PIPE TRADES INDUSTRY HEALTH AND WELFARE PLAN

RESTATED PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

EFFECTIVE APRIL 1, 2025

INTRODUCTION

The Board of Trustees of the Pipe Trades Industry Health and Welfare Plan is pleased to provide you with this Combination Plan Document and Summary Plan Description (Booklet), which contains current health and welfare benefits information. The benefits described in this Booklet are effective April 1, 2025. This Booklet replaces and supersedes prior Plan Documents and Summary Plan Descriptions. There have been changes to the Plan since the last Booklet was distributed. As a result, you should **READ THIS BOOKLET CAREFULLY** so that you are up to date on the current Plan rules and Benefits.

It is the Trustees' goal to maintain a financially stable Plan while providing quality health care coverage to you and your family. The Plan has implemented cost-saving methods such as deductibles and out-of-pocket maximums to ensure that we can meet your current and future health care needs. You can do your part in helping the Plan manage health care costs by:

- **Visiting In-Network Providers** – In-Network providers, including Hospitals, and providers, charge negotiated, reduced rates.

- **Examining emergency treatment alternatives** – In the event of an emergency, the most important consideration is to seek medical care, especially in a life-threatening situation. However, in some cases, you can obtain the same level of care at a Physician's office or through the Plan's telehealth provider, as in an emergency room. Keep your Physician's telephone number easily accessible and locate the nearest urgent care facility so you will be prepared in case of an emergency.

If you have questions about how the Plan works, please call or write the Plan Office at:

PO Box 3040
Terre Haute, IN 47803-0040

(812) 877-2581

- **Utilizing generic medications** – Often medications come in two forms: generic and brand name. Generic medications must meet the same quality standards for pureness and effectiveness but can cost much less than their brand name equivalent. Check with your Physician to see if a generic medication is appropriate for you.

To become familiar with the provisions of the Plan, we encourage you to read your new Booklet carefully and to share it with your spouse. You will want to keep the Booklet with your other important papers for future reference.

Sincerely,
Board of Trustees

IMPORTANT LIFE EVENTS

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 OR YOUR DEPENDENT(S) BECOME INSURED UNDER ANOTHER HEALTH INSURANCE PLAN.**
- **YOU GO INTO OR 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
P.O. Box 3040
Terre Haute, IN 47803-0040
(812) 877-2581
www.pthwplan.org

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IMPORTANT NOTICE

This Booklet is intended to describe the medical, prescription drug, death, accidental death and dismemberment, weekly disability, and Health Reimbursement Account (HRA) benefits adopted by the Trustees. Only the full Board of Trustees has the authority to interpret the benefits described in this Booklet. Their interpretation will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. The Plan contains appeal procedures that may be used if you feel that benefits have been wrongfully denied. The Trustees decision can be challenged in court only after those procedures are exhausted. No Employer or Union nor any representative of any Employer or Union, in such capacity, is authorized to interpret this Plan nor can any such person act as an agent of the Trustees. Any formal interpretations regarding this Plan must be communicated in writing signed on behalf of the full Board of Trustees either by the Trustees or, if authorized by the Trustees in writing, by the Administrative Manager.

Trustee Authority

The Board of Trustees, as Plan Administrator, has full authority to increase, reduce or eliminate benefits and to change the Eligibility Rules or other provisions of the Plan at any time. However, the Trustees intend that the Plan terms, including those relating to coverage and benefits, are legally enforceable and that the Plan is maintained for the exclusive benefit of the Participants and their eligible Dependents. **Benefits under this Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.**

Grandfathered Plan Notice

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 Administrative Manager.

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.

CONTACT INFORMATION

If You Need To …	Contact …
Locate An In-Network Medical Provider	Anthem www.anthem.com 1-800-837-5678
Check Eligibility, File an Enrollment Form, Add/Delete a Dependent, Update your Contact Information, File a Beneficiary Form, Notify the Plan of Other Health Coverage	Plan Office (812) 877-2581
Obtain Prior Authorization and Medical Care Management for Medical Services	Valenz 1-800-367-1934
File a Medical Claim	In Network: File to the Provider's local Anthem BCBS Out-of-Network: Pipe Trades Industry H&W Plan P.O. Box 3040 Terre Haute, IN 47803
Find a Participating Pharmacy or inquire about a Prescription Drug clinical program	Sav-Rx https://www.savrx.com/ (800) 228-3108
To Register For and Access Telehealth Benefits	LiveHealth Online www.livehealthonline.com
File a HRA, Death Benefit, AD&D or Weekly Disability Claim	Pipe Trades Industry H&W Plan P.O. Box 3040 Terre Haute, IN 47803 (812) 877-2581

ARTICLE ONE: 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 – Air Ambulance Services
Air Ambulance Services means medical transport by helicopter or airplane for patients.

Section 1.03 – Act or ERISA
"Act" means the Employee Retirement Income Security Act of 1974, as amended.

Section 1.04 – 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 1.05 – Ambulatory Surgical Center
" Ambulatory Surgical Center" means a licensed facility that:

(A) has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;

(B) provides treatment by or under the supervision of licensed medical doctors or oral surgeons and provides nursing services when the covered individual is in the facility;

(C) does not provide inpatient accommodations; and

(D) is not, other than incidentally, a facility used as an office or clinic for the private practice of a licensed medical doctor or oral surgeon.

An Ambulatory Surgical Center includes any licensed facility described in section 1833(i)(1)(A) of the Social Security Act.

Section 1.06 – Associations
"Associations" means the Associations of participating Employers who are parties to the Trust Agreement which funds the Plan.

Section 1.07 – Beneficiary
"Beneficiary" means a person designated by a participant or by the terms of the Plan who is or may be entitled to a Death and/or Accidental Death and Dismemberment benefit.

Section 1.08 – 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 1.09 – Coinsurance
"Coinsurance" means the percentage of the total covered medical expense paid by the Plan.

Section 1.10 – Co-Payment
"Co-Payment" means the portion of an expense the Eligible Individual pays before the Plan pays its portion of the benefit.

Section 1.11 – Cosmetic
"Cosmetic" means any Surgical Procedure, procedure or treatment performed primarily to improve the physical appearance or to change or restore bodily form without materially correcting a bodily malfunction.

Section 1.12 – Covered Employee
"**Covered Employee**" means an Employee who has met the Plan's eligibility criteria in Article Three to receive benefits from the Plan.

Section 1.13 – Covered Expense
An Expense for an item or service is a "**Covered Expense**" if:

(A) The expense is for Medically Necessary items or services for treatment of a non-occupational Sickness, Injury, or Accident, including prescription drugs, or a Wellness benefit, and

(B) The Expense for such item or service is not otherwise excluded or limited by a term or condition of the Plan.

Even if an item or service is determined to be a Covered Expense, payment on such item and service will be limited by the Usual, Customary and Reasonable charge for such an item or service.

Section 1.14 – Covered Facility
"**Covered Facility**" means the following institutions which are licensed as required by applicable law, are not used more than incidentally as offices or clinics for the private practice of a Physician or Covered Provider:

(A) Hospitals

(B) Outpatient Ambulatory Surgical Center

(C) Substance Abuse Treatment Center

(D) Dialysis facility

(E) Residential Treatment Facility

(F) Urgent care facility

(G) Birthing Centers

Section 1.15 – Covered Provider

"**Covered Provider**" means a licensed or board-certified provider of medical, mental health or substance abuse disorder services who are act within the scope of their licenses and specialty, including (but not limited to) Physicians, nurses, midwives, physiotherapists, speech therapists, pharmacists, psychiatrists, counselors, licensed clinical mental health providers such as social workers, licensed clinical psychologist (PhD), licensed nurse practitioner (LNP), physician's assistant (PA); certified registered nurse anesthetist (CRNA).

Section 1.16 – 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 1.17 – Deductible

"Deductible" means a specified dollar amount of eligible medical expenses which have previously been paid by an Eligible Individual or a Family Unit during the calendar year before the Coinsurance is applicable.

Section 1.18 – Developmental Care

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

(A) Are provided to a Eligible 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 1.19 – 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 1.20 – Disabled Individual

"**Disabled Individual**" means a former Employee who has coverage from the Plan in accordance with the eligibility rules in Section 3.11.

Section 1.21 – 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.

Examples of Durable Medical Equipment shall include, but shall not be limited to,

- 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.
- oxygen concentrator units and the rental of equipment to administer oxygen,
- delivery pumps for tube feedings
- Artificial eyes and limbs to replace lost or natural eyes and/or limbs.
- surgical dressings and bandages, casts, splints, trusses, crutches or braces that stabilize an injured body part

Section 1.22 – Eligible Dependent
"Eligible Dependent" means:

(A) The legal spouse of the eligible Employee;

(B) A child, adopted child, stepchild or legal ward of the Participant 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 a Participant 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 Participant terminates upon the termination of the legal obligation set forth above; or

(C) An unmarried child, adopted child, stepchild or legal ward of the Participant over age twenty-six (26) who is incapable of self-sustaining employment due to mental or physical handicap, who is dependent upon the Participant 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 a Participant e 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 (QMCSO).

Section 1.23 – Eligible Individual
"Eligible Individual" means each Participant and each Eligible Dependent.

Section 1.24 – Emergency Medical Condition
"Emergency Medical Condition" means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

Section 1.25 – Emergency Services
Emergency Services with respect to an Emergency Medical Condition, include:

(A) An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

(B) Such further medical examination and treatment to stabilize the patient within the capabilities of the staff and facilities available at the hospital or the Independent Freestanding Emergency Department, and

(C) Further services that are furnished by an out-of-network provider or Out-of-Network Emergency Facility after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay (regardless of the department of the hospital in which such further examination or treatment is furnished)

Section 1.26 – 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.

Section 1.27 – 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 1.28 – Expense

"Expense" means the cost incurred for a 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 1.29 – 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 1.30 – Family Unit

"Family Unit" means the Participant and all of his Eligible Dependents. If both the Employee and legal Spouse are Covered Employees, 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.

Section 1.31 – 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).

"Hospital" includes a long-term acute care hospitals or long-term care hospitals that provide care to people with complex medical needs requiring long term hospital stay in acute or critical settings if the institution meets the definition of Hospital in the preceding sentence.

"Hospital" does NOT include an institution or part an 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 1.32 – Hybrid Employee
"**Hybrid Employee**" means any person employed by an Employer who performs a combination of work covered under a collective bargaining agreement with the Union, as well as non-covered work of an executive, managerial, or supervisory nature.

Section 1.33 – Independent Freestanding Emergency Department
"Independent Freestanding Emergency Department" means a health care facility that (i) is geographically separate and distinct and licensed separately from a Hospital under applicable State law; and (ii) Provides any "Emergency Services" as defined in Section 1.25.

Section 1.34 – 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 1.35 – 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 1.36 – 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 Eligible Individual's Injury or Sickness;

(C) Provided in accordance with generally accepted medical practice on a national basis based on established medical criteria and current standards of care; 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.

The Trustees in their discretion will interpret what is Medically Necessary. The Trustees will take into account relevant information including, but not limited to, clinical utilization management

guidelines or medical policies approved, accepted or endorsed by the organizations selected by the Trustees to provide utilization review or medical management.

Section 1.37 – 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 1.38 – Network Health Care Facility
"Network Health Care Facility" means, in the context of non-Emergency Services, a network hospital, hospital outpatient department, critical access hospital, or ambulatory surgical center (as defined in the Social Security Act).

Section 1.39 – Nonparticipating/Out-of-Network Emergency
"**Nonparticipating/Out-of-Network Emergency Facility**" means an emergency department of a hospital, or an Independent Freestanding Emergency Department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with the Plan, with respect to the furnishing of an item or service.

Section 1.40 – 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 1.41 – Out-of-Network Rate
"**Out-of-Network Rate**" will be determined in the following order:

(A) the amount that the state approves under an All-Payer Model Agreement, if applicable

(B) the amount determined by a state law, if applicable;

(C) the payment amount agreed to by the Plan and provider or facility, if applicable;

(D) the amount approved under the independent dispute resolution (IDR) process.

