid on behalf of a deceased Eligible Dependent, widow or widower.

Section 4.02 - Accidental Death And Dismemberment Benefit
When bodily Injury caused solely by a non-occupational Accident results in the death or dismemberment of an active, eligible Employee or retired or Disabled individual, the Plan shall pay a benefit as set forth in the Schedule of Benefits upon receipt of proper proof of loss.

No Accidental Death or Dismemberment Benefits shall be paid on behalf of a deceased or dismembered Eligible Dependent, widow or widower.

Section 4.03 - Weekly Disability Benefit
(Active, Eligible Employee Only)
Accrued Weekly Disability Benefits shall, subject to receipt of proper proof of loss, be paid provided the period for which payment is sought has elapsed.

When Sickness or Injury suffered on or off the job shall disable and prevent an active, eligible Employee in the labor market area from engaging in any gainful employment, the Plan shall pay the benefit set forth in the Schedule of Benefits. Benefits shall be paid for full weeks of disability only and no benefits shall be paid for partial weeks of disability. In the case of a disability which extends over two (2) calendar years, the maximum period of benefits will NOT extend beyond

the maximum period of fifteen (15) weeks. In order to qualify for additional benefits after a calendar year period, the Employee must return to active employment for one (1) full week consisting of forty (40) hours.

In the case of an Accident or Injury, payment will be made beginning with the first day of the Accident or Injury. In the case of a Sickness, payment will begin on the eighth day of the Sickness.

Payment will NOT be made if:

(A) the Employee engages in any work or gainful employment during any period for which he is claiming benefits; or

(B) the Employee is NOT under the regular care and treatment of a Physician or surgeon; or

(C) the Employee is receiving a salary or would be receiving pay while in either a retired status or while sick or Injured.

In accordance with federal law, the appropriate amount of Social Security taxes (FICA) shall be withheld from each payment and forwarded to the appropriate governmental agency.

No Weekly Disability Benefits shall be paid on behalf of an Eligible Dependent, a retired or Disabled individual or a widow or widower.

Section 4.04 - Hospital Room And Board Benefit

If a non-occupational Accident, Injury or Sickness causes an eligible individual to be confined in a Hospital, except for expenses related to Maternity in the case of an Eligible Dependent child, and provided that the confinement commenced while the individual was eligible under this Plan, the Plan shall pay benefits at the rate of eighty percent (80%) of the Usual, Customary and Reasonable Charge incurred for an average semi-private room per confinement. **(SUBJECT TO THE DEDUCTIBLE)** For Hospital confinements which overlap calendar years, all benefits shall be calculated as if the entire confinement occurred during the calendar year of admittance.

NOTE: Weekend (Friday, Saturday or Sunday) admissions and charges related thereto shall NOT be covered except in the case of a medical Emergency or when a Surgical Procedure is scheduled for the following day.

Section 4.05 - Intensive Care, Coronary Care And Constant Care Unit Benefit

If a non-occupational Accident, Injury or Sickness causes an eligible individual to be confined in an Intensive Care, Coronary Care or Constant Care Unit of a Hospital, except for expenses related to Maternity in the case of an Eligible Dependent child, and provided that the confinement commenced while the individual was eligible under this Plan, the Plan shall pay benefits at the rate of eighty percent (80%) of the Usual, Customary and Reasonable charge incurred for the Intensive Care, Coronary Care or Constant Care Unit per confinement. **(SUBJECT TO THE DEDUCTIBLE)** For Hospital confinements which overlap calendar years, all benefits shall be calculated as if the entire confinement occurred during the calendar year of admittance.

Section 4.06 - Hospital Miscellaneous Expense Benefit

If a non-occupational Accident, Injury or Sickness causes an eligible individual to incur Expense for miscellaneous services while confined in a Hospital as an inpatient or while treated as an outpatient, except for expenses related to Maternity in the case of an Eligible Dependent child, the Plan shall pay benefits at the rate of eighty percent (80%) of the Usual, Customary and Reasonable Charge incurred for eligible miscellaneous expenses. **(SUBJECT TO THE DEDUCTIBLE)** For Hospital confinements which overlap calendar years, all benefits shall be calculated as if the entire confinement occurred during the calendar year of admittance.

Medical Services Covered

The Plan shall pay expenses for the following Medically Necessary medical related services:

(A) general nursing services;

(B) inpatient radiology, pathology and cardiology;

(C) pharmacy charges;

(D) local professional emergency ambulance service;

(E) emergency transportation to the nearest Hospital equipped to furnish special or unique treatment if the Injury or Sickness requires such treatment;

(F) use of the operating, delivery, recovery and treatment rooms and equipment;

(G) administration of blood or fractionalized blood products;

(H) medical and surgical dressings, supplies, casts, splints, trusses and crutches;

(I) rental (up to the purchase price) of a hospital type bed, or iron lung;

(J) diagnostic and therapy services; and

(K) artificial limbs and eyes to replace natural limbs and eyes lost.

Dental Services Covered

The Plan shall pay expenses for the following Medically Necessary dental related services:

(A) Dental services rendered by a Physician or dentist for treatment within one (1) year of an Injury to the jaw or natural teeth, including the initial replacement of those teeth and any necessary dental x-rays, provided such Injury is the result of an accident. For purposes of this Section, the term "accident" does not include Injuries to a tooth caused while eating or chewing.

(B) General anesthesia and monitored anesthesia care as well as related medical facility expenses for dental services for dependent children exhibiting physical, intellectual or medically compromising conditions, for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and which, under anesthesia, can be expected to produce a superior result. Conditions must be verified by medical documentation and include but are not limited to mental retardation, cerebral palsy, epilepsy, and autism.

Section 4.07 - Physician's Visits (In Hospital)
The Plan shall pay eighty percent (80%) of the Usual, Customary and Reasonable Charge for Expense incurred for professional services and/or visits by a Physician while an eligible individual is confined in a Hospital as an inpatient except for expenses related to Maternity in the case of an Eligible Dependent child. (**SUBJECT TO THE DEDUCTIBLE**) For Hospital confinements which overlap calendar years, all benefits shall be calculated as if the entire confinement occurred during the calendar year of admittance.

Section 4.08 - Surgery Benefit (In/Outpatient)
The Plan shall pay eighty percent (80%) of the Usual, Customary and Reasonable Charge for Expense incurred for a qualified surgeon for covered Surgical Procedures performed on an eligible individual except for expenses related to Maternity in the case of an Eligible Dependent child. Surgery Benefits shall be payable whether the Surgical Procedure was performed in a Hospital, the Physician's office or elsewhere. **(SUBJECT TO THE DEDUCTIBLE)** For Hospital confinements which overlap calendar years, all benefits shall be calculated as if the entire confinement occurred during the calendar year of admittance.

Section 4.09 - Anesthesia Benefit
The Plan shall pay eighty percent (80%) of the Usual, Customary and Reasonable Charge for Expense incurred for a qualified anesthesiologist for services performed during a covered Surgical Procedure performed on an eligible individual except for expenses related to Maternity in the case of an Eligible Dependent child. **(SUBJECT TO THE DEDUCTIBLE)** For Hospital confinements which overlap calendar years, all benefits shall be calculated as if the entire confinement occurred during the calendar year of admittance.

Section 4.10 - Maternity Benefit
The Plan shall pay eighty percent (80%) of the Usual, Customary and Reasonable Charge for Expense incurred by an eligible female Employee or dependent spouse for Physician's services, Hospital and obstetrical services and supplies ordered by a Physician, local emergency ambulance service to and from the Hospital due to pregnancy and/or resulting childbirth, and any anesthesia administered during childbirth. **(SUBJECT TO THE DEDUCTIBLE)** For Hospital confinements which overlap calendar years, all benefits shall be calculated as if the entire confinement occurred during the calendar year of admittance.

Under the Newborns' and Mothers' Health Protection Act, group health plans and health insurance issuers offering group health insurance coverage generally may NOT restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, the Plan, or issuer, may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48) hour or ninety-six (96) hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to forty-eight (48) hours or ninety-six (96) hours, as applicable.

Nursery charges shall be paid in accordance with the above.

Maternity Benefits shall NOT be paid for expenses incurred by an Eligible Dependent child.

Section 4.11 - Physician's Visits (In Office)
The Plan shall pay eighty percent (80%) of the Usual, Customary and Reasonable Charge for Expenses incurred by an eligible individual for services rendered by a Physician in his office for treatment for an Accident, Injury or Sickness. **(SUBJECT TO THE DEDUCTIBLE)**

Section 4.12 - X-Ray And Laboratory Benefit (Outpatient)
The Plan shall pay eighty percent (80%) of the Usual, Customary and Reasonable Charge incurred by an eligible individual for outpatient x-ray and laboratory services used in the diagnosis or treatment for an Accident, Injury or Sickness. **(SUBJECT TO THE DEDUCTIBLE)**

Section 4.13 - Chiropractic Benefit
The Plan shall pay eighty percent (80%) of the Usual, Customary and Reasonable charge incurred by an eligible individual for chiropractic services and x-rays, subject to a maximum annual benefit of One Thousand Dollars ($1,000.00) per person (**SUBJECT TO THE DEDUCTIBLE**).

Any out-of-pocket expense incurred under this benefit shall NOT be included in or accrue towards the Out-of-Pocket Limit.

Section 4.14 - Prescription Drug Benefit
Prescription Drug Benefits are available to all participants and Eligible Dependents. The Plan has contracted with a Pharmacy Benefit Manager (PBM) to provide participants and Eligible Dependents with prescription drugs through both a retail pharmacy program and a mail order program. The Plan has also contracted with a Medicare Part D carrier to provide the Medicare eligible participants with both a Part D plan as well as a “wrap” that supplements the Medicare Part D plan. If medication is needed for only a short time (two months or less), it is best to choose a retail pharmacy to fill the prescription. If medication is needed for more than two months (maintenance prescription drugs), it is best to choose the mail order pharmacy to fill the prescription in order to receive the highest benefit. The benefits applicable to both programs are shown on the Schedules of Benefits and are explained in this Section.

IN-NETWORK RETAIL PHARMACY

ACTIVES

Up to 34 day supply

One hundred percent (100%) of the covered charge for maintenance drugs and medications after the Co-Payment of Thirty-Five Dollars ($35.00) per prescription for brand name drugs and the Co-Payment of Twenty Dollars ($20.00) per prescription for generic drugs if purchased **IN-NETWORK** (retail pharmacy). **(THE DEDUCTIBLE IS WAIVED UNDER THIS PROGRAM)**

35 to 60 day supply

One hundred percent (100%) of the covered charge for maintenance drugs and medications after the Co-Payment of Seventy Dollars ($70.00) per prescription for brand name drugs and the Co-Payment of Forty Dollars ($40.00) per prescription for generic drugs if purchased **IN-NETWORK** (retail pharmacy). **(THE DEDUCTIBLE IS WAIVED UNDER THIS PROGRAM)**

61 to 90 day supply

One hundred percent (100%) of the covered charge for maintenance drugs and medications after the Co-Payment of One Hundred Five Dollars ($105.00) per prescription for brand name drugs and the Co-Payment of Sixty Dollars ($60.00) per prescription for generic drugs if purchased **IN-NETWORK** (retail pharmacy). **(THE DEDUCTIBLE IS WAIVED UNDER THIS PROGRAM)**

NON-MEDICARE RETIREES

Up to 34 day supply

One hundred percent (100%) of the covered charge for maintenance drugs and medications after the Co-Payment of Thirty Dollars ($30.00) per prescription for brand name drugs and the Co-Payment of Fifteen Dollars ($15.00) per prescription for generic drugs if purchased **IN-NETWORK** (retail pharmacy). **(THE DEDUCTIBLE IS WAIVED UNDER THIS PROGRAM)**

35 to 60 day supply

One hundred percent (100%) of the covered charge for maintenance drugs and medications after the Co-Payment of Sixty Dollars ($60.00) per prescription for brand name drugs and the Co-Payment of Thirty Dollars ($30.00) per prescription for generic drugs if purchased **IN-NETWORK** (retail pharmacy). **(THE DEDUCTIBLE IS WAIVED UNDER THIS PROGRAM)**