Section 1.42 – Out-Of-Pocket Limit
"Out-of-Pocket Limit" means a specific dollar amount of eligible Covered Expenses which have been paid by an Eligible Individual or a Family Unit 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) amount over the Usual Customary and Reasonable amount for a Covered Expense;

(C) any Expenses incurred by an Eligible Individual which exceed the Plan maximums or limitations for a particular benefit.

Section 1.43 – Participant
"**Participant**" means a Covered Employee, Disabled Individual, or a Retiree.

Section 1.44 – Physician
"Physician" means legally qualified doctor or surgeon who is a Doctor of Medicine (M.D.) a Doctor of Osteopathy (D.O.), a Doctor of Chiropractic (D.C.), a Doctor of Dentistry (D.D.S.), a Podiatrist (D.P.M.), or a Doctor of Optometry (O.D.), provided that any such individual renders treatment only within the scope of his/her license and specialty.

Section 1.45 – Plan
"Plan" means the Pipe Trades Industry Health and Welfare Plan as described herein and as hereafter amended.

Section 1.46 – 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 1.47 – 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 is 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 1.48 – Qualifying Payment Amount (QPA)

"Qualifying Payment Amount (QPA)" generally means, the median amount the Plan has contractually agreed to pay network providers, facilities, or providers of Air Ambulance Services for a particular covered service. This amount is updated annually to account for inflation.

Section 1.49 – Recognized Amount

"Recognized Amount" means for items and services furnished by an Out-of-Network provider or Out-of-Network emergency facility, the Recognized Amount will be determined in the following order:

(A) An amount determined by an All-Payer Model Agreement, if applicable;

(B) An amount determined by a specified state law, if applicable;

(C) The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

Section 1.50 – Residential Treatment Facility

"**Residential Treatment Facility**" means a facility established and operated as required by the laws of the state, district or territory and may be accredited, where required, by a nationally recognized organization to provide residential treatment for mental health and/or substance use disorder conditions. The Residential Treatment Facility must meet the following requirements:

(A) Provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.

(B) Offers organized treatment services that feature a planned and structured regimen of care in a 24- hour setting and provides at least the following basic services:

(1) Room and board

(2) Evaluation and diagnosis.

(3) Referral and orientation to specialized community resources.

Section 1.51 – Retiree

"**Retiree"** means a former Employee who has coverage from the Plan in accordance with the eligibility rules in Section 3.11.

Section 1.52 – Shop Owner

"**Shop Owner**" means any person with an ownership interest in an Employer, such as a member, shareholder, or partner, who is actively involved in the Employer's day to day operations, but does not perform work covered under a collective bargaining agreement with the Union, as well as immediate family (such as parents, children, step-children, brothers and sisters) of the members, shareholders, or partners who are employed by the Employer in a non-bargained position and who are actively engaged in the Employer's day to day business.

Section 1.53 – Sickness

"Sickness" means a disease, disorder or condition which requires treatment by a Physician., including pregnancy.

Section 1.54 – Substance Abuse Treatment Center
"Substance Abuse Treatment Center" means a Hospital, Residential Treatment Facility or clinic licensed for outpatient drug or alcohol abuse treatment. Facilities providing outpatient services must be licensed for the level of care and services being performed and must be supervised by a Physician. Facilities providing outpatient services may include partial hospitalization and intensive outpatient treatment services.

Section 1.55 – 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 1.56 – 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 1.57 – 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 1.58 – 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 1.59 – 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 provided by an out-of-network provider 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.

Notwithstanding any other Plan provision, if for any reason the contracted PPO fee for a Covered Expense 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.

For services covered by the No Surprises Act, the Usual, Customary, and Reasonable Charge shall be based on the amount required under the No Surprises Act, which may differ between the amount that the Plan uses to determine the Eligible Employee or Eligible Dependent’s cost-sharing and the amount paid in total. See Section 8.26 – Protections from Surprise Medical Bills for more information on the No Surprises Act.

ARTICLE TWO: SCHEDULE OF BENEFITS

This Article provides a high-level summary of the benefits from the Plan. Eligibility requirements, limitations, and exclusions may apply to specific benefits.

Death Benefit	
Covered Employee	$11,500.00
Retiree or Disabled Individual	$4,500.00
• *No Death Benefits shall be paid on behalf of a deceased Eligible Dependent, widow or widower*	
Accidental Death and Dismemberment (AD&D) Benefit	
Covered Employee	
Loss of Life	$11,500.00
Loss of Both Hands, Feet, Eyes or any combination of the two (2)	$11,500.00
One (1) Hand, Foot, or Eye	$ 5,750.00
Retiree or Disabled Individual	
Loss of Life	$4,500.00
Loss of Both Hands, Feet, Eyes or any combination of the two (2)	$4,500.00
One (1) Hand, Foot, or Eye	$2,250.00
➢ *No AD&D Benefits shall be paid on behalf of a deceased or dismembered Eligible Dependent, widow or widower*	
Weekly Disability Benefit	
Covered Employee Only ➢ *Maximum Benefit of 15 weeks per calendar year* ➢ *Waiting Period Due to Sickness – 8 days* ➢ *No Waiting Period for Accident, Injury or if Covered Employee on maternity leave after the birth of a child*	$500.00 per week

MEDICAL BENEFITS

- **Covered Employees & Eligible Dependents**
- **Non-Medicare Eligible Retirees & Disabled Individuals and their Eligible Dependents Not Entitled to Medicare**

Certain items and services or treatments may require prior authorization or are otherwise subject to benefit maximums, limitations and exclusions. Please see Section 8.26 for more information regarding coverage of certain Out-of-Network items and services

Calendar Year Deductible	Individual $700.00 Family Unit $2,100.00

- *In-Network and Out-of-Network Covered Expenses are combined to meet the Deductible*
- *Deductible does not apply to Wellness Benefits, LiveHealth Online Visits, in-network prescription drug expenses*

Calendar Year Out-of-Pocket Maximum	Individual $4,000.00 Family Unit $8,000.00

- *In-Network and Out-of-Network Covered Expenses apply to the Out-of-Pocket Maximum*
- *Does not include prescription drug expenses, excluded services, amounts exceeding Plan maximums, cost-share amounts for items deemed not to be Covered Expenses or balance billed charges*

General Co-Insurance for Major Medical Benefit	Plan pays 80% of UCR, after Deductible is Met

- *Plan payment percentages are payable after satisfaction of deductible(s) and before satisfaction of the person's or family's out-of-pocket maximum.*
- *Only applies to items and services deemed to be Covered Expenses*
- *Items and services may require prior authorization or are subject to limitations and exclusions*

LiveHealth Online Visit Benefit	Plan pays 100%

- *Medical, Mental Health, and Substance Use Disorders*
- *In-Network Benefits through Live Health Online only*
- *No Co-Payment, Coinsurance or Deductible applies*
- *LiveHealth Online not available for Medicare-Eligible Retirees and Medicare Eligible Dependents of Retirees*

Sword Health -Virtual Physical Therapy	Plan pays 100%

- *Must meet specific eligibility criteria*
- *In-Network Benefits through Sword Health only*
- *No Co-Payment, Coinsurance or Deductible applies*

Chiropractic	Plan pays 80% of UCR, after Deductible is Met

- *Calendar Year Maximum - $1,000.00 per person*

Wig Benefit	Plan pays 80% of UCR, after Deductible is Met

- *Calendar Year Maximum – 2 wigs*

Wellness Benefit	Plan pays 100% of UCR

- *Routine Physical examination – one office visit per year age two and over*
- *Cervical Cancer Screening (Pap Smear) – one per year*
- *Prostate Specific Antigen (PSA) test – one per year*
- *Mammogram – one per year age 40 and over*
- *Sigmoidoscopy – one every five years, age 45 and over*
- *Colonoscopy – one every five years, age 45 and over*
- *Well-Child Exam & Routine Immunizations through age 24 months*
- *Routine Adult and Childhood Immunizations – age two (2) and over*

PRESCRIPTION DRUG BENEFITS

- **Covered Employees & Eligible Dependents**
- **Non-Medicare Eligible Retirees & Disabled Individuals and their Eligible Dependents Not Entitled to Medicare**

Below is an overview of the Prescription Drug Benefit. Each Co-Payment or Co-Insurance applies per prescription. Step therapy, prior authorization, use of SavRx Specialty Pharmacy for specialty drugs, and other benefit management programs apply to certain Prescription Drug benefits. Please see Article Six for more information on these programs.

RETAIL PHARMACY	**In-Network**		**Out-of-Network**
	Covered Employees	**Non-Medicare Retirees & Disabled Individuals**	**Both Groups**
Up to 34-day fill	Generic: You pay $20 Brand: You pay $38*	Generic: You pay $15 Brand: You pay $32*	Plan will pay 50% of the cost of the drug, after Medical Deductible is met
Up to 60-day fill	Generic: You pay $40 Brand: You pay $70*	Generic: You pay $30 Brand: You pay $60*	
Up to 90-day fill	Generic: You pay $60 Brand: You pay $105*	Generic: You pay $45 Brand: You pay $90*	
MAIL ORDER	**In-Network**		**Out-of-Network**
	Covered Employees	**Non-Medicare Retirees & Disabled Individuals**	**Both Groups**
Up to 90-day fill for maintenance drugs	Generic: You pay $38 Brand: You pay $77*	Generic: You pay $25 Brand: You pay $64*	No coverage

**If there is a generic equivalent available and you choose the brand name drug and do not have an approved letter of Medical Necessity from your Physician as described in Section 6.05, you will be responsible for the brand name Co-Payment plus the difference in cost between the brand name drug and the generic equivalent.*

MEDICAL BENEFITS

- **Medicare Eligible Retirees & Dependents of Retirees 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.

On the date a Retiree or Dependent of a Retiree becomes eligible for Medicare Parts A and B, all medical coverage from this Plan will be coordinated with Medicare Parts A and B whether or not the individual is enrolled in Medicare. For more information on how to enroll in Medicare, please contact the Plan Office.

Calendar Year Deductible	Individual $700.00 Family Unit $2,100.00

- *In-Network and Out-of-Network covered charges are combined to meet the Deductible*
- *Deductible does not apply to Wellness Benefits, in-network prescription drug expenses*

Coordination of Benefits with Medicare Parts A and B

Generally, Medicare-eligible retirees are eligible for the same medical benefits offered to non-Medicare eligible Retirees, except for telehealth benefits through LiveHealth. The Plan coordinates the coverage it offers with Medicare 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, 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.

The Plan follows the Medicare guidelines for this group of Participants, meaning that these individuals can go to any provider contracted with Medicare and the Plan will coordinate benefits with Medicare. The Plan shall pay only what Medicare does not pay only after the Plan's Deductible is met, only if the expenses are Covered Expenses under the Plan and provider further, in no event shall amounts paid 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. If the participant incurs a charge that is not covered by Medicare, but would otherwise be covered by the Plan, the Plan will pay at 80% UCR, after Deductible, unless otherwise noted.

The Plan shall pay all deductible amounts required by Medicare when the Retiree or Eligible Dependent is initially hospitalized and after the Plan's Deductible has been met. **The Plan shall pay no benefits for charges incurred over or above the prevailing reserve days established by Medicare.**

Sword Health -Virtual Physical Therapy	Plan pays 100%

- *Must meet specific eligibility criteria*
- *In-Network Benefits through Sword Health only*
- *No Co-Payment, Coinsurance or Deductible applies*

Chiropractic	Plan pays after Deductible is Met

- *Calendar Year Maximum - $1,000.00 per person*

Wig Benefit	Plan pays after Deductible is Met

- *Calendar Year Maximum – 2 wigs*

MEDICAL BENEFITS

- **Medicare Eligible Retirees & Dependents of Retirees Eligible for Medicare**

Wellness Benefit Plan pays 100% of UCR

- *Routine Physical examination – one office visit per year age two and over (all other covered charges during office visit paid in accordance with Schedule of Benefits)*
- *Cervical Cancer Screening (Pap Smear) – one per year*
- *Prostate Specific Antigen (PSA) test – one per year*
- *Mammogram – one per year age 40 and over*
- *Sigmoidoscopy – one every five years, age 45 and over*
- *Colonoscopy – one every five years, age 45 and over*
- *Well-Child Exam & Routine Immunizations through age 24 months*
- *Routine Adult and Childhood Immunizations – age two (2) and over*

PRESCRIPTION DRUG BENEFITS

The Plan provides its own fully insured Medicare Part D coverage through an Employer Group Waiver Plan (EGWP) with self-funded wrap coverage for medications not covered by the EGWP.

More information about prescription drug coverage for this group can be found in Section 6.02. The following copayments and coinsurance apply to both portions of the Medicare prescription drug program. Step therapy, prior authorization, use of SavRx Specialty Pharmacy for specialty drugs, and other benefit management programs apply to certain Prescription Drug benefits.

Retail Pharmacy	**In-Network**	**Out-of-Network**
Up to 34-day fill	Generic: You pay $15 Brand: You pay $32*	Plan will pay 50% of the cost of the drug, after Medical Deductible is met
Up to 60-day fill	Generic: You pay $20 Brand: You pay $50*	
Up to 90-day fill	Generic: You pay $30 Brand: You pay $75*	
Mail Order Pharmacy	**In-Network**	**Out-of-Network**
Up to 90-day fill for maintenance drugs	Generic: You pay $25 Brand: You pay $64*	No coverage

**If there is a generic equivalent available and you choose the brand name drug and do not have an approved letter of Medical Necessity from your Physician as described in Section 6.05, you will be responsible for the brand name Co-Payment plus the difference in cost between the brand name drug and the generic equivalent.*

ARTICLE THREE: ELIGIBILITY RULES

Section 3.01 – Initial Eligibility for Collectively Bargained Employees
Initial Eligibility shall begin on the first day of the Benefit Month that corresponds with the Calendar Month during which an Employee is credited with one hundred (100) hours of contributions at the current contribution rate. See the chart below for Calendar Months and corresponding Benefit Months. Contributions begin with the first hour, first day of covered employment for an Employer or Employers.

Calendar Month *Hours Worked In*	**Benefit Month** *Gives Eligibility In*
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February

If an Employee works less than one hundred (100) hours in his initial Calendar Month or his Employer(s) make(s) payment for less than one hundred (100) 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 one hundred (100) multiplied by the applicable Employer contribution rate and may only be made at the beginning of the initial Benefit Month.

Section 3.02 – Continuation of Eligibility for Collectively Bargained Employees
Subject to the termination rules in Section 3.09, once a collectively bargained Employee establishes initial eligibility, his or her coverage will be continuous for each subsequent Benefit Month that the Employee:

(A) Worked for a contributing Employer and the Plan receives at least one hundred (100) hours of contributions at the current contribution rate on his behalf for each corresponding Calendar Month;

(B) Continues eligibility through use of his Reserve Credit in accordance with Section 3.03; or

(C) Makes self-contribution payments in accordance with Section 3.04.

Section 3.03 – Reserve Credit for Collectively Bargained Employees

Once a collectively bargained Employee establishes initial eligibility, contributions received at the current contribution rate in excess of the required one hundred (100) hours in each Calendar Month shall be considered Reserve Credit. The maximum amount of Reserve Credit which shall be credited to any individual's account shall be equal to six (6) months of coverage at the current contribution rate.

Reserve Credit shall be used to provide continuous eligibility only and shall not be used to establish or reestablish Eligibility. When using the Reserve Credit, the Plan shall reduce the collectively-bargained Employee's accumulated balance by the self-contribution rate in effect for active members or in a manner otherwise determined by the Trustees.

Section 3.04 – Self-Contribution Payments

(A) Self-Payments when Available to Work in Jurisdiction of affiliated local Union

If a collectively bargained 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 multiplied by the current contribution rate for the Calendar Month and the required one hundred (100) hours multiplied by the current contribution rate to continue coverage for the corresponding Benefit Month.

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

If the Employee has some credited hours in the applicable Calendar Month, there is no limit to the number of self-contribution payments an Employee may make. Self-contribution payments for the full one hundred (100) hours can be made for no more than twenty-four (24) consecutive months, unless the Employee has applied for Social Security Disability as is in the waiting period before Medicare starts. After twenty-four (24) consecutive full self-contribution payments are made, the Employee may continue coverage from the Plan as explained in Section 3.17 – Continuation Coverage Under COBRA.

Failure to make a timely or correct self-contribution payment shall result in a loss of eligibility, the forfeiture of all unused Reserve Credit hours, and termination of the right to make future self-contribution payments until eligibility is reestablished according to Section 3.10 – Reinstatement of Eligibility.

(B) Employment Outside of Jurisdiction

A Covered 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 Month to maintain eligibility. The amount

to maintain eligibility for a Benefit Month is an amount equal to one hundred (100) times the applicable hourly contribution rate.

The self-contribution payment must be made quarterly or monthly and received by the Plan Office on or before the tenth day of the first month of the quarter or before the tenth day of the Benefit 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 3.05 – Eligibility for Shop Owners and Self-Employed Members

Participation and eligibility for Shop Owners and Hybrid Employees 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 covered employment by a Hybrid Employee, 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. An Employer's Shop Owner(s) may participate under this section only if the Employer covers all full-time, non-bargaining employees, and if it signs a Participation Agreement. An Employer must be signatory to either a collective bargaining agreement with the Union and have signed a participation agreement for its Shop Owners and Hybrid Employees to participate in the Plan.

Section 3.06 – Eligibility for Non-Bargained Employees

Participation and eligibility for non-bargained Employees shall be based upon the reporting and payment of all hours worked by participating non-bargained employees, with terms as further described in a required Participation Agreement. Coverage is only available to those full-time, non-bargained employees who are actively engaged in the Employer's daily operations.

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 Month). 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 month 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 Under The Family And Medical Leave Act Of 1993

When a Covered 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 3.09 – Termination Of Coverage for Covered Employees

An Employee's coverage will terminate on the earliest of the following days:

(A) The first day of the Benefit Month in which the Plan did not receive at least one hundred (100) hours of contributions at the current contribution rate on behalf of a collectively bargained Employee for the corresponding Calendar Month, and the Employee did not use Reserve Credits in accordance with Section 3.03, or self-pay in accordance with Section 3.04;

(B) The date a non-bargained Employee, Shop Owner, or Hybrid Employee no longer meets the applicable eligibility rules for coverage; or the date the participation agreement covering such Employee is terminated;

(C) The date the Employee's Union withdraws from the Plan. In the event of such withdrawal, all rights or interest in or to any balance in the Employee's Reserve Credit shall be terminated and 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;

(D) The date the Plan is terminated; or

(E) The first day of the month following the Employee's death.

If an Employee's coverage is terminated, the Employee may qualify for COBRA Continuation Coverage pursuant to the rules in Section 3.17.

Section 3.10 – Reinstatement of Eligibility for Collectively Bargained Employees

An Employee who loses his eligibility shall become a Covered Employee again on the first day of the Benefit Month that corresponds with the Calendar Month during which an Employee worked and is credited with one hundred (100) hours of contributions at the current contribution rate. If an Employee receives credit for less than the one hundred (100) hours at the current contribution rate, the Employee may not self-pay the difference to reinstate eligibility.

Section 3.11 – 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 if he meets the following terms and conditions*:*

(A) Initial Eligibility

(1) The individual submits an application and provides proof that he either:

(A) 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, or via COBRA, for twelve (12) consecutive months immediately preceding the date the individual intends to begin coverage from this Plan as a Retiree or Disabled Individual; or

(B) In the absence of the above pension plan requirement, 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; and

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

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

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) Initial Date of Coverage

If qualified, the initial date of coverage for the Retiree or Disabled Individual under this section shall be the first day of the Benefit Month following the date the application is approved or proof of pension or disability payments is received and proper payment is received.

(C) Coverage for Eligible Dependents

If you are a retiree or Disabled individual, you may also elect coverage for your Eligible Dependents. However, you may not select coverage for your Eligible Dependents if you decline coverage for yourself. If you elect coverage for yourself, but decline coverage for your Eligible Dependents, you may not subsequently obtain coverage for any Eligible Dependents who could have been enrolled at the time of you enrolled in the Retired and Disabled Employee Program, unless the Special Enrollment provisions in Section 3.14 apply.

(D) Contribution Payments

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

Failure to make timely and continuous payments for described above shall terminate the individual's right to make further payments and be covered under this Plan.

NO LATE PAYMENTS SHALL BE ACCEPTED.

(E) Benefits Offered

The benefits offered to each group of Retirees are outlined in the Schedule of Benefits. For Medicare eligible Retirees, Disabled Individuals and Medicare-eligible Eligible Dependents of Retirees, the Plan provides its own fully insured Medicare Part D coverage through an Employer Group Waiver Plan (EGWP) with a self-funded wrap coverage for medications not covered by the EGWP. The following enrollment rules apply to the Plan's Medicare Part D program.

(1) Initial Enrollment

All current and future Medicare eligible participants in the Plan will be automatically enrolled in Medicare Part D when the participant is first eligible to enroll.

(2) 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.

(3) 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.

(4) 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. You are also not eligible for the Plan's self-funded wrap. 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.

(F) Termination of Coverage

Coverage for a Retiree or Disabled Individual shall terminate on the earliest of the following:

(1) The last day of the month preceding the Benefit Month for which you did not make a proper and on-time retiree contribution;

(2) The last day of the month preceding the Benefit Month in which the individual fails to meet the eligibility rules

(3) The last day of the month preceding the Benefit Month for which you have earned coverage from the Plan as an Active Employee;

(4) The effective date of the withdrawal from the Plan of the Union that Retiree or Disabled Individual was affiliated with;

(5) The date the Plan is terminated, or the date the Plan terminates retiree benefits; or

(6) The date of your death.

The Trustees reserve the right to terminate benefits or to change the requirements for participation of Retirees or Disabled Individuals

Section 3.12 – Initial Coverage for Eligible Dependents

Participants must enroll their Eligible Dependent(s) for their Eligible Dependents to be covered by the Plan. To enroll their Eligible Dependents in the Plan, the Participant must complete an enrollment form, and provide any requested documentation of dependent status.

Coverage for Eligible Dependents that are your current dependents will begin at the same time as the Participant, provided however, that an enrollment form must be provided to the Plan Office to complete the enrollment process within sixty (60) days after the date in which you become a Participant. If your eligible Dependent is not enrolled in the Plan within sixty (60) days of you becoming eligible, your Eligible Dependent will become eligible for coverage from the Plan on the first day of the calendar month following the date that the enrollment form and requested documentation is received by the Plan Office. The failure to properly identify and enroll Eligible Dependents may result in denial of claims and/or coverage from the Plan,

Retirees and Disabled Individuals must enroll their Eligible Dependents in accordance with the rules found in Section 3.11(C).

Misrepresenting eligibility criteria for dependents (for example, marital status, age, relationship status), to obtain or continue coverage for an individual who is not eligible for coverage from the Plan will be considered an act or an omission that constitutes fraud and an intentional misrepresentation of a material fact that is prohibited by the terms of the Plan.

Section 3.13 – Opt-Out Provisions

A spouse of a Covered Employee may opt out of the Plan's coverage due to eligibility under a high deductible health plan 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 3.14 – Special Enrollment Provisions for new Eligible Dependents

If a person becomes a dependent of a Participant through marriage, birth, adoption, placement for adoption or a court order (including a QMCSO) that dependent will be entitled to a 60 day special enrollment period beginning on the date of marriage, birth, adoption, placement for adoption or date a court order is entered. This means that if the dependent is enrolled within 60 days of the marriage, birth, adoption, placement for adoption or date a court order is entered, the dependent will be covered from the date of the marriage, birth, adoption, placement for adoption or effective date of the court order.

Additionally, an Eligible Dependent can be added within 61 days if coverage under a State Children's Health Insurance Program is lost, or if the Eligible Dependent becomes eligible for CHIP or Medicaid Coverage. Contact the Plan Office for more information.