61 to 90 day supply

One hundred percent (100%) of the covered charge for maintenance drugs and medications after the Co-Payment of Ninety Dollars ($90.00) per prescription for brand name drugs and the Co-Payment of Forty-Five Dollars ($45.00) per prescription for generic drugs if purchased **IN-NETWORK** (retail pharmacy). **(THE DEDUCTIBLE IS WAIVED UNDER THIS PROGRAM)**

MEDICARE RETIREES
Up to 34 day supply
One hundred percent (100%) of the covered charge for maintenance drugs and medications after the Co-Payment of Twenty-Five Dollars ($25.00) per prescription for brand name drugs and the Co-Payment of Ten Dollars ($10.00) per prescription for generic drugs if purchased **IN-NETWORK** (retail pharmacy). **(THE DEDUCTIBLE IS WAIVED UNDER THIS PROGRAM)**

35 to 60 day supply
One hundred percent (100%) of the covered charge for maintenance drugs and medications after the Co-Payment of Fifty Dollars ($50.00) per prescription for brand name drugs and the Co-Payment of Twenty Dollars ($20.00) per prescription for generic drugs if purchased **IN-NETWORK** (retail pharmacy). **(THE DEDUCTIBLE IS WAIVED UNDER THIS PROGRAM)**

61 to 90 day supply
One hundred percent (100%) of the covered charge for maintenance drugs and medications after the Co-Payment of Ninety Dollars ($75.00) per prescription for brand name drugs and the Co-Payment of Forty-Five Dollars ($30.00) per prescription for generic drugs if purchased **IN-NETWORK** (retail pharmacy). **(THE DEDUCTIBLE IS WAIVED UNDER THIS PROGRAM)**

IN-NETWORK MAIL ORDER

ACTIVES
One hundred percent (100%) of the covered charge for maintenance drugs and medications after the Co-Payment of Sixty-Five Dollars ($65.00) per prescription for brand name drugs and the Co-Payment of Thirty-Five Dollars ($35.00) per prescription for generic drugs if purchased through **the mail order pharmacy program**. **(THE DEDUCTIBLE IS WAIVED UNDER THIS PROGRAM)**

NON-MEDICARE RETIREES
One hundred percent (100%) of the covered charge for maintenance drugs and medications after the Co-Payment of Fifty-Five Dollars ($55.00) per prescription for brand name drugs and the Co-Payment of Twenty-Five Dollars ($25.00) per prescription for generic drugs if purchased through **the mail order pharmacy program**. **(THE DEDUCTIBLE IS WAIVED UNDER THIS PROGRAM)**

MEDICARE RETIREES
One hundred percent (100%) of the covered charge for maintenance drugs and medications after the Co-Payment of Fifty Dollars ($50.00) per prescription for brand name drugs and the Co-Payment of Twenty Dollars ($20.00) per prescription for generic drugs if purchased through **the mail order pharmacy program**. **(THE DEDUCTIBLE IS WAIVED UNDER THIS PROGRAM)**

OUT-OF-NETWORK RETAIL PHARMACY
Fifty percent (50%) of charges, after satisfaction of the Deductible, if the drug was purchased in a retail pharmacy without using the prescription drug card. **Out-of-Network retail pharmacy drugs are not covered for Medicare Retirees.**

DEFINITIONS

The following definitions apply to all Prescription Drug Benefits.

Legend Drugs
"Legend Drugs" means drugs which have the following legend on the container: CAUTION, FEDERAL LAW PROHIBITS DISPENSING WITHOUT A PRESCRIPTION.

Prescription Drugs
"Prescription Drugs" means Legend Drugs and drugs which:

(A) require a written prescription executed by a Physician according to state law; and

(B) are dispensed by a licensed pharmacist or a Hospital Pharmacy for take home use.

Compounded Medication
"Compounded Medication" is an extemporaneously prepared dosage form. If liquid, it must include the weighing of at least one (1) solid or the measuring and mixing of at least three (3) liquid ingredients. It must also contain at least one (1) federal Legend Drug or state restricted drug in a therapeutic amount, or a combination of ingredients which require a prescription by law when compounded into a specific dosage form for an individual patient at the direction of the prescriber, and which is also therapeutic.

PRESCRIPTION EXCLUSIONS AND LIMITATIONS

Payment for prescription drugs and medications shall be subject to the following limitations and exclusions:

(A) injectable insulin, insulin needles and syringes (disposable or permanent) shall be payable only if by prescription;

(B) diaphragm kits and introducers shall be payable only if by prescription;

(C) reimbursement shall be limited to a thirty-four (34) day supply per prescription or a three (3) month supply if filled by mail order;

(D) prescriptions refills shall be limited to a maximum of five (5) in a six (6) month period;

(E) no payment shall be made for a prescription refill which is six (6) months or more after the original issue date;

(F) no payment shall be made for drugs which can be legally obtained without a prescription, except for insulin;

(G) no payment shall be made for drugs or medications labeled: "Caution - limited by federal law to investigational use", or experimental drugs, even though a charge may be made to the individual;

(H) no payment shall be made for prescription refills which are in excess of the number authorized by the prescribing Physician;

(I) no payment shall be made for drugs and insulin dispensed in a rest home, sanitorium, extended care facility, convalescent Hospital, nursing home, skilled nursing facility or similar institution which operates an outpatient facility on its premises;

(J) no payment shall be made for contraceptive jellies, ointments, creams, foams or other devices intended to prevent pregnancy;

(K) no payment shall be made for drugs or medications for which no charge is made or for which the charges were covered under a Workers Compensation or Occupational Disease law, or by a state or federal governmental agency; or

(L) no payment shall be made for drugs or medications for treatment of sexual dysfunction.

Prescriptions for smoking cessation drugs purchased using the Pharmacy Benefit Manager's drug card are payable at the normal retail Co-Payment rate up to a lifetime limit of $500 per person, available only to the eligible Employee and spouse. Eligible Dependent children are not eligible for reimbursement of these prescriptions.

Section 4.15 - Alcohol And Drug Related Illnesses Benefit
When alcoholism, chemical dependency or substance abuse causes an eligible Employee or Eligible Dependent to incur expenses for inpatient or outpatient treatment at a Hospital or Substance Abuse Treatment Center, the Plan shall pay benefits at eighty percent (80%) of the Usual, Customary and Reasonable Charges for the Hospital, Substance Abuse Treatment Center and Physician's charges (including psychiatrists, psychologists and licensed clinical social workers) incurred for treatment of alcohol and drug related Sicknesses. **(SUBJECT TO THE DEDUCTIBLE)**

Inpatient services must be provided by an In-Network facility.

Certain participating Local Unions have an employee assistance program available through the Union at no cost to the eligible Employee or Eligible Dependent. Please contact your Local Union for more information regarding these programs.

Detoxification Services
Treatment for detoxification will be covered if performed in a Hospital or Substance Abuse Treatment Center that is licensed for this level of care, has a Physician on staff and have registered nurses on staff 24/7.

Substance Abuse Treatment Conditions
Substance Abuse treatment including detoxification, inpatient rehab, a partial Hospital program or intensive outpatient program will be covered provided the services are Medically Necessary and the attending Physician, as defined under the Welfare Plan, prepares and maintains a written plan for admission, care, treatment and discharge for each patient based on the diagnostic assessment of the patient's medical, psychological and social needs, with documentation that the plan is under the direction of a Physician.

Contact the Fund's case management provider, Med-Care Management, Inc., toll-free at (800) 367-1934 to obtain pre-certification for inpatient stays or to receive more information regarding this benefit.

Section 4.16 - Nervous, Mental, Or Psychiatric Disorder Treatment Benefit
The Plan shall pay eighty percent (80%) of the Usual, Customary and Reasonable Charge incurred for Expenses incurred by an eligible individual for the treatment of a nervous, mental or psychiatric disorder. Benefits are paid on the same basis as any other medical condition. **(SUBJECT TO THE DEDUCTIBLE)**

Section 4.17 - Durable Medical Equipment Benefit
The Plan shall pay eighty percent (80%) of the Usual, Customary and Reasonable Charge for Expense incurred by an eligible individual for covered Expenses for Durable Medical Equipment. **(SUBJECT TO THE DEDUCTIBLE)**

Examples of Durable Medical Equipment shall include, but shall not be limited to, artificial eyes and limbs to replace lost or natural eyes and/or limbs; oxygen concentrator units and the rental of equipment to administer oxygen, delivery pumps for tube feedings, surgical dressings and bandages, casts, splints, trusses, crutches or braces that stabilize an injured body part, mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions and rental, up to the purchase price, of a standard Hospital type bed, or an iron lung. Nondurable supplies (i.e. tubing, connectors and masks) are a Covered Expense when used with covered Durable Medical Equipment. This Plan does not cover special fittings, adaptations or maintenance agreements related to covered Durable Medical Equipment.

Covered Expenses shall include rental (up to the purchase price), purchase, fitting, necessary adjustments, repairs and replacement of integral parts of the Durable Medical Equipment.

Section 4.18 - Wheelchair Or Motorized Scooter Benefit
The Plan shall pay eighty percent (80%) of the Usual, Customary and Reasonable Charge for Expense incurred by an eligible individual for the purchase of a wheelchair, motorized scooter, lift chair or like equipment. **(SUBJECT TO THE DEDUCTIBLE)**

Only one wheelchair may be rented, or if less costly, purchased at a time. The type of wheelchair is based on the patient’s physical condition and should be usable primarily inside, but

also outside the home. The Plan follows Medicare guidelines when determining what type of equipment is covered. Please use the pre-certification process in order to make sure coverage is available for the type of equipment you need.

A replacement wheelchair is considered medically necessary only when there is a change in the patient's physical condition or when the wheelchair is inoperative and cannot be repaired at a cost less than rental or replacement.

A one month rental of a wheelchair is covered if a patient owned wheelchair is being repaired

Please call the Plan Office with any questions about the Wheelchair or Motorized Scooter benefit.

Section 4.19 - Private Duty Nursing And Rehabilitative Services
The Plan shall pay eighty percent (80%) of the Usual, Customary and Reasonable Charge for Expense incurred by an eligible individual for covered Expenses of a licensed physical therapist, registered graduate nurse (R.N.) or licensed practical nurse (LPN) for private duty nursing services only when prescribed by the attending Physician. **(SUBJECT TO THE DEDUCTIBLE)**

Section 4.20 - Enteral Or Parenteral Nutrition Therapy
The Plan shall pay eighty percent (80%) of the Usual, Customary and Reasonable Charge for Expense incurred by an eligible individual for covered Expenses for enteral or parenteral nutrition therapy under the following guidelines. **(SUBJECT TO THE DEDUCTIBLE)**

Enteral nutritional therapy shall be considered reasonable and necessary for an individual with a functioning gastrointestinal tract which, due to a pathologic cause or the non-function of the structures that normally permit food to reach the digestive tract, cannot maintain weight and strength commensurate with the individual's general condition. Enteral nutritional therapy may be given through nasogastric, jejunostomy or gastrostomy tubes. The therapy can be provided in the home by a nonprofessional who has undergone special training. The standard guidelines for consideration of coverage require that the individual have a permanently inoperative internal body organ or function thereof and that the impairment be of long and indefinite duration. Temporary impairments shall not be covered. The use of a pump is usually not necessary and shall only be covered if medical documentation establishes that gravity feeding is not satisfactory. Enteral nutrients shall be a covered expense and shall be limited to a one (1) month supply at a time.

Parenteral nutrition therapy involves an indwelling catheter by which intravenous transfusion of nutrients is given for part of a day. During periods between infusions, the catheter is plugged by the individual.

Daily parenteral nutrition therapy shall be considered reasonable and necessary for a patient with severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the individuals general condition such as a massive bowel resection resulting in severe nutritional deficiency in spite of adequate oral intake.