If a Participant fails to timely enroll a new dependent or provide evidence of a dependent's eligibility, coverage will begin on the first of the month following the completion of enrollment and will not be retroactive to the date of birth, marriage, adoption or placement for adoption. The Plan will not be responsible for any bills or charges incurred prior to the first of the month following completion of enrollment. Please contact the Plan Office for more information.

Section 3.15 – Termination of Coverage for a Dependent

An Eligible Dependent's coverage will terminate on the earliest of the following dates:

(A) The last day of the month in which the dependent ceases to meet the definition of an Eligible Dependent;

(B) The date in which the Participant's coverage from the Plan terminates, unless the dependent's coverage continues through the Widow/Widower Program as described in Section 3.16; or

(C) The date an opt-out of coverage for the Dependent becomes effective.

All Covered Individuals are responsible for promptly notifying the Plan Office when a dependent ceases to meet the Plan's eligibility criteria.

For example, the Plan Office should be immediately notified in the event of divorce, dissolution of marriage, legal separation or separate maintenance, or when a dependent child is no longer an Eligible Dependent.

If an Eligible Dependent's coverage is terminated, the dependent may qualify for COBRA Continuation Coverage pursuant to the rules in Section 3.17.

Section 3.16 – Coverage for Dependents of Deceased Participants

The widow or widower of a deceased Participant and his Eligible Dependents that were eligible under this Plan at the time of death may maintain eligibility for benefits from the Plan under the following terms and conditions:

(A) Eligibility

To be eligible for the Widow/Widower's program, the widow or widower must:

(1) Elect to maintain eligibility for benefits from the Plan and receive approval of coverage from the Plan;

(2) Make applicable self-payments in a timely manner as set by the Trustees;

(3) contact the Plan 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 receive approval from the Plan.

However, a dependent child is not eligible for coverage under the Widow/Widower program if the widow/widower does not maintain coverage.

(B) Effective Date of Coverage

Coverage under the Widow/Widower's program shall commence with the first day of the month following the receipt of the required self-payment and approval of coverage by the Trustees.

(C) Contribution Payments

Contribution payments must be made on a monthly basis and must be made by the tenth day of the Benefit Month. 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, Retired, or Disabled Employees. In addition, all benefits shall be coordinated with Medicare or Medicaid program. If the Widow reaches retirement, and is still eligible for the Widow/Widower Program, the Plan will use her date of retirement to determine eligibility for retiree benefits. 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 the earliest of the following:

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

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

(3) the first day of the month 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 Deceased Employee's Union from the Plan; or

(5) the date the Plan is terminated, either in full or the group in which the dependent belongs.

The Trustees reserve the right to terminate benefits or to change the requirements for participation in the Widow/Widower Program.

Section 3.17 – Continuation Coverage Under COBRA

In compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan offers certain Employees and Eligible Dependents 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. If eligible, you must take certain actions within specified time periods to initiate and maintain COBRA coverage.

You may have other options 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) Eligibility For COBRA Coverage

An Employee or Eligible Dependent who becomes eligible for COBRA coverage shall be known as a Qualified Beneficiary. An event which causes an Employee or Eligible Dependent to become a Qualified Beneficiary to become eligible for COBRA shall be known as a Qualifying Event. 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) Benefits Available

Only the health care and prescription drug 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.

(C) Procedure for Obtaining COBRA Coverage

When the 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 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 act 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. The Plan shall not be liable and shall be held harmless if 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 Office 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 Section 1.22.

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 Administrative Manager within sixty (60) days after it occurs, COBRA coverage shall NOT be provided.

The monthly COBRA self-payment rate 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.

When the Administrative Manager is properly notified of an election to purchase COBRA coverage, they 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. The first self-payment shall cover the Qualified Beneficiary from the date of the Qualifying Event through the last day of the current 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. However, the Plan will give you a 30-day grace period for payment of the monthly self-payments. The last self-payment due shall be prorated to reflect the actual number of days of coverage up to the date COBRA coverage terminates.

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 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.

(D) 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, 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.

(E) Termination of COBRA Coverage

COBRA coverage shall terminate on the first date 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.

ARTICLE FOUR: DEATH, ACCIDENTAL DEATH & DISMEMBERMENT, AND WEEKLY DISABILITY BENEFITS

Section 4.01 – Beneficiary Designation for Benefits Payable on Account of Death

For the purposes of the Death Benefit in Section 4.02 and Accidental Death & Dismemberment Benefit in Section 4.03, any payable benefits on account of the death of the individual will be made to the person(s) designated by the Participant on the beneficiary designation form provided by the Plan, unless another rule in this section applies.

In the event the Participant dies without designating a Beneficiary or in the event that the designated Beneficiary has predeceased the Participant, the amount of any payable Death Benefit and/or Accidental Death & Dismemberment benefit shall be paid to the first applicable of the following surviving individuals in equal shares, in descending order:

(A) The Participant's surviving Spouse;

(B) child or children;

(C) parents;

(D) siblings; or

(E) failing these, to the deceased individual's estate.

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

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

Section 4.02 – Death Benefit

Upon the death of a Participant 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 as described in Section 4.01. No Death Benefits shall be paid on behalf of a deceased Eligible Dependent, widow or widower.

Section 4.03 – Accidental Death And Dismemberment Benefit

When bodily Injury caused solely by a non-occupational Accident results in the death or dismemberment of a Covered Employee, Retiree, or Disabled individual, the Plan shall pay a benefit as set forth in the Schedule of Benefits upon receipt of proper proof of loss. In the event that benefits are payable under this section due to the death of the Eligible Individual, benefits will be paid to the Participant's designated Beneficiary, as described in Section 4.01. No Accidental Death or Dismemberment Benefits shall be paid on behalf of a deceased or dismembered Eligible Dependent, widow or widower.

Section 4.04 – Weekly Disability Benefit

When Sickness, Accident or Injury suffered on or off the job shall disable and prevent a Covered 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.

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. 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. However, if the Sickness is due to maternity leave after the birth of a child for a child-bearing Covered Employee working under a Collective Bargaining Agreement, payment will begin on the first 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, a widow or widower**.**

ARTICLE FIVE: COMPREHENSIVE MEDICAL BENEFITS

Section 5.01 – General Information

The Plan provides benefits to help cover the cost for a wide range of Medically Necessary services, treatments and supplies for non-work related Accident, Injury or Sickness, including Physician, Hospital and Facility charges, diagnostic testing and surgery. The Plan also provides benefits for some preventative care services that are specifically listed under the Wellness Benefit.

For the items and services listed in Sections 5.03 through Section 5.06, please refer to the Schedule of Benefits for details about:

(A) The amounts payable for an item or service if it is a Covered Expense (including any applicable Deductible, Copayment and/or Coinsurance) and

(B) Any visit, day and/or dollar limit that applies.

It is important to remember that the medical program is not designed to cover every health care expense. The Plan pays charges for Covered Expenses under the conditions established under the Plan's rules. The decisions about how and when you receive medical care are up to you and your Physician—not the Plan. The Plan determines how much it will pay; you and your Physician must decide what medical care is best for you.

Section 5.02 – Prior Authorization

Prior authorization is the process the Plan uses to evaluate the Medical Necessity of certain services, treatments, and facility stays, the number of days required to treat your condition, and any applicable benefit limitations and criteria. In most cases, your Covered Provider or Covered Facility will take care of requesting prior authorization. As you are still responsible for ensuring that prior authorization is completed, you should always ask your physician, hospital, inpatient residential treatment center, whether or not they have contacted the Plan's medical management vendor and provided all necessary information.

The following medical services require prior authorization: Please see the Prescription Drug benefit for information on drugs and services covered by the Prescription Drug benefit that may require prior authorization.

Inpatient Services	
Acute Hospital Care - Medical and Mental Health/ Substance Use	Inpatient Surgery
Acute Rehab	Long Term Acute Care
Chemotherapy	Observation Stay
Transplant	Residential Treatment Facility
Outpatient Services	
Arteriograms/Angiograms/Aortagraphy	Orthotics & Prosthetics
Cardiac Rehab	Occupational Therapy
Chemotherapy	Pain Management Epidural Steroid Injections

Cochlear Implants/Other Auditory Implants	Pain Management Trigger Point or Facet Injection
CT/CTA	Photodynamic Therapy
Dental General Anesthesia	Physical Therapy
Durable Medical Equipment (C-Pap doesn't require prior authorization)	Pulmonary Rehab
Genetic Testing	Radiofrequency Ablation/Rhizotomy
Home Health Care	Shock wave lithotripsy/radiation for Plantar Fasciitis
Home Infusion Therapy	Sleep Studies
Medical Supplies	Spinal Procedures
Medication by Infusion & by Injection	Speech Therapy
Mental Health IOP	Surgery in an outpatient Facility
Mental Health PHP	Vein Ablation/ Varicose Vein Treatment
MRI/MRA	Vision Therapy

This list may change over time and should not be considered an exhaustive list of services requiring prior authorization. For more information, contact the Fund Office.

If you are enrolled in Medicare on a primary basis (Medicare pays before the Plan), the prior authorization requirements for services covered by Medicare do not apply to you. Since Medicare is the primary payer, the Plan will process payments as secondary payer.

Section 5.03 – Major Medical Benefit

The following services and supplies may be payable by the Plan for the diagnosis or treatment of a non-occupational Accident, Injury or Sickness when Medically Necessary, unless otherwise limited or excluded by the terms of the Plan.

(A) Ambulance Services

The Plan covers licensed ambulance services for the following circumstances:

(1) To transport an Eligible Individual to the nearest appropriate Covered Facility for care for an Emergency Medical Condition;

(2) To transport an Eligible Individual who has received Emergency Services or who is an inpatient at a Hospital the nearest appropriate Hospital equipped to furnish special or unique treatment if the Injury or Sickness requires such treatment;

(3) local emergency ambulance service to and from the Hospital due to pregnancy and/or resulting childbirth.

(4) Air ambulance services are covered for an Emergency Medical Condition or when otherwise Medically Necessary only to the nearest Covered Facility that can treat the Eligible Individual.

(B) Hospital Services – Inpatient Care

The Plan covers services provided during an inpatient stay in a Hospital, including:

(1) Room and Board charges;

- If intensive care or other specialized unit confinement is Medically Necessary, room and board in such intensive care or specialized unit is covered;
- If confinement in a private room is Medically Necessary, room and board for such private room is covered; or
- In all other cases, room and board for a semi-private room. Is covered

(2) Inpatient radiology, pathology and cardiology services from Covered Providers;

(3) Other charges from the Hospital for other services and supplies received during the Inpatient stay, including general nursing services; use of operating room, surgical and anesthesia services and supplies; blood and blood products; ordinary casts, splints and dressings; drugs and oxygen used in the Hospital; laboratory and diagnostic services; electrocardiograms

(4) Pharmacy charges, including specialty infusions and injectable prescription drugs not approved under the clinical programs offered through the Pharmacy Drug Benefit

For Hospital confinements which overlap calendar years, all benefits shall be calculated as if the entire confinement occurred during the calendar year of admittance.

(C) Surgical Services

The Plan covers certain inpatient and outpatient Surgical Procedures provided by a Physician at a Physician's office or other Covered Facility. The Plan also covers services performed in connection with and related to covered surgical procedures, including charges from Covered Facility, preoperative care, postoperative care, and anesthesia provided by a properly licensed or certified Covered Provider.

The following surgical services are subject to special terms and conditions:

(1) The Plan does not cover Cosmetic Surgery or Reconstructive surgery, unless for:

- Accidental Injuries;
- To repair congenital defects of newborn eligible children;
- For repair of the effects of a previous Surgical Procedure performed;
- Mastectomy Surgery, as follows:

  The Plan covers mastectomies and related services that are treated in accordance with the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). If you are receiving benefits from the Plan in connection with a mastectomy and you elect breast reconstruction in connection with such

mastectomy, the Plan will provide coverage for the following treatments in a manner determined in consultation with you and the attending Physician:

- All stages of reconstruction of a breast on which a mastectomy has been performed;
- Surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance in a manner determined between the Eligible Individual and the attending Physician;
- Coverage for prostheses and physical complications of all states of mastectomy (including lymphedema); and
- Treatment of physical complications of the mastectomy, including lymphedema.