Section 4.21 - Organ Transplant Benefit
The Plan will pay eighty percent (80%) of the Usual, Customary and Reasonable Charge for the eligible Expense incurred by an eligible individual for an organ transplant up to the limits of the Plan. Benefits shall be limited to organ procurement (acquisition) costs and the costs associated with the actual transplantation of the organ. **(SUBJECT TO THE DEDUCTIBLE)**

No benefits will be paid for any expenses incurred by the organ donor.

Section 4.22 - Wellness Benefits

Benefits will be paid in full for the routine preventative services listed in the chart below.

Routine Physical Exam	Age two (2) and over: Maximum one (1) visit per Calendar Year – office call paid at 100%. All other Covered Charges in connection with the Routine Physical Exam will be paid under the Medical Benefit Provisions at 80% after the Deductible Amount has been met.
Routine Cervical Cancer Screening (Pap Smear Test)	One (1) per year.
Routine PSA Test (Prostate Specific Antigen for Prostate Cancer Screening)	One (1) per year.
Mammogram (Breast Cancer Screening)	Age forty (40) and over: One (1) per year.
Sigmoidoscopy (Colorectal Cancer Screening)	Age fifty (50) and over: One (1) sigmoidoscopy every five (5) calendar years.
Colonoscopy (Colorectal Cancer Screening)	Age fifty (50) and over: One (1) colonoscopy every five (5) calendar years.
Well-Child Exam & Routine Immunizations	From birth through age twenty-four (24) months for routine well child visits and all routine immunizations recommended by the Center for Disease Control.

Routine Adult and Childhood Immunizations (age two (2) and over)	If recommended by the Physician, excluding occupation or vacation travel necessity, as recommended by the Center for Disease Control.

Section 4.23 - LiveHealth Online Doctor Visit Benefit

The LiveHealth Online Doctor Visit Benefit utilizes Anthem's LiveHealth Online program to give covered persons the capability to speak with a certified physician online (with a webcam) or through a smartphone in order to get quick access to certain prescriptions or other advice regarding a medical situation. This on-line doctor visit benefit is available 24 hours a day, 7 days a week and can be accessed at www.livehealthonline.com. You can get technical assistance by calling toll-free at (855) 603-7985. This benefit is not meant for emergency situations but it can help in deciding whether a medical situation is an emergency. You do not have to pay any Co-Payment, Coinsurance or Deductible to use LiveHealth Online. Benefits for LiveHealth Online Doctor Visits are payable according to the Schedule of Benefits. No benefits will be payable for any other online program.

MISCELLANEOUS PROVISIONS

Section 5.01 - Exclusions And Limitations
The Plan provides benefits only for those Expenses expressly described herein and any omission shall be presumed to be an exclusion even though not expressly stated as such.

No benefits shall be paid for any expense incurred as a result of:

(1) treatment, services or supplies that are not Medically Necessary;

(2) services or supplies for tooth extractions or other dental care, including orthodontics that involves any tooth or tooth structure, alveolar process, abscess, periodontal disease or disease of the gingival tissue except for the surgical extraction of an impacted wisdom tooth or teeth, or the medically necessary extraction of teeth required prior to providing a medical procedure or treatment for a life-threatening medical condition;

(3) eye examinations, refractions or the fitting or cost of eyeglasses;

(4) services or supplies for radial keratotomy, LASIK or other medical procedures to eliminate the need for glasses or contacts;

(5) hearing aids or examinations to prescribe or fit them;

(6) Cosmetic surgery or reconstructive surgery except for: (A) accidental Injuries; (B) for repair of congenital defects of newborn eligible children; (C) for repair of the effects of a previous Surgical Procedure performed; (D) for reconstruction of a breast on which a mastectomy has been performed; (E) for surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance in conjunction with a mastectomy performed; (F) coverage for prostheses; and (G) physical complications of all states of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient;

(7) treatment, services or supplies which are NOT provided in accordance with generally accepted professional medical standards or for Experimental or investigative treatment or drugs and/ or medications which have NOT been proven to be safe and effective, including, but not limited to, drugs, medicines, services or supplies NOT covered by Medicare;

(8) hospitalization, medical or surgical treatment provided in a hospital or infirmary on any military installation, any Veterans' Administration facility or Public Health Service facility if such service or supply is rendered as a result of a military or armed service related condition;

(9) a self-inflicted Injury, Sickness or other condition or attempt at self destruction unless the Injury is in connection with a Medical Condition (except for Death Benefit);

(10) participation in or as a result of the commission of a criminal act (except for Death Benefit);

(11) Injury or Sickness which arises out of or occurs in the course of any occupation or employment for wage or profit, or which would entitle the individual to benefits under a Worker's Compensation or Occupational Disease law;

(12) bodily Injury or Sickness suffered or contracted while in the armed forces of any country;

(13) treatment, services or supplies rendered by a person who is a member of the eligible individual's immediate family or who normally resides in the household of the eligible individual;

(14) weight loss or diet control treatment of any type, including surgery;

(15) housekeeping or Custodial Care;

(16) treatment of temporomandibular joint dysfunction (TMJ), myofacial treatment or repair or mandibular or maxilla osteotomy;

(17) weekend (Friday, Saturday or Sunday) Hospital admissions unless due to medical Emergency or when surgery is scheduled for the following day;

(18) non-prescription or over-the-counter drugs and medications, even though prescribed by a Physician;

(19) pregnancy or childbearing by dependent children;

(20) travel, even though prescribed by a Physician;

(21) charges which are in excess of the Usual, Customary and Reasonable Charge in the geographical area where the services or supplies were rendered;

(22) services or supplies without a diagnosis of Injury or Sickness, except for covered preventative services and prophylactic simple mastectomies when medically necessary;

(23) Weekly Disability Benefits for retired individuals or individuals who are receiving disability payments from the Social Security Administration;

(24) expenses incurred for a penile prosthesis or any loss, expense or charge for sex transformation or treatment related to a sexual dysfunction;

(25) speech therapy, except when used to regain normal speech lost due to Accident, Injury or Sickness;

(26) corrective shoes;

(27) charges, Deductible Amounts or noncompliance penalties due to the failure of an eligible Employee or Eligible Dependent to use a preferred provider network when said individual is covered by the network and the Plan is the secondary plan;

(28) court ordered care unless the Plan is required to by applicable federal law;

(29) disposable supplies, except for colostomy supplies, syringes, lancets or chem-strips;

(30) personal hygiene and convenience items, such as but not limited to, air conditioners, humidifiers, hot tubs or spas, whirlpools, sunbeds, saunas, steambaths, waterbeds, physical fitness equipment or like items, health club or country club memberships even though a Physician may prescribe them or services by a masseuse or massage therapist. However, notwithstanding the foregoing, "oxygen humidifiers" are not excluded if the humidifier's use has been prescribed by a Physician in connection with Medically Necessary Durable Medical Equipment for purposes of moisturizing oxygen;

(31) services or supplies related to the treatment for use of nicotine from tobacco and other sources, except as allowed under the Plan's prescription drug program;

(32) telephone consultations, charges for the failure to keep a scheduled visit or for completing a claim form;

(33) services, supplies, medications or procedures related to infertility, sexual dysfunction or the inability to conceive including, but not limited to, sexual therapy or counseling, pharmaceutical treatment, in vitro or in vivo fertilization, gamete intrafallopian transfer or other forms of reproductive technologies or artificial insemination;

(34) services or supplies for sterilization reversal;

(35) personal items, including but not limited to, telephones, televisions, newspapers, cots, and visitors' meals;

(36) inpatient services at nursing homes, skilled nursing facilities, hospice care facilities or other similar extended care facilities (except for physical or rehabilitative therapy when performed on an outpatient basis);

(37) blood donations;

(38) recreational therapy, even though prescribed by a Physician;

(39) services or supplies to treat hair loss or to restore lost hair;

(40) chelation therapy except for acute arsenic, gold, mercury or lead poisoning;

(41) elective abortions, except in the case of rape, incest or to save the life or to protect the life of the mother;

(42) Developmental Care, as defined in this Plan, regardless of where or by whom provided;

(43) hospice care or transitional care; or

(44) any Injury or Sickness which arises out of or occurs as a result of a third party whose insurance may be responsible for paying your or your Eligible Dependents related medical expenses.

(45) Treatment, services or supplies provided outside the United States of America, except for Emergencies.

(46) Inpatient Alcohol and Drug Related Illnesses services at an Out-of-Network residential substance abuse treatment facility.

Section 5.02 - Coordination Of Benefits

If an eligible individual is entitled to benefits under any other "Plan" (as that term is defined below) which will pay all or part of the expenses incurred for treatment for an Accident, Injury or Sickness, the amount of benefits payable under this Plan and any other Plan shall be coordinated so that the total amount paid will NOT exceed one hundred percent (100%) of the expenses incurred. In no event shall the amount of benefits paid by this Plan exceed the amount which would have been paid in the absence of any other Plan.

The term **"Plan"**, as used in this Section, shall include any plan providing benefits or services for or by reason of hospitalization, medical or dental care or treatment, which benefits or services are provided by: a) group, blanket or franchise insurance coverage; b) group Blue Cross/Blue Shield and other prepayment coverage provided on a group basis; c) automobile insurance policy, which provides medical payments; d) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefit organization or any other arrangement of benefits for individuals or a group; and e) any coverage under governmental programs, and any coverage required or provided by any statute.

(A) **EFFECT ON BENEFITS**

When more than one (1) Plan covers the person for whom Allowable Expenses were incurred, benefits shall be paid according to the Order of Benefit Determination. **"Allowable Expenses"** means any reasonable and customary charge which: (1) is a charge for an item of necessary medical expense; (2) is an expense which the covered person must pay; and (3) is an expense at least part of which is covered under at least one (1) of the Plans which covers the person for whom the claim is made. When a Plan provides fixed benefits for specified events or conditions rather than benefits based upon expenses, any benefits under the Plan shall be deemed to be an

Allowable Expense. When a Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid. Allowable Expenses do NOT include expenses for services rendered because of an occupational Injury or Sickness.

(B) ORDER OF BENEFIT DETERMINATION

The order of benefit determination shall be as follows:

(1) The Plan that covers the eligible person as an employee shall be the "primary Plan" and shall pay its benefits first.

(2) The Plan that covers the eligible person as a dependent shall be the "secondary Plan" and shall pay its benefits after the "primary Plan".

(3) Active/Inactive Employee Rule: If one spouse is actively working and is covered by his or her employer's plan as an active employee and the other spouse is laid off or retired and is covered by his or her employer's plan as anything other than as an active employee, the following rules apply:

   (a) The plan of the spouse that is covered as an active employee pays benefits first (for the employee and the employee's dependents).

   (b) The plan of the spouse that is covered as anything other than an active employee (as a laid off or retired employee) pays benefits second (for that person and that person's dependents).

   (c) If the laid off or retired employee is eligible for Medicare, Medicare would pay second and the plan of the spouse that is covered as anything other than an active employee (as a laid off or retired employee) pays benefits third.

(4) With regards to dependent children:

   (a) The Plan, if any, which covers the dependent child as an Employee shall pay first.

   (b) The Plan, if any, which covers the dependent child as a Spouse shall pay second.

   (c) Once any insurance available via Employee (a above) or Spouse (b above) coverage is exhausted, the "primary plan" between parents shall be the Plan of the parent whose birthday (excluding the year of birth) occurs first in a calendar year; provided that, if both parents have the same birthday (excluding the year of birth), the Plan which has covered the parent for the longer period of time shall be the "primary Plan".

   (d) When the parents are separated or divorced, if there is a court order establishing the responsibility for medical, dental or other health care expenses with respect to said children, benefits shall be determined in accordance with the court order. In the absence of a court order, if the parent with custody has NOT remarried, the

Plan of the parent with custody shall be the "primary plan". If the parent with custody has remarried, the Plan of the parent with custody shall be the "primary plan", the plan of the stepparent shall be the "secondary plan", and the plan of the parent without custody shall pay third.

(5) If none of the above rules determine the order of benefit determination or if the other Plan has a rule which is in conflict with these provisions, the plan which has covered the person for the longer period of time shall be the "primary plan".

The Coordination of Benefits provisions shall apply to all benefits provided under the Plan with the exception of the Death Benefit, Accidental Death and Dismemberment Benefit and the Weekly Disability Benefit.

Section 5.03 - Subrogation (Right Of Restitution)

Were you or your Eligible Dependent Injured in an Accident for which someone else is liable? If so, that person or his insurance may be responsible for paying your or your Eligible Dependent's related medical expenses and these expenses would not be covered under the Plan. However, waiting for a third party to pay for these Injuries may be difficult; recovery from a third party may take a long time (you may have to go to court) and your creditors may not wait patiently. Because of this, as a service to you, the Plan will advance you or your Eligible Dependent benefit payments related to such an accident based on the Plan's rights of restitution and subrogation. This means, you must reimburse the Plan if you obtain recovery from any person or entity.

The Plan shall receive restitution for all benefit payments made as the result of the Injuries or Sicknesses which are caused by the actions of a third party and which give rise to a court ordered financial award or out-of court settlement to you or your Eligible Dependent from a third party tort-feasor, person or entity. This Plan will provide benefits, otherwise not payable under this Plan, to or on behalf of you or your Eligible Dependent, only on the following terms and conditions:

(A) In the event of any payment under this Plan, the Plan shall be subrogated to all of your or your Eligible Dependent's rights of recovery against any person or organization.

This means that the Plan has an independent right to bring an action in connection with such Injury or Sickness in your or your Eligible Dependent's name and also has a right to intervene in any such action brought by you or your Eligible Dependent, including any action against an insurance carrier under any uninsured or underinsured motor vehicle policy.

(B) Consistent with the Plan's rights set forth in this Section, if you or your Eligible Dependent submit claims for or receive any benefit payments from the Plan for an Injury or Sickness that may give rise to any claim against any third-party, you and or your Eligible Dependent or your Eligible Dependent's representative will be required to execute a **"Subrogation Assignment of Rights, and Restitution Agreement"** affirming the Plan's rights of restitution and subrogation with respect to such benefit payments and claims. This form will assist the Plan in recovering benefits paid from a third party who was responsible for the Injuries giving rise to the claims. This Agreement must also be executed by you or your Eligible Dependent's attorney, if applicable.

Because benefit payments are not payable unless you sign a Subrogation Assignment of Rights, and Restitution Agreement, you or your Eligible Dependent's claims will not be paid until the fully signed Agreement is received by the Plan.

This means that, if you file a claim and your Subrogation Assignment of Rights, and Restitution Agreement is not received promptly, the claim will not be paid.

(C) You or your Eligible Dependent shall do whatever is necessary to secure the Plan's subrogation rights and shall do nothing after the loss to prejudice such rights. You or your Eligible Dependent must do nothing to impair or prejudice the Plan's rights. For example, if you or your Eligible Dependent chooses not to pursue the liability of a third party, you or your Eligible Dependent may not waive any rights covering any conditions under which any recovery could be received. Where you or your Eligible Dependent choose not to pursue the liability of a third party, the acceptance of benefits from the Plan authorizes the Plan to litigate or settle your claims against the third party. If the Plan takes legal action to recover what it has paid, the acceptance of benefits obligates you or your Eligible Dependent (and your attorney if you have one) to cooperate with the Plan in seeking its recovery, and in providing relevant information with respect to the accident.

(D) You or your Eligible Dependent shall agree to cooperate with the Plan and/or any representatives of the Plan in completing such forms and in giving such information surrounding any accident as the Plan or its representatives deem necessary to fully investigate the incident. Failure to execute the necessary forms will result in no benefits being paid.

(E) The Plan is also granted a right of restitution from the proceeds of any settlement, judgment or other payment obtained by you or your Eligible Dependent. This right of restitution is cumulative with and not exclusive of the subrogation right granted in (A) above, but only to the extent of the benefits paid by the Plan.

(F) The Plan's rights of restitution and subrogation provide the Plan with first priority to any and all recovery in connection with the Injury or Sickness, whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified. Such recovery includes amounts payable under your or your Eligible Dependent's own uninsured motorist insurance, under-insured motorist insurance, or any medical pay or no-fault benefits payable.

This right of subrogation is specifically and unequivocally pro tanto subrogation, that is, subrogation from the first dollar received by you or your Eligible Dependent, and the pro tanto subrogation is to take effect before the entire debt is paid to you or your Eligible Dependent. In addition to its pro tanto rights, the Plan is entitled to restitution of the full amount of benefits paid, regardless of whether you or your Eligible Dependent is made whole by the third party for all damages.

(G) The Plan's rights of restitution and subrogation apply regardless of the terms of the claim, demand, right of recovery, cause of action, judgment, award, settlement, compromise, insurance or order, regardless of whether the third party is found responsible or liable for

the Injury or Sickness, and regardless of whether you or your Eligible Dependent actually obtain the full amount of such judgment, award, settlement, compromise, insurance or order.

The Plan, by payment of any proceeds, is granted an equitable lien on the proceeds of any settlement, judgment or other payment received by you or your Eligible Dependent, and you or your Eligible Dependent consents to said lien and agrees to take all steps necessary to help the Plan Administrator secure such lien.

The Plan shall have a lien on any amount received by you, your Eligible Dependent or a representative of you or your Eligible Dependent (including your attorney) that is due to the Plan under this Section, and any such amount shall be deemed to be held in trust by you or your Eligible Dependent for the benefit of the Plan until paid in full to the Plan.

(H) The subrogation and restitution rights and liens apply to any recoveries made by you or your Eligible Dependent as a result of the Injuries sustained or Sickness suffered, including but not limited to the following:

(a) Payments made directly by the third party tort-feasor or any insurance company on behalf of the third party tort-feasor or any other payments on behalf of the third party tort-feasor;

(b) Any payments, settlements, judgments, or arbitration awards paid by any insurance company under an uninsured, under insured motorist policy or medical pay provisions on the insured's behalf; and

(c) Any payments from any source designed or intended to compensate an insured for Sickness, Injury or Disability sustained as the result of the negligence or wrongful action or alleged negligence or wrongful action of another person.

(I) It is the obligation of you or your Eligible Dependent to:

(1) Notify the Plan within ten (10) days of any Injury, Sickness or Disability for which someone else may be liable;

(2) Notify the Plan in writing of any Injury, Sickness or Disability for which the Plan has paid medical expenses on behalf of you or your Eligible Dependent that may be attributable to the wrongful or negligent acts of another person;

(3) Notify the Plan in writing if you or your Eligible Dependent retains services of an attorney, and of any demand made or lawsuit filed on behalf of you or your Eligible Dependent, and of any offer, proposed settlement, acceptance settlement, judgment, or arbitration award;

(4) You or your Eligible Dependent must notify the Plan before accepting any payment prior to the initiation of a lawsuit. If you do not, and you accept payment that is less than the full amount of the benefits that the Plan has advanced you, you will still be required to repay the Plan, in full, for any benefits it has paid on your behalf;

(5) You or your Eligible Dependent must notify the Plan within ten (10) days of the initiation of any lawsuit arising out of the Accident and of the conclusion of any settlement, judgment or payment relating to the Accident in any lawsuit initiated to protect the Plan's claims;

(6) Provide the Plan or its agents with information it requests concerning circumstances that may involve subrogation, provide any reasonable assistance requested in assimilating such information and cooperate with the Plan or its agents in defining, verifying or protecting its right of subrogation and restitution; and

(7) Promptly provide restitution to the Plan for benefits paid on behalf of you or your Eligible Dependent attributable to Sickness, Injury or Disability, once you or your Eligible Dependent have obtained money through settlement, judgment, award or other payment.

(J) You or your Eligible Dependent shall not make any settlement which specifically excludes or attempts to exclude the medical expenses paid by the Plan.

(K) The Plan's right of recovery shall be a prior lien against any proceeds recovered by you or your Eligible Dependent, which right shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine," "Rimes Doctrine" or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

(L) You or your Eligible Dependent shall not incur any expenses on behalf of the Plan in pursuit of the Plan's rights, specifically, no court costs nor attorney's fees may be deducted from the Plan's recovery without the prior expressed written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine," "Common Fund Doctrine," "Attorney's Fund Doctrine," or any other such doctrine purporting to reduce the Plan's recovery amount.

(M) If you or your Eligible Dependent fails to notify the Plan, as required herein, then upon recovery made, whether by suit, judgment, settlement, compromise or otherwise, by you or your Eligible Dependent, the Plan shall be entitled to restitution to the extent of the benefits paid by the Plan, immediately upon demand, and shall have the right to recovery thereof, by suit or otherwise.

(N) If you or your Eligible Dependent refuse to provide restitution to the Plan from any recovery or refuse to cooperate with the Plan regarding its subrogation or restitution rights, the Plan has the right to recover the full amount of all benefits paid by methods which include, but are not necessarily limited to, offsetting the amounts paid against your future benefit payments under the Plan. "Non-cooperation" includes the failure to execute a Subrogation, Assignment of Rights, and Restitution Agreement and the failure of any party to respond to the Plan's inquiries concerning the status of any claim or any other Injury, Sickness or Disability relating to the Plan's rights of restitution and subrogation.

(O) If you or your Eligible Dependent are compensated for your Injury, Sickness or Disability you are responsible for any and all future medical benefits that are a result of this Injury, Sickness or Disability.

Failure to comply with any of these requirements may result in:

- The Plan's withholding payment of future benefits;
- An obligation by you or your Eligible Dependent to pay costs, attorneys fees and other expenses incurred by the Plan in obtaining the required information or restitution.

This restitution and subrogation program is a service to you and your Eligible Dependents. It provides for the early payment of benefits and also saves the Plan money (which saves you money too) by making sure that the responsible party pays for your Injuries.

Section 5.04 - Right To Receive And Release Information

In order to implement the provisions of the Plan, the Trustees or its agent may, without notice to any person, release to or obtain any information which the Plan deems necessary from any other welfare plan, group plan, insurance company, person(s) or other organization. All persons claiming benefits from the Plan shall furnish any information required to implement this provision as a prerequisite to receiving benefits from the Plan.

Section 5.05 - Rights Of Recovery

Whenever benefit payments are made by the Plan which are in excess of eligible Expenses or other Plan limits (including mistaken payments), the Trustees shall have the right to recover the mistaken or excess amount from either:

(A) the person or agency who received it; or

(B) the eligible Employee or Eligible Dependent.

In the case of the eligible Employee or Eligible Dependent, the Trustees reserve the right to reduce or withhold future benefit payments under the Plan in order to correct a prior overpayment.

Section 5.06 - Notice And Proof Of Loss

Written notice of Accident, Injury or Sickness upon which a claim may be based shall be given to the Trustees within one (1) year of the date of the commencement of the first loss for which a benefit arising out of such Accident, Injury or Sickness may be claimed. Written proof of medical expense and Hospital confinement shall be furnished to the Trustees within one (1) year after the termination of the period for which claim is made. Written proof of loss for all other Expenses shall be furnished to the Trustees within one (1) year after the date of the loss.

Section 5.07 - Facility Of Payment

In the event that the Trustees shall determine that an eligible Employee or Eligible Dependent entitled to benefits under this Plan is unable to care for his affairs due to Injury or Sickness or for any other reason, any benefits due may, to the extent permitted by law, unless claim shall have

been made therefore by a duly appointed guardian, conservator, or other legal representative, be made at the direction of the Trustees to the spouse, child, parent or other blood relative or to any person deemed by the Trustees to have incurred Expenses for the eligible Employee or Eligible Dependent and the payment of such benefits shall be a complete discharge of the liabilities of the Plan therefore.

Section 5.08 - Time Of Payment Of Benefits
Subject to receipt of proper proof of loss, benefits for loss of life due to either natural causes or accidental bodily Injury, shall be payable to the designated Beneficiary, if living, and otherwise to the estate of the deceased eligible Employee.

Accrued Weekly Disability Benefits shall, subject to receipt of proper proof of loss, be paid provided the period for which payment is sought has elapsed.