(2) The Plan does not require a diagnosis of an Injury or Sickness for a prophylactic simple mastectomy when Medically Necessary.

(3) Coverage 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:

- one hundred percent (100%) of the Usual, Customary and Reasonable Charge for the primary procedure;
- fifty percent (50%) of the Usual, Customary and Reasonable Charge for the secondary procedure, including any bilateral procedure; and
- 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.

(4) 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.

(D) Physician's Services

(1) Hospital Services and Visits

The Plan covers professional services and/or visits by a Physician or Covered Provider while an Eligible Individual is confined in a Hospital. For Hospital confinements which overlap calendar years, all benefits shall be calculated as if the entire confinement occurred during the calendar year of admittance.

(2) Physician's Office Services

The Plan covers services rendered by a Physician or Covered Provider for diagnosis or medical care at their office or through a virtual visit.

(E) Emergency Services

The Plan covers services and supplies that you receive for Emergency Services from an emergency department of a Hospital or as otherwise required by the No Surprises Act. See Section 8.26 for more information on the No Surprises Act.

(F) Diagnostic and Laboratory Services

The Plan covers diagnostic and laboratory services that are ordered by a physician or other Covered Provider when appropriate, including facility charges, supplies and equipment. Diagnostic and laboratory services include:

(1) Laboratory and radiology/X-ray services

(2) Mammography (See Section 5.06 regarding coverage of mammograms under the Plan's Wellness benefit)

(3) Genetic Testing

(4) CT scans, MRI, nuclear medicine and major diagnostic services

(G) Durable Medical Equipment and Medical Supplies

The Plan covers Durable Medical Equipment and related supplies prescribed by a Physician, including:

(1) Rental (up to the purchase price), purchase, fitting, necessary adjustments, repairs and replacement of integral parts of the Durable Medical Equipment; and

(2) Nondurable supplies (i.e. tubing, connectors and masks) when used with covered Durable Medical Equipment.

(3) A one-month rental of a wheelchair if a patient-owned wheelchair is being repaired.

This Plan does not cover special fittings, adaptations or maintenance agreements related to covered Durable Medical Equipment. The Plan will not cover equipment that serves solely for your convenience or comfort. For wheelchair, motorized scooter, lift chair or like equipment, the Plan follows Medicare guidelines for Medicare Eligible Individuals when determining what type of equipment is covered.

(H) Dental Services

The Plan covers the following dental related services provided at a Hospital or Covered Facility by a Covered Provider:

(1) Dental services rendered by a Physician, including a 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;

(2) General anesthesia materials, their administration, and Covered Facility charges for Dependent Children who may have physical, intellectual or medically compromising conditions requiring general anesthesia when dental care is provided. Conditions must

be verified by medical documentation and include but are not limited to mental retardation, cerebral palsy, epilepsy, and autism;

(3) the surgical extraction of an impacted wisdom tooth or teeth; and

(4) extraction of teeth required prior to providing a medical procedure or treatment for a life-threatening medical condition.

(I) Maternity Services

The Plan covers services provided to a Covered Employee or their spouse in connection with pregnancy and childbirth for Covered Provider's services, Hospital and obstetrical services and supplies ordered by a Covered Provider, local emergency ambulance service to and from the Hospital or Covered Facility due to pregnancy and/or resulting childbirth, and any anesthesia administered during childbirth, follow-up Hospital care for the mother and newborn, and nursery charges. For Hospital confinements which overlap calendar years, all benefits shall be calculated as if the entire confinement occurred during the calendar year of admittance.

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

(J) Other Medical Services and Supplies

The Plan covers the following medical services and supplies when provided by a Covered Provider:

(1) Chemotherapy and radioisotope, radiation and nuclear medicine therapy that are FDA approved for such diagnosis and not part of a clinical trial;

(2) Administration of blood or fractionalized blood products;

(3) Surgical dressings, casts, splints, braces, trusses, and crutches;

(4) Artificial eyes and limbs to replace lost or natural eyes and/or limbs;

(5) Enteral or parenteral nutrition therapy for certain conditions that require specialized nutrients or formula;

(6) Acupuncture provided by Physician ;

(7) Home health care provided by a licensed physical therapist, registered graduate nurse (R.N.) or licensed practical nurse (LPN) when prescribed by the attending Physician;

(8) Chiropractic services and x-rays provided during a visit to the chiropractor’s office.

(K) Organ Transplant Services

The Plan covers certain organ transplant services and supplies. Organ Transplant services are limited to Hospital charges, Physician charges, organ procurement, and the costs associated with the actual transplantation of the organ. The Plan does not pay for any expenses incurred by the organ donor.

(L) Rehabilitative Services

The Plan covers speech therapy, physical therapy, occupational therapy, cardiac rehabilitation, and pulmonary therapy or rehabilitation to regain skills and functioning due to Accident, Injury or Sickness when such therapy is provided by a properly licensed Covered Provider. Benefits include rehabilitation services provided in a Physician's office or on an outpatient basis at Covered Facility. The Plan does not cover services for Developmental Care.

Virtual Physical Therapy: See Section 5.05 for more information on the Plan's virtual physical therapy benefit through Sword Health.

(M) Substance Use Disorder and Mental Health Benefits

(1) Substance Use Benefits

The Plan covers Hospital, Residential Treatment Facility, Substance Abuse Treatment Center, Physician's or Covered Provider's charges incurred for treatment of substance use disorder Sicknesses. Services include detoxification treatment, inpatient rehab, a partial Hospital program or intensive outpatient program.

Inpatient services at an Out-of-Network Residential Treatment Facility are not covered by the Plan. Certain participating Local Unions have an employee assistance program available through the Union at no cost to the eligible Employee or Eligible Dependent and include a number of free visits for various services. Please contact your Local Union for more information regarding these programs.

(2) Nervous, Mental, or Psychiatric Disorder Treatment Benefit

The Plan covers Expenses incurred for the treatment of a nervous, mental or psychiatric disorder. Benefits are paid on the same basis as any other Medical Condition.

(N) Wig Benefit

The Plan covers a wig prescribed by a Physician as a prosthetic for hair loss due to the following Sickness or Injury or treatment of such Sickness or Injury:

(1) Burns resulting in permanent alopecia;

(2) Lupus;

(3) Alopecia areata, alopecia totalis, alopecia universalis;

(4) Fungal infections not responding to a course of anti-fungal treatment resulting in complete cranial hair loss;

(5) Chemotherapy;

(6) Radiation therapy.

Section 5.04 – Telehealth Benefits through Anthem's LiveHealth Online
This benefit is not available to Medicare-eligible Retirees and Medicare-eligible Dependents of Retirees.

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 (using a computer, cell phone, tablet, or other mobile internet device)in order to get quick access to certain prescriptions or other advice regarding a medical situation. This online 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 be subject to the Plan's Deductible to use LiveHealth Online, as described in the Schedule of Benefits. Benefits from LiveHealth Online are available for medical and behavioral health services.

If you have a virtual visit with a Provider other than through LiveHealth Online, your claim will be subject to the Plan's cost-sharing provisions applicable to other provider visits.

Section 5.05 –Virtual Physical Therapy through Sword Health
The Plan will provide virtual physical therapy for majority of qualified musculoskeletal diagnosis to an Eligible Individual who qualifies through the Plan's preferred musculoskeletal virtual provider Sword Health at no cost (i.e. You do not have to pay any Co-Payment, Coinsurance or be subject to the Plan's Deductible to use Virtual Physical Therapy through Sword Health), as described in the Schedule of Benefits.

An Eligible Individual must be suffering from pain in his or her neck, lower back, shoulder, knee, hip, ankle, wrist, or elbow, or has undergone surgery in these areas. To be eligible for this benefit, an Eligible Individual must meet the following criteria:

(A) is over 13 years of age,

(B) is able to perform 20 minutes of light to moderate physical activity,

(C) does not have recent onset fever, chills, or visible inflammation in the affected area,

(D) does not have signs of progressive neurological issues in the area of pain,

(E) does not have an active cancer or is receiving treatment for cancer, and

(F) pain is not related to significant trauma to that area.

If qualified, the Eligible Individual will receive required monitoring equipment in the mail and will access their physical therapy sessions through a smart phone, computer or tablet. As mentioned above, there is no cost to the Eligible Individual and no annual visit limit for virtual physical therapy. Injuries incurred while on the job (i.e. Workers' compensation injuries) are not covered under the Plan or this virtual program.

Section 5.06 – Wellness Benefits

Benefits will be paid for the specific routine preventive services listed in this section, as set forth in the Schedule of Benefits. If you do not meet the requirements and limitations for the wellness services described in this Section 5.06, these services and supplies will be subject to coverage under the Plan's Major Medical Benefit, as described in Section 5.03 and the Schedule of Benefits.

(A) Routine Adult Physical Exam

One (1) office visit for a routine adult physical exam per Calendar Year is available for Eligible Individuals age two (2) and over. All other services and supplies provided in connection with a Routine Adult Physical Exam may be paid under the Plan's Major Medical Benefit, as described in Section 5.03 and the Schedule of Benefits.

(B) Routine Pap Smear for Cervical Cancer Screening

One (1) routine pap smear per year is available.

(C) Routine Prostate Specific Antigen (PSA) Test for Prostate Cancer Screening

One (1) routine PSA test per year is available.

(D) Routine Mammogram for Breast Cancer Screening

One (1) routine mammogram per year is available to a Covered Individual aged forty (40) and over.

(E) Routine Sigmoidoscopy for Colorectal Cancer Screening

One (1) routine sigmoidoscopy every five (5) years is available to a Covered Individual aged forty-five (45) and over.

(F) Routine Colonoscopy for Colorectal Cancer Screening

One (1) routine colonoscopy every five (5) years is available to a Covered Individual aged forty-five (45) and over.

(G) Well-Child Exam and Routine Immunizations

Routine well child exams and all routine immunizations recommended by the Center for Disease Control are available for Covered Individuals from birth through age twenty-four (24) months.

(H) Routine Adult and Childhood Immunization

Routine adult and childhood immunizations recommended by the Center for Disease Control are available for Covered Individuals age two (2) and over if (1) the immunization is recommended by a Physician and (2)not for the purposes of occupation and/or vacation travel.

Section 5.07 – Breast Pump Benefit

The Plan's breast pump benefit will include expenses incurred for a breast pump that is ordered by a Physician for an Employee or a Dependent Spouse during the 3rd trimester of pregnancy through six months after delivery. The Plan will reimburse the Employee or Dependent Spouse for a breast pump subject to the following limitations:

(A) 100% of the cost of one of the following breast pumps; not subject to the Plan's annual Deductible;

- Abana™ Hands-Free Wearable Breast Pump
- Ameda® Mya Joy Double Electric Pump
- Cimilre® E1 Portable Breast Pump
- Lansinoh® SignaturePro® Double Electric Pump
- Lansinoh® DiscreetDuo™ Breast Pump
- Medela Pump In Style with MaxFlow Double Electric Breast Pump
- Motif Twist Breast Pump
- Zomee Z2 Double Electric Breast Pump

and;

(B) 1 breast pump per birth.

To receive reimbursement under this benefit, the Employee or Dependent Spouse must provide a copy of:

- the Physician's prescription written for the Employee or Dependent Spouse for the breast pump, and
- the itemized bill/invoice of the breast pump, and
- the paid in full receipt from the vendor/provider providing the breast pump.

Breast pump supplies or replacement costs will not be covered by the Plan.

ARTICLE SIX: PRESCRIPTION DRUG BENEFIT

Prescription Drug Benefits are available to all Participants and Eligible Dependents. and are payable as set forth in the Schedule of Benefits.