Section 5.09 - Employment Rights
The establishment of this Plan shall not be construed as conferring any legal rights upon any Employee or any other person for continuation of employment, nor shall it interfere with the rights of any Employer to discharge any Employee and/or treat him without regard to the effect which such treatment might have upon him as a participant in this Plan.

Section 5.10 - Change In Eligibility Rules
The Trustees shall have the authority to change or amend the eligibility rules governing this Plan from time to time as conditions warrant.

Section 5.11 - Medical Examination
No medical examination shall be required of any person in order to obtain coverage for benefits initially. However, the Trustees shall have the right to require any eligible Employee or Eligible Dependent whose Accident, Injury, Sickness or Disability is the basis of a claim to be examined by a Physician selected by them as often as they may reasonably deem necessary in order to process the claim.

Section 5.12 - Assignment Of Benefits
No right or interest of any eligible Employee to the Death, Accidental Death and Dismemberment or Weekly Disability Benefits provided under the Plan shall be assignable, pledged, alienated, transferred or otherwise encumbered. Health care benefits may only be assigned to the provider of medical services by the eligible individual.

Section 5.13 - Amendment And Termination Of Plan
The Trustees shall have the right to amend, modify or terminate the Plan or any part of the Plan (including, but not limited to benefits for retired and Disabled individuals and widow and widowers) at any time and for any reason, including but not limited to such modifications or amendments to the Plan that are necessary to qualify or maintain the Plan as a plan meeting the requirements of any appropriate governmental agency. Such amendment, modification, or termination shall be accomplished by a Board resolution adopted by written consent or by a majority vote of the Trustees present at a board meeting. In the event of the termination of the Plan, coverage will terminate and pending claims as of that date will be paid according to the terms of the Plan then in effect.

Section 5.14 - Reciprocal Agreements
Notwithstanding anything to the contrary, any reciprocal agreement entered into by the Trustees with a national, state, or local fund that is effective on or before the adoption date of this Plan document shall apply for the period of effectiveness of such reciprocity agreement. The terms of this document shall be modified to the extent set forth in such reciprocity agreement. The Trustees shall have the authority to amend the Plan to reflect the termination of any existing reciprocity agreement or any reciprocity agreement entered into by the Trustees after the adoption date of this Restated Plan Document and Summary Plan Description; provided, however, that in no event shall such amendment result in reduced benefits for claims incurred under the provisions of the Plan on the date the amendment is made.

Section 5.15 - Administration
The Trustees shall be responsible for the administration of the Plan. The Trustees shall have all such powers as may be necessary to carry out the provisions hereof and may, from time to time establish rules for the administration of the Plan and the transaction of the Plan's business. In making any such determination or rule, the Trustees shall pursue uniform policies as from time to time established by them and shall not discriminate in favor of or against any eligible individual.

The Trustees shall have the exclusive right and discretion to make any finding of fact necessary or appropriate for any purpose under the Plan including, but not limited to, the determination of eligibility for and the amount of any benefit payable under the Plan. The Trustees shall have the exclusive right and discretion to interpret the terms and provisions of the Plan and to determine any and all questions arising under the Plan or in connection with the administration thereof, including, without limitation, the right to remedy or resolve possible ambiguities, inconsistencies, or omissions, by general rule or particular decision. The Trustees shall make, or cause to be made, all reports or other filings, necessary to meet the reporting and disclosure requirements of the Act which are the responsibility of the "Plan Administrator" as defined under the Act. All decisions made by the Trustees, any action taken by them in respect of the Plan or the Trust Agreement, shall be conclusive and binding on all persons, and shall be given the maximum possible deference allowed by law. This means it is intended by the Board of Trustees that the standard of interpretation to be used by the court is "arbitrary and capricious."

Section 5.16 - Administrative Manager
The Trustees may appoint an administrative manager and necessary personnel to conduct the affairs and manage the Trust Fund in accordance with the Trust Agreement, under the supervision of the Secretary-Treasurer.

Section 5.17 - Delegation Of Authority
The Trustees may appoint one (1) or more persons or firms, including, but not limited to, attorneys, actuaries, accountants, consultants, investment managers or other qualified persons or entities, and delegate such of their powers and duties as they deem desirable to such persons or entities, in which case every reference herein made to the Trustees shall be deemed to mean or include those persons or entities also as to matters within their jurisdiction, whether or not a specific reference to delegation is made herein.

Section 5.18 - Records
All resolutions, proceedings, act, and determinations of the Trustees shall be recorded by the Secretary-Treasurer thereof or under his supervision, and all such records, together with such documents and instruments as may be necessary for the administration of the Plan, shall be preserved in the custody of the Plan Office.

Section 5.19 - Rules
Subject to the limitations contained in the Plan, the Trustees shall have the authority to, in their discretion, adopt bylaws and establish rules for the conduct of Plan affairs and the exercise of the duties imposed upon them under the Plan.

Section 5.20 - Claims Procedures
Federal claims regulations categorize all claims into Pre-Service Claims (urgent and non-urgent), Post-Service Claims and Disability Claims. Different time frames for the Plan to make a decision on the claim apply to each type of claim. If your claim is denied, the following time frames apply. Following the table below (which summarizes these time frames) are special definitions applying to benefit claims, the timing of benefit claim denial notices and the manner in which such notices are required to be given and the required content of such notices.

Time Limits	**Type of Claim**			
THE LISTED ACTION MUST OCCUR WITHIN THESE TIME LIMITS	**Urgent health care**	**Pre-service health care (non urgent)**	**Post-service health care**	**Disability**
For Plan to make initial claim determination (either approve or deny claim)	72 hours (depending on medical circumstances)	15 days (depending on medical circumstances)	30 days (sooner if reasonable)	45 days
For Plan to obtain extension of time (if proper notice given to claimant and delay is beyond Plan control)	None	15 days	15 days	30 days, plus another 30 days
For Plan to request missing information from claimant after receipt of claim by Plan	24 hours	15 days	30 days	45 days
For claimant to provide missing information after request for information by Plan	48 hours	45 days	45 days	45 days

DEFINITIONS

The following terms are applicable to the procedures which apply to a Claim Denial and appeals of Claim Denials and shall have the meanings set forth below. You or your Beneficiary making a claim are referred to as "claimants":

Claim Denial or Denial of Claim

The term **"Claim Denial"** or **"Denial of Claim"** means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of an eligible Employee's or Beneficiary's eligibility to participate in a Plan, including, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or investigational or not Medically Necessary or appropriate.

Claim Involving Urgent Care

A **"Claim Involving Urgent Care"** is any claim for medical care or treatment with respect to which the application of the time periods for making *non-urgent care* determinations –

(A) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or,

(B) 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.

Whether a claim is a "Claim Involving Urgent Care" is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Except, any claim that a Physician with knowledge of the claimant's Medical Condition determines is a "Claim Involving Urgent Care" within the meaning of this Section shall be treated as a "Claim Involving Urgent Care" for purposes of this Section.

Group Health Plan

The term **"Group Health Plan"** means an employee welfare benefit Plan within the meaning of Section 3(1) of ERISA to the extent that such Plan provides "medical care" within the meaning of Section 733(a) of ERISA. Your health care coverage is considered "Group Health Plan" coverage under this definition.

Health Care Professional

The term **"Health Care Professional"** means a physician or other health care professional licensed, accredited or certified to perform specified health services consistent with State law.

Notice Or Notification

The term **"Notice"** or **"Notification"** means the delivery or furnishing of information to an individual in a manner that satisfies the standards of 29 CFR 2520.104b-1(b), as appropriate, with respect to material required to be furnished or made available to an individual.

Pre-Service Claim
The term **"Pre-Service Claim"** means any claim for a benefit under a Group Health Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Post-Service Claim
The term **"Post-Service Claim"** means any claim for a benefit under a Group Health Plan that is not a Pre-Service Claim.

Relevant
A document, record, or other information shall be considered **"Relevant"** to a claimant's claim if such document, record, or other information –

(A) was relied upon in making the benefit determination;

(B) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

(C) demonstrates compliance with the administrative processes and safeguards required pursuant to 29 CFR 2560.503-1(m)(b)(5) in making the benefit determination; or

(D) in the case of a Group Health Plan or a Plan providing disability benefits, constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION

In General – Claims Other Than Group Health Care Or Disability Claims
If a claim is wholly or partially denied, the Plan Administrator shall notify the claimant of the Plan's Appeal Procedures within a reasonable period of time, but not later than ninety (90) days after receipt of the claim by the Plan, unless the Plan Administrator determines that special circumstances require an extension of time for processing the claim. If the Plan Administrator determines that an extension of time for processing is required, written Notice of the extension shall be furnished to the claimant prior to the end of the initial ninety (90) day period. In no event shall such extension exceed a period of ninety (90) days from the end of such initial period. The extension Notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

Health Care Claims
In the case of a claim for health care benefits, the Plan Administrator shall notify a claimant of the Plan's benefit determination, as appropriate, as shown below:

(A) **Urgent Care Claims**
In the case of a Claim Involving Urgent Care, the Plan Administrator shall notify the claimant of the Plan's benefit determination (whether an approval or denial) as soon as possible, taking into account the medical circumstances, but not later than seventy-two (72) hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan Administrator shall notify the claimant as soon as possible, but not later than twenty-four (24) hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. The Plan Administrator shall notify the claimant of the Plan's benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of –

(1) The Plan's receipt of the specified information, or

(2) The end of the period afforded the claimant to provide the specified additional information.

(B) **Concurrent Care Decisions**
If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments:

(1) Any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute a Denial of Claim. The Plan Administrator shall notify the claimant of the Claim Denial at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that Claim Denial before the benefit is reduced or terminated.

(2) Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a Claim Involving Urgent Care shall be decided as soon as possible, taking into account the medical circumstances, and the Plan Administrator shall notify the claimant of the benefit determination, whether an approval or a denial, within twenty-four (24) hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any Claim Denial concerning a request to extend the course of treatment, whether involving *urgent care* or not, shall be given to the claimant, and any appeal shall be governed by the procedures under the appeals rules.

(C) **Other Claims**

In the case of a claim not described above, the Plan Administrator shall notify the claimant of the Plan's benefit determination, as appropriate.

(1) **Pre-Service Claims**

In the case of a Pre-Service Claim, the Plan Administrator shall notify the claimant of the Plan's benefit determination (whether an approval or denial) within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim by the Plan. This period may be extended one (1) time by the Plan for up to fifteen (15) days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial fifteen (15) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the Notice of extension shall specifically describe the required information, and the claimant shall be afforded at least forty-five (45) days from receipt of the Notice within which to provide the specified information.

(2) **Post-Service Claims**

In the case of a Post-Service Claim, the Plan Administrator shall notify the claimant, within a reasonable period of time, but not later than thirty (30) days after receipt of the claim. This period may be extended one (1) time by the Plan for up to fifteen (15) days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the Notice of extension shall specifically describe the required information, and the claimant shall be afforded at least forty-five (45) days from receipt of the Notice within which to provide the specified information.

(D) **Disability Claims**

In the case of a claim for disability benefits, the Plan Administrator shall notify the claimant of the Plan's Appeal of Claims Denials Procedures within a reasonable period of time, but not later than forty-five (45) days after receipt of the claim by the Plan. This period may be extended by the Plan for up to thirty (30) days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial forty-five (45) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If, prior to the end of the first thirty (30) day extension period, the Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for

making the determination may be extended for up to an additional thirty (30) days, provided that the Plan Administrator notifies the claimant, prior to the expiration of the first thirty (30) day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. In the case of any extension under this paragraph, the Notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least forty-five (45) days within which to provide the specified information.

(E) **Calculating Time Periods**

For purposes of this Section, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the procedures of a Plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be paused or stopped extended from the date on which the Notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

The Plan Administrator shall provide a claimant with a written or electronic Notification of any Denial of Claim other than a claim for disability benefits. The Notification of Denial shall set forth, in a manner calculated to be understood by the claimant –

(A) The specific reason or reasons for the Claim Denial;

(B) Reference to the specific Plan provisions on which the Claim Denial is based;

(C) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary;

(D) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following a Claim Denial on review;

(E) In the case of a Claim Denial for Health Care:

(1) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Claim Denial, either the specific rule, guideline, protocol or other similar criterion shall be provided to the claimant; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the Claim Denial and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the claimant upon request; or

(2) If the Claim Denial is based on a Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances shall be provided to the claimant, or a statement that such explanation will be provided free of charge upon request.

(F) In the case of a Claim Denial concerning a Claim Involving Urgent Care, a description of the expedited review process applicable to such claims.

In the case of a Claim Denial concerning a Claim Involving Urgent Care, the information described above may be provided to the claimant orally within the time frame prescribed, provided that a written or electronic Notification is furnished to the claimant not later than three (3) days after the oral Notification.

(G) In the case of a Claim Denial of a claim for Disability Benefits, the Notification of Denial shall set forth, in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the Claim Denial;

(2) Reference to the specific Plan provisions on which the Claim Denial is based;

(3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(4) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(a) The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

(b) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in making the benefit determination; and

(c) A disability determination regarding the Claimant presented by the claimant to the Plan made by the Social Security Administration;

(5) If the Claim Denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(6) The specific internal rules, guidelines, protocols, standards or other similar criteria the Plan relied upon in making the Claim Denial on review or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

(7) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

(8) The notification of a Claim Denial shall be provided in a culturally and linguistically appropriate manner as described below, if necessary under the "10% Rule" discussed at the end of this Section.

The Plan is considered to provide relevant notices in a "culturally and linguistically appropriate manner" if the Plan meets the following requirements:

(a) The Plan must provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals in any applicable non-English language;

(b) The Plan must provide, upon request, a notice in any applicable non-English language; and

(c) The Plan must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan.

With respect to an address in any United States county to which a notice is sent, a non-English language is an "applicable non-English language" if ten percent or more ("10% Rule") of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary of HHS.

If your claim for benefits is denied, you should first use the Plan's appeal procedures found in Section 5.21 before filing suit in court. Failure to file such an appeal under Section 5.21 could result in any court action you may file to be considered premature and could result in your case being dismissed in such a manner as to preclude any further court actions. If your claim for benefits is denied again on appeal under Section 5.21, you may then proceed to court since you will then have exhausted this Plan's administrative review procedures.

Section 5.21 - Appeals Procedures

APPEAL OF ADVERSE BENEFIT DETERMINATIONS

Federal claims and appeals regulations categorize all claims and appeals of Denials of Claims into Pre-Service Claims (urgent and non-urgent), Post-Service Claims and Disability Claims. Different time frames for the Plan to make a decision on the appeal of a Denial of Claim apply to

each type of claim. If your claim is denied, and you file for an appeal or review of the Claim Denial, the following time frames apply. Following the table below (which summarizes these time frames) are Sections on: the rules governing an appeal, the timing of benefit Claim Denial notices, the manner such notices are given and the required content of such notices.

Time Limits	**Type of Claim**			
THE LISTED ACTION MUST OCCUR WITHIN THESE TIME LIMITS	**Urgent health care**	**Pre-service health care (non urgent)**	**Post-service health care**	**Disability**
For claimant to request appeal after Denial	180 days	180 days	180 days	180 days
For Plan to make determination on appeal	72 hours (depending on medical circumstances)	30 days	Appeal will be heard at the next quarterly Board of Trustees meeting after the claimant filed the appeal (or if appeal is filed within 30 days of the next scheduled meeting, the appeal will be heard at the second quarterly meeting). Claimant to be notified within 5 days of Plan decision.	Appeal will be heard at the next quarterly Board of Trustees meeting after the claimant filed the appeal (or if appeal is filed within 30 days of the next scheduled meeting, the appeal will be heard at the second quarterly meeting). Claimant to be notified within 5 days of Plan decision.
For Plan to obtain extension of time (if proper notice given to claimant and delay is beyond Plan control)	None	None	Plan may extend the appeal hearing by one additional quarterly meeting if the claimant is notified prior to the meeting determined above.	Plan may extend the appeal hearing by one additional quarterly meeting if the claimant is notified prior to the meeting determined above.

APPEAL OF DENIED CLAIMS

Full And Fair Review Of Claims Other Than Health Care Or Disability Claims

As part of your rights of appeal for a Claim Denial other than a Claim for Health Care Benefits or Disability Benefits:

(A) Claimants shall have sixty (60) days following receipt of a Notification of an Adverse Benefit Determination within which to appeal the determination;

(B) Claimants shall have the opportunity to submit written comments, documents, records, and other information relating to the Claim for benefits;

(C) Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the claimant's Claim for benefits.

(D) The review on appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Health Care Benefits

As part of your rights of appeal of a Denial of a Claim for Health Care Benefits:

(A) Claimants shall have at least one hundred eighty (180) days following receipt of a notification of a Denial of Claim within which to appeal the Denial;

(B) The review of the Claim Denial on appeal shall not rely on any aspect of the initial Claim Denial and shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Claim Denial that is the subject of the appeal, nor the subordinate of such individual;

(C) In deciding an appeal of any Claim Denial that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(D) The Plan shall provide the claimant with the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Claim Denial, without regard to whether the advice was relied upon in making the benefit determination;

(E) The appeal review process shall provide that the Health Care Professional engaged for purposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the Claim Denial that is the subject of the appeal, nor the subordinate of any such individual; and

(F) Provide, in the case of a Claim Involving Urgent Care, for an expedited review process pursuant to which:

  (1) A request for an expedited appeal of a Claim Denial may be submitted orally or in writing by the claimant; and

  (2) All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or any other available similarly expeditious method.

Plans Providing Disability Benefits

The appeals process of a Claim for Disability Benefits shall comply with:

(A) the requirements listed below in the paragraph titled "**In General, Claims Other than Health or Disability Claims";**

(B) the requirements listed above in paragraphs (A) through (E) in the paragraph regarding the **Appeal of Denied Claims** related to **Health Care Benefits**; and

(C) the following requirements:

- Before the Plan can issue a Denial on review of a Disability Benefit claim, the Plan Administrator shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, or other person making the Denial on review (or at the direction of the Plan or such other person) in connection with the claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of Denial on review is required to be provided under the Plan to give the claimant a reasonable opportunity to respond prior to that date.

- In addition, before the Plan can issue a Denial on review of a Disability Benefit claim based on a new or additional rationale, the Plan Administrator shall provide the claimant, 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 Denial on review is required to be provided under the Plan to give the claimant a reasonable opportunity to respond prior to that date.

- If the Plan fails to strictly adhere to all the requirements of the claims and appeals sections of the Plan with respect to a claim, the claimant is deemed to have exhausted the administrative remedies available under the Plan, except for de minimis violations explained below. As such, the claimant is entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under Section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

The administrative remedies available under a Plan with respect to claims for Disability Benefits will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan. The claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within ten (10) days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects the claimant's request for immediate review under this section on the basis that the Plan met the standards for the exception under this paragraph, the claim shall be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Plan shall provide the claimant with notice of the resubmission.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

In General, Claims Other Than Health or Disability Claims

The appropriate named fiduciary shall make a benefit determination no later than the date of the meeting of the committee or Board that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within thirty (30) days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Plan Administrator shall provide the claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Plan Administrator shall notify the claimant of the benefit determination as soon as possible, but not later than five (5) days after the benefit determination is made.

Health Care Claims

In the case of an appeal of a Denial of Claim for Health Care Benefits, the Plan Administrator shall notify a claimant of the Plan's benefit determination on review as set forth below, as appropriate.

(A) **Urgent Care Claims**

In the case of a Claim Involving Urgent Care, the Plan Administrator shall notify the claimant of the Plan's benefit determination on review on appeal as soon as possible, taking into account the medical circumstances, but not later than seventy-two (72) hours after receipt of the claimant's request for review on appeal of a Claim Denial by the Plan.

(B) **Pre-Service Claims**

In the case of a Pre-Service Claim, the Plan Administrator shall notify the claimant of the Plan's benefit determination on review on appeal within a reasonable period of time appropriate to the medical circumstances. Such notification shall be provided not later than thirty (30) days after receipt by the Plan of the claimant's request for review of a Claim Denial.

(C) **Post-Service Claims**

In the case of a Post-Service Claim, the appropriate named fiduciary shall make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within thirty (30) days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Plan Administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Plan Administrator shall notify the claimant of the benefit determination as soon as possible, but not later than five (5) days after the benefit determination is made.

Disability Claims

In the case of a Disability Claim, the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within thirty (30) days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the Plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Plan Administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Plan Administrator shall notify the claimant of the benefit determination as soon as possible, but not later than five (5) days after the benefit determination is made.

Calculating Time Periods

For purposes of this Section, the period of time within which a benefit determination on review on appeal is required to be made shall begin at the time an appeal is filed in accordance with the reasonable procedures of a Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be paused or stopped from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Furnishing Documents
In the case of a Claim Denial on review on appeal, the Plan Administrator shall provide the claimant such access to, and copies of, documents, records and other information as is appropriate.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

The Plan Administrator shall provide a claimant with written or electronic notification of a Plan's benefit determination on review. In the case of a Claim Denial other than a claim for disability benefits, the notification shall set forth, in a manner calculated to be understood by the claimant–

(A) The specific reason or reasons for the Claim Denial on appeal;

(B) Reference to the specific Plan provisions on which the Claim Denial is based;

(C) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's Claim for benefits;

(D) A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under Section 502(a) of the ERISA; and

(E) In the case of a Claim Denial of Health Care Benefits –

(1) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Claim Denial, either the specific rule, guideline, protocol, or other similar criterion shall be provided to the claimant; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Claim Denial and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(2) If the Claim Denial is based on a Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances shall be provided to the claimant, or a statement that such explanation will be provided free of charge upon request.

(F) In the case of a Claim Denial of a Disability Benefit on review, the Notification of Denial shall set forth, in a manner calculated to be understood by the claimant:

(1) the specific reason or reasons for the Claim Denial on review;

(2) reference to the specific Plan provisions on which the Claim Denial on review is based;

(3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant, to the claimant's claim for Disability Benefits;

(4) a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(a) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

(b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Claim Denial on review, without regard to whether the advice was relied upon in making the Claim Denial on review; and

(c) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration.

(5) if the Claim Denial on review is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of change upon request; and

(6) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Claim Denial on review or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

(7) a statement of the claimant's right to bring an action under Section 502(a) of ERISA; which lawsuit must be filed within three (3) years from the date of the denial on appeal to be considered timely. The statement shall include the calendar date the three (3)-year period would run.

(8) In the case of a Claim Denial on review, the notification shall be provided in a culturally and linguistically appropriate manner as described below. The Plan is considered to provide relevant notices in a "culturally and linguistically appropriate manner" if the Plan meets the following requirements as described below, if necessary under the "10% Rule" discussed at the end of this Section.

The Plan is considered to provide relevant notices in a "culturally and linguistically appropriate manner" if the Plan meets the following requirements:

(a) The Plan must provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals in any applicable non-English language;

(b) The Plan must provide, upon request, a notice in any applicable non-English language; and

(c) The Plan must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan.

With respect to an address in any United States county to which a notice is sent, a non-English language is an "applicable non-English language" if ten percent or more ("10% Rule") of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary of HHS.

Right to Bring Legal Action

A claimant may not begin any legal action, including proceedings before administrative agencies, until these procedures and the opportunities described in this Section have been exhausted. The review procedures described in this Section shall be the exclusive mechanism through which determinations of eligibility and benefits may be appealed. If, after following the review process outlined here, a claimant is not satisfied with the result, legal action may be filed within three (3) years of receiving the final review notice under these procedures.

If a Plan fails to strictly adhere to requirements of the claims and appeals sections of the Plan with respect to a claim, the claimant is deemed to have exhausted the administrative remedies available under the Plan, except for de minimis violations explained below. As such, the claimant is entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under Section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

The administrative remedies available under the Plan with respect to disability benefits will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing and good faith exchange of information between the Plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan. The claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within ten (10) days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects the claimant's request for immediate review under this section on the basis that the Plan met the standards for the exception under this paragraph, the claim shall be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Plan shall provide the claimant with notice of the resubmission.