Section 6.01 – General Information on Prescription Drug Coverage for Covered Employees and their Eligible Dependents, and non-Medicare eligible Retirees and their non-Medicare Eligible Dependents

For Covered Employees and non-Medicare eligible retirees and their dependents, the Plan has contracted with a Prescription Benefit Manager (PBM), Sav-Rx, to provide participants and Eligible Dependents with prescription drugs through both a retail pharmacy program and a mail order program.

The Plan has implemented cost and benefit management programs that may apply to certain medications. Those programs are explained in further detail in this Article. Prescription Drug copayments and coinsurance are shown on the applicable Schedule of Benefits.

Section 6.02 – General Information on Prescription Drug Coverage for Medicare-eligible Retirees and Medicare-eligible Dependents of Retirees

The prescription drug plan for retirees and their Eligible Dependents who are Medicare-eligible consists of two parts. The first part is a standard Medicare Part D prescription drug plan sponsored by the Plan and offered through UnitedHealthcare (UHC). The Trustees have added a supplemental benefit (called a "wraparound" benefit) to the Part D plan to close the gaps between the standard Part D plan and the prescription drug plan offered to Covered Employees and non-Medicare retirees. This wraparound benefit is administered by Sav-Rx, the Plan's PBM for Covered Employees and non-Medicare eligible Retirees.

The standard Medicare Part D prescription drug plan is administered by UHC, the Plan's insurance carrier for Medicare eligible Retirees and Medicare eligible dependents. UHC provides you with the *Evidence of Coverage* that explains your rights and the rules you need to follow to get covered services and prescription drugs covered by the Medicare Part D portion of your coverage.

NOTE: Covered Employees and their Eligible Dependents are covered under the prescription drug plan for Covered Employees, even if they are Eligible for Medicare. Additionally, Eligible Dependents (including spouses) of Medicare-eligible retirees, who themselves are not yet eligible for Medicare will continue to be covered under the prescription drug plan offered to non-Medicare Retirees and Covered Employees until such time the dependent becomes eligible for Medicare.

For information on clinical management programs, and claims and appeal information that may apply to drugs covered by the Medicare Part D portion of the Plan, please refer to the *Evidence of Coverage* document. Prescription drugs covered by the Plan's self-funded wrap coverage are subject to the clinical programs and claims information found in this SPD.

Section 6.03 – Application of Deductible and Out-of-Pocket Maximum
Any in-network, out-of-pocket expense incurred under the Prescription Drug Benefit shall NOT be included in or accrue towards the Out-of-Pocket or the Deductible.

Section 6.04 – Specialty Drugs
Specialty drugs require prior authorization through the Clinical Department of the Pharmacy Benefit Manager. If approved, specialty drugs are limited to no more than a 30-day supply. Some specialty drugs are included in the Sav-Rx High Impact Advocacy Program. This program manages the use of selected medications to reduce or eliminate the out-of-pocket expense, as well as reducing the cost to the fund. Your prescription will be filled at the Sav-Rx Specialty Pharmacy and Sav-Rx will facilitate the enrollment into a manufacturer sponsored coupon program, if available.

Section 6.05 – Mandatory Generic Program
The Plan has implemented the Sav-Rx Mandatory Generic Program to help decrease prescription drug costs for both you and the Fund. Before you try a prescribed brand name drug, you'll try a generic equivalent. The substitution applies to generic medications that are rated by the U.S. Food and Drug Administration (FDA) as being equivalent to the brand name medication.

In certain situations, the brand name medication is Medically Necessary. In these situations, your prescribing Physician must submit a written letter of Medical Necessity indicating the medical reason as to why you require the brand name product. If clinically appropriate, you are not required to pay the difference in cost, only your applicable brand name Co-Payment.

If your prescribing Physician does not submit a letter of Medical Necessity and you still fill the brand name drug, you will be responsible for the brand name drug Co-Payment PLUS the difference in cost between the generic equivalent and the brand name drug.

The Plan is combining a "Try One on Us" offer with the Mandatory Generic Program which provides an additional incentive for Participants to try a generic alternative risk free. The first fill of the generic alternative – at retail or mail order pharmacies – would be available at no Co-Payment, while subsequent refills would be at the applicable Co-Payment.

Section 6.06 – Mandatory Step Therapy
The Plan has implemented the Sav-Rx Step Therapy Program in an effort to maintain and preserve a high quality and cost-effective program for you. This program is mandatory for certain medication classes. The Step Therapy Program through Sav-Rx is designed to ensure you take the most cost-effective medications to treat certain conditions. The program promotes the use of generic medications because they are proven to be as safe and effective as brand name medications for most patients, but cost much less.

The Step Therapy Program groups certain medications into "steps". Generic medications, which are the most cost effective, fall into the "first-step" category, brand-name medications fall within the "second-step" category. The Step Therapy Program steers members to take first-step medications prior to coverage of a second-step medication.

The medication classes which qualify for the Step Therapy Program include, but are not limited to: cholesterol-lowering statins, ARB antihypertensives, SSRI/SNRI antidepressants, oral osteoporosis medications, migraine medications, Cox 2 And Non-Steroidal, Anti-Inflammatory Agents, steroid nasal sprays, Proton Pump Inhibitors, Beta and Calcium Channel Blockers and Glaucoma Eye Drops.

You will be required to use the following procedures if you are prescribed any second-step prescriptions of the above medication classes:

(A) Contact your Physician and share the step therapy information contained in your letter. Your Physician can decide which first-step medication is right for you.

(B) If you have previously tried one of the first-step medications and your Physician has determined that you require a different medication for medical reasons, then your Physician can call Sav-Rx to request a prior authorization for you to take the medication. The Sav-Rx Clinical Department can advise your Physician if a second-step medication is required. Just remember that you pay a higher co-payment for brand medications.

(C) You have the option to take any medication that your Physician prescribes, however it may not be covered under the benefit plan if the proper steps are not taken first.

The Plan is combining a "Try One on Us" offer with the Step Therapy Program which provides an additional incentive for Participants to try a generic alternative risk free. The first fill of the generic alternative – at retail or mail order pharmacies – would be available at no Co-Payment, while subsequent refills would be at the applicable Co-Payment.

Section 6.07 – Medical to Pharmacy (M2P) Program

The Plan participates in the M2P Program, a clinical program focusing on specialty drug savings through the PBM network, in an effort to maintain and preserve a high quality and cost-effective program for participants and Eligible Dependents. Under this program, Medically Necessary specialty infusions and injections not otherwise excluded under the Plan will now be covered through the Prescription Drug Benefit instead of provided directly from medical providers. This program is mandatory for certain specialty infusions and injections to treat chronic conditions, including specialty infusions and injections received through a home health provider. Prior authorization will be required for drugs being used for off-label treatment.

Section 6.08 – Smoking Cessation

Prescriptions for smoking cessation drugs purchased using the Pharmacy Benefit Manager's drug card are payable at the normal retail Co-Payment rate and are available to the eligible Employee and Eligible Dependents.

Prescription coverage is provided for two tobacco cessation attempts per calendar year per eligible person as a preventive service. For this purpose, covering a cessation attempt includes coverage for all Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regiment when prescribed by a Provider without prior authorization. Prescription coverage after two tobacco

cessation attempts is subject to the Plan's prescription drug Schedule of Benefits. There is no limitation on Physician's visits for counseling related to smoking cessation.

Section 6.09 – Prior Authorization Program

The Sav-Rx Prior Authorization Program is an extension of the Specialty Drug Program and targets medications that do not quite qualify as specialty medications but do benefit from additional clinical management. This requirement helps to ensure that members are receiving the appropriate drugs for the treatment of specific conditions and in quantities as approved by the U.S. Food and Drug Administration (FDA).

Section 6.10 – Therapeutic Quantity Limits Program

The Sav-Rx Therapeutic Quantity Limits Program ensures proper dosing and dispensing of certain medications based upon FDA and manufacturer guidelines. The program monitors prescription utilization and helps identify potential overuse or misuse of medications such as narcotic pain relievers and sedative hypnotics, migraine treatments, respiratory, and nasal medications.

Section 6.11 – Biosimilar Program

The Mandatory Biosimilar Program requires the use of biosimilar prescription drug equivalents (in lieu of brand-name biological products, sometimes called "biologics") whenever available, beginning February 11, 2025 for new prescriptions. If the Covered Person or Physician requests a brand-name, prescription biologic instead of its biosimilar equivalent, the Covered Person must submit a Letter of Medical Necessity to the Plan's Pharmacy Benefit Manager for clinical management. If you choose not to participate and submit a Letter of Medical Necessity from your Physician, your brand-name prescription drug at issue (with the biosimilar equivalent) will not be covered under the Plan. Medicare Retirees and Medicare eligible dependents are subject to this program if prescriptions benefits are not covered through the fully-insured prescription plan through United Healthcare.

Section 6.12 – Impact Program

The Fund has adopted the Sav-Rx Impact Program at no cost to you. This program will begin providing coverage for certain high-cost medications, most considered "specialty medications," through the Fund's prescription benefit manager, Sav-Rx, Impact Program. For such eligible medications, a Sav-Rx concierge representative will contact you to complete the enrollment process. Sav-Rx will verify physician information and assist with setting up a brief 15-minute telehealth appointment scheduled with a pharmacist at the dispensing pharmacy. This telehealth appointment, applicable annually for refills, will allow the pharmacist to understand your prescription needs and address any questions or concerns.

Participation in this program is voluntary for coverage under the Fund for specialty drugs available through the program. Sav-Rx maintains a list of drugs in the Impact Program, and the list may change. If you have questions about the Impact Program, contact the Fund Office at (765) 447-8803 or Sav-Rx at (800) 552-6550. Medicare Retirees and Medicare eligible dependents are subject to this program if prescriptions benefits are not covered through the fully-insured prescription plan through United Healthcare

Section 6.13 – Prescription Drug Exclusions And Limitations

Payments under the Prescription Drug Benefit shall be subject to the following limitations and exclusions:

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

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

(C) Reimbursement shall be limited to the applicable supply maximum per prescription;

(D) no payment shall be made for a prescription refill which is one (1) year or more after the original issue date;

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

(F) experimental and investigational drugs, which is a medicinal product (a drug or vaccine) that has not yet received approval from governmental regulatory authorities for routine use in human or veterinary medicine. A medicinal product may be approved for use in one disease or condition but still be considered experimental for other diseases or conditions.;;

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

(H) 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;

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

(J) 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

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

(L) no payment shall be made for drugs or medications for Cosmetic purposes.

ARTICLE SEVEN: HEALTH REIMBURSEMENT ACCOUNT

Section 7.01 – Health Reimbursement Account

The Health Reimbursement Account (HRA) component of the Plan allows for Employer contributions to be allocated into a Health Reimbursement Account (HRA or Account) to reimburse some participants for certain expenses as allowed by law. That rate will be set by the Board of Trustees. No Employee contributions are permitted. At this time, only Local 157 participates in this benefit. Reciprocity contributions made on behalf of members of Local 136 or Local 184 may participate in the Local 157's HRA. Individuals for which an HRA account has been established will be known as an "HRA Participant."

A. Establishment of Separate Account

The Plan Administrator will establish and maintain a separate Account for each eligible HRA Participant. This Account will be used to receive the Employer HRA contributions and to reimburse allowable expenses. Although each HRA Participant's Account will be separately identified, the combined assets of all Accounts will be held by the Plan and identified in the Plan's financial statements as the HRA reserves. The Account established for an HRA Participant will merely be a record-keeping account for the purpose of keeping track of Employer HRA contributions and available reimbursement amounts from the Plan. The Accounts shall not be credited with any interest income earned on the HRA reserves. The Accounts will be charged with any expenses for administration of the HRA, as noted in Section 7.12. The Accounts are not a vested benefit and are not the property of the HRA Participant except for the purposes set forth herein.

B. Crediting of Accounts

A HRA Participant's Account will be credited at the end of the month with contributions made for work performed by the HRA Participant in the preceding month. For example, Employer contributions made for a HRA Participant hours worked in July will be contributed to a Participant's Account on August 31st. Only amounts actually received by the Plan will be credited to an HRA Participant's Account.

C. Debiting of Accounts

An HRA Participant's Account will be debited for the amount of monies reimbursed upon payment of the reimbursement.

Section 7.02 – Eligibility

To be eligible for reimbursements from the HRA, HRA Participants must meet the following eligibility rules:

A. For medical claim reimbursements, HRA Participants must have previously satisfied the Plan's initial eligibility rule; and,

B. To use the HRA for self-payments (see Section 7.09 below), HRA Participants must have been eligible the preceding month; and,

C. HRA Participants must have a balance in their HRA.

Section 7.03 – Reciprocity
If an Employee works in Local 157's jurisdiction but is not a member of Local 157, contributions will be transferred to the Employee's home fund under the International Reciprocity Agreements. If the home fund does not have an HRA, the contributions will credit toward the Health and Welfare Fund of their home local. Contributions made on behalf of members of Local 136 or Local 184 may participate in Local 157's HRA.

Section 7.04 – Medical Care Expenses Covered
Medical Care Expenses eligible for reimbursement under the HRA are all expenses incurred by the HRA Participant, the HRA Participant's spouse and/or the HRA Participant's dependents for medical care as that term is defined in section 213(d) of the Internal Revenue Code. For a resource of expenses that may be reimbursed by the HRA, refer to IRS Publication 502. The Publication can be found on the Internet at http://www.irs.gov/pub/irs-pdf/p502.pdf. If you do not have Internet access, contact the Plan Office for a copy of Publication 502. However, even if not listed in IRS Publication 502 as eligible reimbursable medical care expenses, expenses for over-the-counter (non-prescription) medications shall be covered under this HRA.

Section 7.05 – Expenses that Do Not Qualify for Reimbursement
Some of the expenses listed in IRS Publication 502 that do not qualify for reimbursement from a Participant's HRA include, but are not limited to:

- Baby Sitting, Childcare, and Nursing Services for a Normal, Healthy Baby
- Controlled Substances
- Cosmetic Surgery (unless necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.)
- Dancing Lessons
- Diaper Service (unless diapers are needed to relieve the effects of a particular disease.)
- Electrolysis or Hair Removal
- Flexible Spending Account (FSA)
- Funeral Expenses
- Future Medical Care
- Hair Transplant
- Health Club Dues
- Health Coverage Tax Credit
- Health Savings Accounts (HSA)
- Household Help (you may be able to include certain expenses paid to a person providing nursing-type services.)
- Illegal Operations and Treatments

- Insurance Premiums For Other Than Health Care
- Maternity Clothes
- Medical Savings Account (MSA)
- Medicines and Drugs From Other Countries (you can include the cost of a prescribed drug you purchase and consume in another country if the drug is legal in both the other country and the United States.)
- Menstrual Care Products
- Nutritional Supplements (unless they are recommended by a medical practitioner as treatment for a specific Medical Condition diagnosed by a physician.)
- Personal Use Items
- Swimming Lessons
- Teeth Whitening
- Veterinary Fees
- Weight-Loss Programs unless under specific terms

Section 7.06 – How to File a Claim for Reimbursement of a Medical Expense

A HRA Participant must satisfy the Plan's initial eligibility rule on or before the date of the claim to be eligible for reimbursement from the HRA.

A HRA Participant can submit a claim using one of the following methods:

- By paying the medical bill and submitting the bill and proof of payment for reimbursement. If the medical bill is paid, the Plan Office will reimburse the HRA Participant.
- By submitting an Explanation of Benefits (EOB) for an unpaid bill. The Plan Office will send payment to the provider.
- For expenses over $1,000, the HRA Participant can set up a documented monthly payment plan with the provider of service and submit monthly payment receipts for reimbursement. The Plan Office will reimburse the HRA Participant for monthly payments.

The HRA Participant must follow the payment procedures as stated herein. Claims must be filed on the appropriate claim form submitted with evidence of payment or the EOB. Each claim can only be paid once, either a partial or full payment. If a claim is partially paid, it cannot be resubmitted for the balance, except with a documented monthly payment plan as described above.

If a claim is submitted for reimbursement and that claim is returned to the HRA Participant with no payment made, that claim can be resubmitted within the six month filing limit. Claims will be processed in a timely manner as they are received.

When the HRA Participant pays the claim first and then submits a request for reimbursement, claims must total at least $200 per family. If needed, a HRA Participant can submit multiple

medical bills with evidence of payment to reach the $200 limit. **No reimbursement will be made to a HRA Participant until the minimum of $200 per family has been met.**

Section 7.07 – Filing Time Limit
Claims for reimbursement from the HRA account must be filed within six months of the date that either the Fund Office paid the portion of the medical claim or the participant paid the claim.. Late filed claims will not be eligible for reimbursement.

Section 7.08 – Appeals of Denied HRA Claims
HRA Participants have the right to appeal any denial, in whole or part, of an HRA claim in accordance with the Plan's claims and appeals procedures.

Section 7.09 – How to Apply HRA Amounts for Self-payments
HRA Participants may use the HRA to make self-payments for continuous coverage under the Plan. When the HRA Participant receives the monthly self-payment notice, he or she must contact the Plan Office to request any eligible HRA account balance be transferred to cover the self-payment obligation. The appropriate form must be completed prior to the HRA payment.

Section 7.10 – COBRA
Continued coverage in the HRA account is provided through COBRA continuation coverage with the Plan. COBRA cannot be purchased for the HRA alone. The HRA can be used to pay the Plan's COBRA premium when requested on the appropriate form.

Section 7.11 – Forfeiture of HRA
Any balance in the HRA will be forfeited upon any one of the following events:

A Termination of coverage from the Plan and no activity (Employer contributions or claim reimbursements) for a period of 36 months, or

B Termination of the Plan or the HRA program, or

C. Death of the HRA Participant with no surviving dependents; or

D. Permanently opting out of participation in the HRA Account.

Forfeitures will be used to offset the administration expenses of the Plan and will be processed in the calendar year following the calendar year in which the period of 36 months of inactivity concludes.

Section 7.12 – Administration Fees
The Trustees have the right to impose a monthly fee to each HRA account to cover the costs of administration.

Section 7.13 – Statements
Each HRA Participant will receive an annual statement in the first quarter of each Plan Year disclosing the activity posted to your HRA account as of the end of the prior Plan Year. Pending forfeitures, if applicable, will be disclosed on the annual statement but not processed until

December of the same year. To avoid forfeiture, there must be activity in your HRA account prior to the final forfeiture date.

Section 7.14 – Permanent Opt-out of Participation

An individual who is eligible to participate in the HRA may elect to permanently opt-out of participation in the HRA. By permanently opting-out out of participation in the HRA, the HRA Participant forfeits all amounts accumulated in his HRA Account and waives all future contributions to his HRA Account. All individuals eligible to participate in the HRA shall be given the option of permanently opting-out of participation at least annually and upon termination of participation in the Pipe Trades Industry Health & Welfare Plan.

ARTICLE EIGHT: MISCELLANEOUS PROVISIONS

Section 8.01 – 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. Exclusions, including complications from excluded services, supplies or equipment are not considered Covered Expenses and will not be payable, except when required to be covered under federal law, including the Consolidated Appropriations Act of 2021 (CAA).

In addition to exclusions and limitations described in other sections of this Plan, no benefits shall be paid for any expense incurred as a result of:

(1) treatment, services or supplies that are not Medically Necessary, except as specifically provided for in the Plan;

(2) treatment, services or supplies not prescribed by or performed under the direction of a Physician or other Covered Provider;

(3) treatment, services or supplies not performed or provided within the scope of the Covered Provider's license;

(4) 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 as provided for in Section 5.03;

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

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

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

(8) Cosmetic surgery or reconstructive surgery, except as provided in Section 5.03;

(9) 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;

(10) 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;

(11) 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);

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

(13) 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;

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

(15) 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;

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

(17) housekeeping or Custodial Care;

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

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

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

(21) pregnancy or childbearing by dependent children, unless as required by law;

(22) travel, even though prescribed by a Physician or Covered Provider;

(23) charges which are in excess of the Usual, Customary and Reasonable Charge;

(24) services or supplies without a diagnosis of Injury or Sickness, except for covered Wellness Benefits, diagnostic items and procedures and prophylactic simple mastectomies when Medically Necessary;

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

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

(27) corrective shoes;

(28) charges, deductible 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;

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

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

(31) 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 However, oxygen humidifiers" prescribed by a Physician in connection with Medically Necessary Durable Medical Equipment for purposes of moisturizing oxygen are not considered a convenience item;

(32) services by a masseuse or massage therapist;

(33) 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;

(34) charges for the failure to keep a scheduled visit or for completing a claim form;

(35) 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;

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

(37) services or supplies for sterilization reversal;

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

(39) blood donations;

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

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

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

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

(44) Developmental Care, including but not limited to care for autism and Asperger's syndrome;

(45) hospice care;

(46) 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, except as may be provided by the Plan's subrogation provisions;

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

(48) Inpatient substance use disorder services at an Out-of-Network Residential Treatment Facility;

(49) 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);

(50) Gene Therapy;

(51) Specialty infusion or injectable prescription drugs that are Medically Necessary and approved under the clinical programs through the Prescription Drug Benefit will not be paid under the Medical Benefit; or

(52) Special fittings, adaptations or maintenance agreements related to covered Durable Medical Equipment.

Section 8.02 – Coordination of Benefits

Eligible individuals may be covered by more than one health insurance plan. As a result, two or more plans are paying for the same expense. For that reason, a coordination of benefits provision has been adopted to coordinate the benefits payable from this Plan with similar benefits payable under other plans. Coordination of Benefits (COB) requires that one plan be designated as the

"primary" payer, while the other plan or plans are designated as "secondary" payer. The following rules explain how this Plan coordinates payment of its benefits with other plans (as that term is defined below) under which you or your Dependents may be covered.

IMPORTANT: You must notify the Plan Office if you or your Dependent(s) have other health coverage. The Fund will not be required to determine the existence of any other Plan, or the amount of benefits payable under any plan other than this Plan. You are responsible for furnishing the Fund with information regarding the existence of such other Plans, including any documents the Fund may request to implement these coordination of benefits rules.

If the Plan makes payments it is not required to pay, it may recover and collect those payments from you, your Eligible Dependents, or any organization or insurance company that should have made the payment. For example: if you fail to notify the Plan of your other coverage and the Plan makes an overpayment, you will be responsible for the overpaid benefits.

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

Terms Used in this Section

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.

"**Allowable Expenses**", as used in this Section, 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.

With respect to claims where Medicare is the primary payer, Medicare's contracted amount is the Allowable Expense.

(A) ORDER OF BENEFIT DETERMINATION

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 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) A homeowners', event, premises, or automobile policy of insurance which provides for the payment of medical benefits (such as no-fault, personal injury protection, or medical payments coverage) shall always pay on a primary basis before the Plan.

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".

(B) EFFECT ON BENEFITS

If it is determined that this Plan is the secondary coverage for you or your Dependents:

(1) Our Plan benefit limits, benefit maximums, Deductibles, Copayments, Coinsurance, and Out-of-Pocket Limit amounts remain the same when this Plan is the secondary payer. When payment is made towards a benefit that includes a benefit limit under Our Plan, our secondary payment amount will be applied towards the benefit limit.

(2) We will coordinate benefits so that the total amount paid by the Other Plan and Our Plan do not exceed 100% of Allowable Expenses. However, 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.

(3) If the Other Plan contains a provision capping its benefits that results in shifting coverage liability to Our Plan in a manner designed to avoid the usual operation of Our Plan's coordination of benefits rules, the benefits of Our Plan will not be determined until the Other Plan provides its customary benefits without regard to such cap.

(4) If another plan is primary but some or all of the benefits are denied or reduced because you or an Eligible Dependent failed to comply with the plan's required procedures, this Plan's secondary benefits will only be paid as if you or your Eligible Dependent had complied with all the required procedures of the other plan. The required procedures could include but are not limited to: complying with utilization review or cost containment procedures, such as Hospital preadmission review or certification, second surgical opinions, and precertification of substance abuse or mental health treatment.