Section 5.22 - Coordination With Medicare
Medicare has three (3) relevant parts - Hospital Insurance (Part A), Medical Insurance (Part B) and Prescription Drug Coverage (Part D). Part A covers Inpatient Hospital care and generally is available to all individuals over age 65 at no cost. Part B covers Physician services, Outpatient Hospital services and other medical supplies and is optional. Part D covers prescription drugs and is provided under this Plan. Generally, a Medicare participant must pay a monthly premium for Parts B and D, however, this Plan pays the Part D premium on behalf of the Medicare participant. The Plan coordinates expenses covered under Medicare Parts A, B and D. If a Medicare participant or beneficiary opts out of this Plan's Part D coverage and enrolls in a different Part D Plan, the supplemental coverage for Part D under this Plan will be discontinued and the Participant will still pay the same amount for the Plan's supplement to Parts A and B.

The Plan shall pay benefits secondary to Medicare Parts A, B and D to the full extent allowed by Section 1862 (b) of the Social Security Act. In no event shall covered Expenses under the Plan, when added to Medicare benefits, exceed the amount the Plan would have paid had the individual covered by the Plan not been entitled to benefits under Parts A, B and D. For purposes of this Section, such individual shall be presumed to be covered by Parts A and B to the extent he has met all of the eligibility rules and is otherwise entitled to benefits under Parts A and B regardless of whether he has actually enrolled in Parts A and B. Typically, after Medicare pays their portion of your claim, Medicare will electronically submit your remaining balance to the Plan Office for payment. When this occurs, you will not need to submit anything to the Plan Office for payment. However, if this does not occur, Explanation of Medicare Benefits (EOMB) must be sent to the Plan Office along with the expenses before any payment will be made by the Plan. For Medicare Part D services, the Plan will automatically coordinate with Part D at the time you receive your medication.

The coordination of benefits with Medicare Part D is performed automatically at the retail pharmacy or mail order facility. The Plan will automatically enroll you in the Plan's Medicare Part D coverage when you are first entitled to Medicare. If you choose to opt out of the Plan's Medicare Part D coverage, you will lose all Part D benefits and you will still pay the same premium for coordination with Medicare Parts A and B only.

This Plan elects treatment under clause (iii) of 42 USC Sec. 1395y(b)(1)(A), and consistent with this election, the Plan Office is hereby authorized and directed to pay claims secondary to Medicare benefits in those cases where such payment is permitted.

Section 5.23 - Termination Of Coverage
Benefits for an eligible individual shall terminate when he fails to meet the eligibility requirements, chooses to opt out of coverage, chooses not to elect continuation coverage under COBRA, fails to make a required self-payment when due, exhausts the maximum period of coverage provided under COBRA, or at the end of the term specified in a Qualified Medical Child Support Order (QMCSO). In the event of the termination of the Plan, coverage will terminate on said date and pending claims as of that date will be paid according to the terms of the Plan then in effect.

Section 5.24 - Participant Claims Audit Reward Program
As part of its cost control program, it is the intention of the Plan to encourage all eligible Employees to examine all the medical bills incurred by them or their Eligible Dependent to determine if billing errors exist. To encourage eligible Employees to examine their medical bills, the Plan will reward the eligible Employee for any medical charge that is adjusted due to the participant's detection and correction of a billing error. The reward shall be fifty percent (50%) of the actual savings realized (after deducting any PPO negotiated discount), subject to a minimum of Twenty-Five Dollars ($25.00).

In order to qualify for a Plan reward, the eligible Employee is responsible to audit their medical bill, detect any errors, notify the Plan Office that an error exists, request a corrected bill from the service provider and submit both the original bill and the corrected bill to the Plan Office.

Upon determination by the Plan Office that a billing error was made, that it was detected through the efforts of the eligible Employee and that a corrected bill has been submitted to the Plan Office, payment of the reward shall be made to the eligible Employee.

Section 5.25 - Preferred Provider Organizations, Utilization Review And Large Case Management Services
The Trustees shall have the authority to enter into agreements for negotiated fee levels with preferred provider organizations (PPO) and to institute utilization review and large case management requirements where such services seem necessary.

Notwithstanding any other Plan provision, if for any reason the contracted PPO fee for a covered service is more than the provider's actual charge, then the Plan will pay benefits so that the participant's Coinsurance amount is no more than what it would have been had the covered amount been the actual charge.

Section 5.26 - Procedural Rules For Determining Qualified Medical Child Support Orders

(A) **INTENT AND CONSTRUCTION**
These Procedures are adopted in order to satisfy the requirements of Section 609 of ERISA as created by the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), and shall be construed consistent with Section 609 of ERISA.

(B) **DEFINITIONS**
As used in these Procedures, unless the context indicates otherwise, the following terms shall have the following meanings:

(1) **"Participant"** means any Employee or former Employee of an Employer in relation to the Plan, or any member or former member of an employee organization dealing with Employers concerning the Plan or organized for the purpose of establishing the Plan, who is eligible to receive a benefit of any type from the Plan.

(2) **"Qualified Medical Child Support Order"** means a medical child support order:

(a) which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits under the Plan, and

(b) with respect to which the requirements of Paragraphs (3)(a) and(b), below, are met.

(3) **"Medical Child Support Order"** means any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which:

(a) provides for child support with respect to a child or a participant under the Plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under such Plan, or

(b) enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to the Plan.

(4) **"Alternate Recipient"** means any child of a participant who is recognized under a Medical Child Support Order as having a right to benefits under the Plan.

(C) INFORMATION TO BE INCLUDED IN QUALIFIED MEDICAL CHILD SUPPORT ORDER AND RESTRICTIONS

(1) **Requirements of a QMCSO**
A Medical Child Support order shall meet the requirements of this Plan only if such order clearly specifies:

(a) The name and last known mailing address, if any, of the participant and the name and mailing address of each Alternate Recipient covered by the order;

(b) A reasonable description of the type of coverage to be provided by the Plan to each such Alternate Recipient, or the manner in which such type of coverage is to be determined;

(c) The period to which such order applies; and

(d) The Plan to which such order applies.

(2) **Restriction on New Types or Forms of Benefits**
A Medical Child Support order meets the requirements of this paragraph only if such order does not require the Plan to provide any type or form of benefits, or an option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993).

(D) PROCEDURES UPON RECEIPT OF AN ORDER

(1) **Notice**
Upon the Plan's receipt of a Medical Child Support Order with respect to a participant, the Plan Administrator shall promptly acknowledge receipt of the order and give notice of these Procedures to the participant and to each person specified in the order as entitled to payment of any Plan benefits under the order, at the addresses the Order specifies. An Alternate Recipient may designate a representative for receipt of copies of notices that are sent to the Alternate Recipient.

(2) **Determination**
The Plan Administrator shall promptly determine whether a Medical Child Support Order is a Qualified Medical Child Support Order; that is, that it contains the information set forth in Paragraph (C)(1) and that it is certified; and, that it does not violate the prohibitions in Paragraph (C)(2).

(3) When the Plan Administrator determines that the Order satisfies the requirements to be a Qualified Medical Child Support Order, the Plan Administrator shall notify, in writing, each person named in the Order and each representative designated in writing by each person ("Interested Party") that a tentative determination has been made that the Order is a QMCSO.

(4) If it appears that the order is not a QMCSO, the Plan Administrator shall notify, in writing, each Interested Party that a tentative determination has been made that the order is not a QMCSO. Such notice shall state the reasons for the determination. Alternatively, the Plan Administrator may directly contact the legal counsel involved for the purpose of amending the order appropriately.

(E) PROCEDURES UPON FINAL DETERMINATION

Within a reasonable period of time from receipt of the Order, the Plan Administrator shall make a final determination that the Order (as modified, if applicable) is a QMCSO, and shall notify the individuals designated in the Order (or their designated agents) of the decision. Thereafter, the Plan Administrator shall follow the terms of the QMCSO. The Plan Administrator shall authorize payment of benefits subject to the QMCSO. Any payment for benefits made by the Plan pursuant to a Qualified Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

(F) **PROCEDURES: MEDICAL CHILD SUPPORT ORDERS FOUND NOT TO BE A QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)**

The following procedures apply only if the Plan Administrator determines that the Medical Child Support Order is not a Qualified Medical Child Support Order.

(1) **Notice**

As soon as practicable following the determination that a Medical Child Support Order is not "qualified" (hereinafter, the "initial determination"), the Plan Administrator shall notify, in writing, the participant and the Alternate Recipient named in such Order. Such notice shall inform each such person of:

(a) such determination, the date thereof and, to the extent reasonably possible, explain the reasons therefore and describe the possible modifications the issuing court or other court of competent jurisdiction must make to such Order to make it "qualified";

(b) his or her opportunity to receive further assistance as described below; and

(c) the fact that the Plan Administrator will review the modified QMCSO.

(2) **Further Assistance**

If assistance in modifying the order to correct its defects is desired by a participant, the Alternate Recipient or any person entitled to receive notices, the Plan Administrator will, to the extent reasonably possible and not in violation of such applicable laws, respond to any written request for assistance. Such response, if any, by the Plan Administrator, shall be in writing and a copy of the response, together with a copy of the request, shall be sent to the participant and the Alternate Recipient.

(3) **Review of Modified Order**

Within a reasonable period of time after it is received by the Plan Administrator, the Plan Administrator shall determine whether the Order, as modified subsequent to the initial determination, meets all the requirements for classification as a QMCSO. Assuming the Order, as modified, is determined by the Plan Administrator to be "qualified":

(a) as soon as practicable following such determination, the Plan Administrator shall notify, in writing, the participant and the Alternate Recipient of the determination and the date thereof;

(b) the terms of the QMCSO shall be observed by the Plan and Plan fiduciaries; and

(c) the Plan Administrator shall take any action necessary with respect to recordkeeping and administration to ensure compliance with the terms of the QMCSO.

If the modified Order is once again determined to be <u>not</u> qualified, the Plan Administrator shall notify the participant, Alternate Recipient and other persons entitled to receive notices of the determination with the following information:

(a) the reason(s) for rejection and possible further modifications to such order so that, as modified, the Medical Child Support Order may be qualified;

(b) the opportunity to receive further assistance as described above; and

(c) the Plan Administrator will again review the Order and make another determination as to its qualified status.

Section 5.27 - Illegality Of Particular Provision

The legality of any particular provision of this Plan shall not affect the other provisions thereof, but the Plan shall be construed in all respects as if such invalid provisions were omitted.

Section 5.28 - Applicable Laws

To the extent state laws are not preempted by the Act or any other federal law, the Plan shall be governed by and construed according to the laws of the State of Indiana. Should any Trust Agreement be entered into by the Trustees, it shall be governed by and construed according to the laws of the State of Indiana. Proper venue for any legal action against the Plan shall be in Vigo County, Indiana.

Section 5.29 - HIPAA Privacy Rule

(A) Plan's Designation of Person/Entity to Act on its Behalf

The Plan has determined that it is a "group health plan" within the meaning of the HIPAA Privacy Rule, and the Plan designates the Plan sponsor, the Board of Trustees, to take all actions required to be taken by the Plan in connection with the Privacy Rule *(e.g.,* entering into Business Associate contracts; accepting certification from the Plan Sponsor). Such responsibility may be delegated by the Board to the Plan's Administrator.

(B) Definitions

All terms defined in the Privacy Rule shall have the meaning set forth therein. The following additional definitions apply to the provisions set forth in this Section.

(1) "<u>Plan</u>" means this Plan.

(2) "<u>Plan Documents</u>" mean the Plan's governing documents and instruments *(i.e.,* the documents under which the Plan was established and is maintained), including but not limited to this Plan Document and Summary Plan Description.

(3) "<u>Plan Sponsor</u>" means the Board of Trustees of this Plan.

(C) The Plan's Disclosure of Protected Health Information to the Plan Sponsor - Required Certification of Compliance by Plan Sponsor

Except as provided below with respect to the Plan's disclosure of summary health information, the Plan will: (i) disclose Protected Health Information to the Plan Sponsor or (ii) provide for or permit the disclosure of Protected Health Information to the Plan Sponsor with respect to the Plan, *only if* the Plan has received a certification (signed on behalf of the Plan Sponsor) that:

(1) The Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the Plan Sponsor, consistent with the "504" provisions;

(2) The Plan Documents have been amended to incorporate the Plan provisions set forth in this Section; and

(3) The Plan Sponsor agrees to comply with the Plan provisions as modified by this Section.

(D) Permitted Disclosure of Individuals' Protected Health Information to the Plan Sponsor

(1) The Plan (and any Business Associate acting on behalf of the Plan, or any health insurance issuer, HMO, PPO, health care provider, etc., as applicable, servicing the Plan) will disclose individuals' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out Plan administration functions. Such disclosure will be consistent with the provisions of this Section.

(2) All disclosures of the Protected Health Information of the Plan's individuals by the Plan's Business Associate, health insurance issuer, HMO, PPO, health care provider, etc., as applicable, to the Plan Sponsor will comply with the restrictions and requirements set forth in this Section and in the "504" provisions.

(3) The Plan (and any Business Associate acting on behalf of the Plan) may not permit a health insurance issuer, HMO, PPO, health care provider, etc., as applicable, to disclose individuals' Protected Health Information to the Plan Sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, unless authorized by the individual or as allowed by law.

(4) The Plan Sponsor will not use or further disclose individuals' Protected Health Information other than as described in the Plan Documents and permitted by the "504" provisions.

(5) The Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides individuals' Protected Health Information received from the Plan (or from the Plan's health insurance issuer, HMO, PPO, health care provider, etc., as applicable), agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information.

(6) The Plan Sponsor will not use or disclose individuals' Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, unless authorized by the individual or as allowed by law.

(7) The Plan Sponsor will report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the "504" provisions, of which the Plan Sponsor becomes aware.

(E) Disclosure of Individuals' Protected Health Information - Disclosure by the Plan Sponsor

(1) The Plan Sponsor will make the Protected Health Information of the individual who is the subject of the Protected Health Information available to such individual in accordance with 45 C.F.R. Section 164.524.

(2) The Plan Sponsor will make individuals' Protected Health Information available for amendment and incorporate any amendments to individuals' Protected Health Information in accordance with 45 C.F.R. Section 164.526.

(3) The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of individuals' Protected Health Information that it must account for in accordance with 45 C.F.R. Section 164.528.

(4) The Plan Sponsor will make its internal practices, books and records relating to the use and disclosure of individuals' Protected Health Information received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.

(5) The Plan Sponsor will, if feasible, return or destroy all individuals' Protected Health Information received from the Plan (or a health insurance issuer, HMO, PPO, health care provider, etc., as applicable, with respect to the Plan) that the Plan Sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan Sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(6) The Plan Sponsor will ensure that the required adequate separation, described in Paragraph (F) below, is established and maintained.

(F) Required Separation between the Plan and the Plan Sponsor

(1) In accordance with the "504" provisions, this Section describes the employees or classes of employees of workforce members under the control of the Plan Sponsor who may be given access to individuals' Protected Health Information received from the Plan or from a health insurance issuer, HMO, PPO, etc, as applicable, servicing the Plan.

(a) Plan Administrator

(b) Claims Supervisors, Processors and clerical support staff

(c) Information Technology Personnel

(2) This list reflects the employees, classes of employees, or other workforce members of the Plan Sponsor who receive individuals' Protected Health Information relating to payment, health care operations of, or other matters pertaining to Plan administration functions that the Plan Sponsor provides for the Plan. These individuals will have access to individuals' Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of individuals' Protected Health Information in violation of, or noncompliance with, the provisions of this Section.

(3) The Plan Sponsor will promptly report any such breach, violation, or noncompliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any harmful effect of the violation or noncompliance.

Section 5.30 - HIPAA Security Rule

Under federal law, health plans (like this one) must comply with the HIPAA Security Rule ("Security Rule") concerning the security of Electronic Protected Health Information (also known as "e-PHI"). This Plan has taken the necessary steps to achieve such compliance.

The Security Rule also requires the Plan to be amended in certain regards. The following portion of this Section is intended to bring the Plan into compliance with the requirements of 45 C.F.R. 164.314(b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations, 45 C.F.R. parts 160, 162 and 164 ("Security Rule") by establishing the Plan Sponsor's (the Board of Trustees) obligations with respect to the security of Electronic Protected Health Information.

(A) **PLAN'S DESIGNATION OF PERSON/ENTITY TO ACT ON ITS BEHALF**

The Plan has determined that it is a "group health plan" within the meaning of the Security Rule, and the Plan designates the Plan Sponsor, the Board of Trustees, to take all actions required to be taken by the Plan in connection with the Security Rule *(e.g.,* entering into Business Associate contracts, etc.). Such responsibility may be delegated by the Board to the Plan's administrator.

(B) **<u>DEFINITIONS</u>**

All terms defined in the Security Rule shall have the meaning set forth therein. The following additional definitions apply to the provisions set forth in this Section.

(1) "<u>Plan</u>" means this Plan.

(2) "<u>Plan Documents</u>" mean the Plan's governing documents and instruments *(i. e.,* the documents under which the Plan was established and is maintained), including but not limited to this Plan Document and Summary Plan Description.

(3) "<u>Plan Sponsor</u>" means the Board of Trustees of this Plan.

(4) "<u>Electronic Protected Health Information</u>" (or "<u>e-PHI</u>") shall have meaning as set forth in 45 C.F.R. 160.103, as amended from time to time, and generally means protected health information ("PHI") that is transmitted or maintained in Electronic Media.

(5) "<u>Electronic Media</u>" shall mean:

(a) Electronic storage material on which data is or may be recorded electronically, including, for example, devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

(b) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the Internet, extranet or intranet, leased lines, dial-up lines, private networks, and the physical movement of removable/ transportable electronic storage media. Certain transmissions, including paper via facsimile, and of voice via telephone are not considered to be transmissions via electronic media if the information being exchanged did not exist in electronic form immediately before the transmission.

(6) "<u>Security Incident</u>" shall have the meaning set forth in 45 C.F.R 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use disclosure, modification, or destruction of information or interference with systems operations in an information system.

(C) **<u>PLAN SPONSOR OBLIGATIONS</u>**

Where Electronic Protected Health Information will be created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

(1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the e-PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(2) Ensure that the adequate separation required by Section 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;

(3) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

(4) Report to the Plan any successful security incident of which it becomes aware within a reasonable time thereafter and report any unsuccessful security incidents quarterly or as such other times as mutually agreed upon between the Plan Sponsor and the Plan.

STATEMENT OF RIGHTS UNDER EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

Your Rights

As a participant in the Pipe Trades Industry Health and Welfare Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Be informed that under the Health Insurance Portability and Accountability Act (HIPAA), the Plan can provide you with a "Certificate of Creditable Coverage" if you lose health care coverage under the Plan for any reason. This Certificate reports data on prior periods of health coverage under the Plan compiled in accordance with federal regulations. Participants should retain this "Certificate of Creditable Coverage" and submit it to a new employer if the new employer maintains a group health care plan. The new employer may be required under federal law to credit such coverage toward any waiting period for coverage of pre-existing conditions under the new employer's plan.

Be informed that the Plan is in compliance with the non-discrimination requirements set forth in Section 2590.701-2 of the DOL's HIPAA regulations. These regulations state that a group health care plan may NOT establish eligibility rules based on any of the following factors: (1) health status; (2) medical condition (including both physical and mental Sickness); (3) prior claims experience; (4) actual receipt of health care; (5) medical history; (6) genetic information; (7) evidence of insurability (including conditions arising out of domestic violence); or, (8) Disability.

Be informed that under the Newborns' and Mothers' Health Protection Act, group health plans and health insurance issuers offering group health insurance coverage generally may NOT restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, the Plan, or issuer, may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or Physician

assistant), after consultation with the mother, discharges the mother or newborn earlier. Under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48) hour or ninety-six (96) hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to forty-eight (48) hours or ninety-six (96) hours, as applicable. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your Plan Administrator.

Be informed that under the Women's Health and Cancer Rights Act, group health plans and health insurance issuers offering group health insurance coverage that includes medical and surgical benefits with respect to mastectomies shall include medical and surgical benefits for breast reconstructive surgery as part of a mastectomy procedure. Breast reconstructive surgery benefits in connection with a mastectomy shall at a minimum provide coverage for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; (3) prostheses; and, (4) physical complications for all stages of mastectomy, including lymphedemas. Such surgery shall be in a manner determined in consultation with the attending physician and the patient. As part of the Plan's Schedule of Benefits, such benefits are subject to the Plan's appropriate cost control provisions, such as Deductible Amounts and Coinsurance.

Continue Group Health Plan Coverage

If you have a loss of coverage under the Plan as a result of a qualifying event, you may continue health care coverage for yourself, spouse or dependents. You or your dependents may have to pay for such coverage. Review this Restated Plan Document and Summary Plan Description on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of 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.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (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 One Hundred Ten Dollars ($110) a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. [Please refer to the last paragraph of Section 5.20 for important details on bringing suit against the Plan]. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

OTHER IMPORTANT INFORMATION

Type of Plan
This Plan provides medical, death, accidental death and dismemberment, weekly disability and other related health care benefits. It is maintained pursuant to collective bargaining agreements between the Local Unions and the Association which is available for examination at the Plan Office. A copy of an agreement may be obtained upon written request to the Plan Office. Also upon written request, the Plan Office will inform you if a particular employer participates in the Plan and, if so, the address of that employer.

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrative Manager at the Plan Office.

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

Source of Contributions
The Plan's benefits for eligible Employees are provided through Employer contributions. Employers are required to make a contribution to the Trust Fund for each hour worked by each Employee. The hourly contribution rate is set by the collective bargaining agreements between the Union and the Associations.

Funding Medium for the Accumulation of Plan Assets
All contributions and investment earnings of the Plan are accumulated in a Trust Fund that is utilized to pay benefits to eligible individuals and to defray reasonable costs of administration. The Plan may use Plan assets to pay any fees (such as the Affordable Care Act's Patient-Centered Outcomes Research Institute (PCORI) fees or reinsurance fees), that is not an excise tax or similar penalty imposed on the Trustees, in connection with a violation of federal law or a breach of the Trustees' fiduciary obligations in connection with the Plan.

Board of Trustees

Union Trustees

Mark Swaner
Plumbers and Steamfitters
Local Union #157
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Kyle Henderson
Plumbers and Steamfitters
Local Union #184
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Mike Falkenstein
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Local Union #136
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Evansville, IN 47720

Management Trustees

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Evansville, IN 47712

Plan Administrative Manager

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(812) 877-2581

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Plan Legal Counsel

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Terre Haute, IN 47808-3517
(812) 232-3388

Plan Auditor

Sackrider & Co., Inc.
1925 Wabash Avenue
Terre Haute, IN 47807-9907

Plan Identification Numbers

When filing with the Department of Labor and the Internal Revenue Service, the Fund uses the following numbers:

Employer Identification Number (EIN)	35-1063466
Plan Number	501

Fiscal Year

The financial records of the Fund are kept on the basis of a fiscal year which begins on July 1 of each year and ends on June 30 of the following year.

Agent For Service of Legal Process

Every effort is made by the Trustees to resolve any disagreement with participants promptly and equitably. If, however, you and your attorney feel that legal action may be necessary, the following person has been designated by the Trustees as the agent for the service of legal process:

Stephanie Morgan
Pipe Trades Industry Health & Welfare Plan
P.O. Box 3040
Terre Haute, IN 47803-0040

Legal process may also be served upon the Board of Trustees collectively or upon any individual Trustee.

Affiliated Local Unions

#136 - 2300 St Joseph Industrial Park Drive
Evansville, IN 47720
(812) 423-8043

#157 - 8801 East Milner Avenue
Terre Haute, IN 47803
(812) 877-1531

#184 - 1332 Broadway
Paducah, KY 42001
(270) 442-3213