(5) The Plan's liability and its benefit payments will not increase because you or your Eligible Dependent elects not to use the primary coverage. You or your Eligible Dependent must file a claim for any benefits from all other sources. Whether or not you or your Eligible Dependent actually file claims with these other sources, this Plan's benefits will be calculated as though you or your Eligible Dependent had.

(C) COORDINATION WITH MEDICARE

(1) If you are a Covered Employee, this Plan will be primary and pay benefits first. If you are a Covered Employee whose eligible Dependent is entitled to Medicare, this Plan will be primary to Medicare for that Dependent.

(2) When You are a Retiree: If you retire and are eligible for Retiree Benefits, Medicare will have primary responsibility and this Plan will pay second.

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

A. If you are eligible for benefits because of the Employee's active status and become entitled to Medicare solely because of ESRD, this Plan will have primary responsibility for your claims during the initial 30-month period and Medicare pays second. If during the initial 30-month period the Employee becomes eligible for Retiree Benefits, the Plan will continue to pay as the primary plan during the balance of the 30-month period. After the initial 30-month period, Medicare has primary responsibility and this Plan will pay second.

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

(4) Effect on Benefits when this Plan is Secondary to Medicare

The decision to enroll in Medicare or any of its plans is yours. However, when you or your Dependents become eligible for Medicare Parts A and B as the primary coverage but choose not to enroll, we will estimate Medicare benefits and will reduce our payment as if Medicare had actually issued payment, coordinating so that no more than 100% of Allowable Expenses are paid. With respect to claims where Medicare is the primary payer, Medicare's contracted amount is the Allowable Expense.

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.

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 8.03 – Subrogation (Right Of Restitution)

Were you or your Eligible Dependent Injured in an Accident or incident for which someone else is liable? If so, that person or an insurance company 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 or incident 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 judgment, settlement, award, or other payment to you or your Eligible Dependent from a third party tort-feasor, person or entity or from any insurer. 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, entity, or insurer.

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 no-fault, 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 or insurer, 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.

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 Injury 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 a claim against the liable third party or insurer, you or your Eligible Dependent may not sign a waiver or release of claims, without prior written permission from the Plan. If 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 cooperate with the Plan and/or any representatives of the Plan in completing such forms and in giving such information surrounding any Accident or incident as the Plan or its representatives deem necessary to fully investigate the Accident or 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 payments 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 Accident- or incident-related claims, is granted an equitable lien on the proceeds of any settlement, judgment, award, 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:

(1) 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;

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

(3) 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;

(4) Any payments from an employer or worker's compensation insurer; or

(5) Any payments or donations made by or through a charitable organization, online fundraising, social media, or crowdfunding platform (for example, GoFundMe).

(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 fully respond to the Plan's inquiries concerning the facts and circumstances surrounding the Accident or incident, or 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, unless the Trustees, in their sole discretion, approve the payment of such benefits.

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 8.04 – 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 8.05 – Rights Of Recovery
Whenever benefit payments are made by the Plan which are in excess of eligible Expenses or other Plan limits (including, but not limited to, mistaken payments or payments resulting from fraud or misrepresentation), the Trustees shall have the right to recover the overpayment from:

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

(B) the eligible Employee or Eligible Dependent on whose behalf the payment was made; or,

(C) from the primary payer, consistent with the Plan's Coordination of Benefits provisions.

The Trustees shall have the sole discretion to choose who will repay the Plan for an overpayment and the terms upon which reimbursement shall be made. When a person or entity does not comply with the terms of a request to reimburse the Plan for the overpayment, the Trustees shall have the authority, in their sole discretion, take any one of, or a combination of, the following actions to recover the overpayment: deny payment of any claims for benefits by the same person or entity (including retroactive denial); deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) to, or on behalf of, the eligible Employee or Eligible Dependent; offset the eligible Employee's Reserve Credit; offset future contributions paid to the Plan on behalf of the eligible Employee; or any other appropriate legal or equitable action.

Section 8.06 – Deadline for filing a Claim
Claims for Comprehensive Medical Benefits, Prescription Drug Benefits, must be filed within one (1) year of the date of service. Claims for Weekly Disability Benefits must be filed within one (1) year of the first date of disability. Claims for Death Benefits and Accidental Death and Dismemberment benefits must be filed within one (1) year of the date of death or date of loss.

Section 8.07 – 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 8.08 – 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 8.09 – Medical Examination
No medical examination shall be required of any person 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 8.10 – Assignment Of Benefits
Benefits payable hereunder shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge by any person. You will not sell, assign, pledge, transfer, or grant any interest in or to these benefits, or any right of reimbursement or payment arising out of these benefits, to any Person or entity. Any such purported sale, assignment, pledge, transfer, or grant is not enforceable against the Fund and imposes no duty or obligation on the Fund. The Fund will not honor any such purported sale, assignment, pledge, transfer, or grant.

However, subject to the exceptions noted below, any eligible individual may direct benefits due him to be paid to a provider. If the Plan receives a document claiming to be an assignment of benefits on behalf of a Provider, the Plan may send payments for the claims to the Provider, but will send all claim documentation, such as an explanation of benefits, and any procedures for appealing a claim denial directly to the eligible individual or his authorized representative, as determined by the Plan. Notwithstanding the preceding, the Trustees reserve the right to make payments directly to the eligible individual without regard to an authorization executed by an eligible individual directing payment to the Provider.

Section 8.11 – 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; and the eligibility rules governing this Plan)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 8.12 – 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. 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.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 8.13 – 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 8.14 – 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 8.15 – 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 8.16 – 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 8.17 – Authorized Representative
You may designate an authorized representative, such as your spouse, to complete the claim form for you, or file an appeal of a denied claim, as described in Section 8.19. To do so, you must designate the individual to act on your behalf, in writing, with respect to claims under the Plan.

Please contact the Plan Office to designate an authorized representative. The Plan reserves the right to establish reasonable procedures and request additional information to determine whether this person is authorized to act on your behalf.

Any individual wishing to designate a Provider as an Authorized Representative for the purposes of the Plan's claims filing procedures must provide the Plan Office with an authorization form. However, a health care professional with knowledge of your Medical Condition may act as an authorized representative in connection with a Claim involving Urgent Care, as defined in Section 8.18, without you having to complete an authorization form.

The authorization will remain in effect unless or until you provide the Plan with written notification that restricts or cancels the authorization.

Section 8.18 – 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.

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 the 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 the 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) 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 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.

In the event that a period of time is extended for either a Pre-Service or Post-Service claim 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 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.

(D) **Weekly Disability and Accidental Death and 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.

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 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.

(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.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

The Plan Administrator, or its designee, shall provide a claimant with a written or electronic Notification of any Denial of Claim. 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;

(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 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 8.19 before filing suit in court. Failure to file such an appeal under Section 8.19 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 8.19, you may then proceed to court since you will then have exhausted this Plan's administrative review procedures.

Section 8.19 – 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) is information 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**	**Weekly Disability and Accidental Death and 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 one hundred (180) 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

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.

All other Claims 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.

EXTERNAL REVIEW FOR NO SURPRISES ACT CLAIMS

A Claimant may request an external appeal review after an initial Claim Denial and subsequent internal review appeal denial to dispute determinations that involve whether the Plan complied with the surprise billing and cost-sharing protections under the No Surprises Act. The process for an external review is as follows:

(A) Request for External Review

An external appeal must be allowed if the Claimant requests an external appeal within four months after receipt of notice of Claim Denial or appeal denial. An immediate external review must also be allowed if the Plan has failed to adhere to the appeals regulations unless the violation was: 1) de minimis; 2) non-prejudicial; 3) attributable to good cause or matters beyond the Plan's control; 4) in the context of an ongoing good-faith exchange of information; and 5) not reflective of a pattern or practice of non-compliance. If the Plan asserts an exception, the claimant is entitled, upon written request, to an explanation of the Plan's basis for asserting the exception. If the

external reviewer rejects the claimant's request for immediate review on the basis that the Plan has met the five-element exception, the claimant is permitted to resubmit and pursue and internal appeal.

(B) Preliminary Review

The preliminary review of the external appeal must be completed within five business days after receipt of request to determine whether:

(1) The Claimant was covered under the Plan at the time the health care item or service was provided;

(2) The initial Claim Denial or internal review Claim Denial did not relate to the Claimant's failure to meet eligibility requirements for eligibility under the Plan;

(3) The Claimant has exhausted the Plan's internal appeal process unless the Claimant is not required to exhaust the internal appeals process under the regulations; and

(4) The Claimant has provided all the information and forms required to process an External Review.

Within one business day after completion of preliminary review, the Plan must issue notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (call toll-free (866) 444-EBSA (3272)). If the request is not complete, such notification must describe the information and materials needed to make the request complete and the Plan must allow the Claimant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of notification, whichever is later. Note that for an urgent care issue, the preliminary review must be done immediately and the claimant must be notified of the decision immediately.

(C) Referral to Independent Review Organization (IRO)

The Plan must utilize an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan must take action against bias and ensure independence.

Accordingly, the Plan must contract with at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). The IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits. The IRO process may not impose any costs, including filing fees, on the claimant requesting the external review.

Within five business days after assignment to an IRO, the Plan must provide all documents and information considered in denying the appeal to the IRO. The IRO must provide written notice of its decision within 45 days of assignment. For urgent care issues, the IRO must provide notice of its decision as soon as possible but in no event more than 72 hours after receipt of the request for expedited external review.

(D) Implementation of Reversal
Upon receipt of notice of final external review decision reversing an adverse benefit determination, the Plan must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits for claim).

Section 8.20 – 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 8.21 – 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.

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 not 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 8.22 – 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 8.23 – 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. Proper venue for any legal action against the Plan shall be in Vigo County, Indiana.

Section 8.24 – 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) "Plan" means this Plan.

(2) "Plan Documents" 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) "Plan Sponsor" 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 8.25 – 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) **DEFINITIONS**

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) "Plan" means this Plan.

(2) "Plan Documents" 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) "Plan Sponsor" means the Board of Trustees of this Plan.

(4) "Electronic Protected Health Information" (or "e-PHI") 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) "Electronic Media" 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) "Security Incident" 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) **PLAN SPONSOR OBLIGATIONS**

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.

Section 8.26 – Protections From Surprise Medical Bills

Under a federal law called the No Surprises Act, you have protection against surprise medical bills from out-of-network providers and facilities. This law mainly applies to Out-of-Network Emergency Services, services provided by out-of-network providers at Network facilities, and Out-of-Network Air Ambulance Services.

A. Out-of-Network Emergency Services
Your cost-sharing for Covered Emergency Services will be based on the Recognized Amount payable for these services.

If you receive Emergency Services from an out-of-network provider, the provider is not permitted to "balance bill" you for the difference between what the provider charges and the total amount collected by the provider, which include payments paid by the Plan and Co-payments, Coinsurance, or deductible amounts paid by you.

B. Out-of-Network Providers at Network Facilities
Unless you consent to receiving services from the out-of-network provider, as described in this section 8.26(D), your cost-sharing for covered services performed by out-of-network providers with respect to visits at Network Health Care Facilities will be based on the Recognized Amount payable for these services.

If you receive services from an out-of-network provider at a network facility, the provider is not permitted to "balance bill" you for the difference between what the provider charges and the total amount collected by the provider, which include payments paid by the Plan and Co-payments, Coinsurance, or deductible amounts paid by you.

C. Out-of-Network Air Ambulance Providers
Your cost-sharing for covered Air Ambulance Services will be based on the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount. If you receive Air Ambulance Services from an out-of-network provider, the provider is not permitted to "balance bill" you for the difference between what the provider charges and the total amount collected by the provider, including payments paid by the Plan and Co-payments, Coinsurance, or deductible amounts paid by you.

D. Waiving Surprise Medical Bill Protections
In certain limited circumstances, you can waive the balance billing and cost-sharing protections provided under the No Surprises Act. You may be able to waive these protections for (1) services from an Out-of-Network Provider at a Network Health Care Facility or (2) services from an Out-of-Network emergency facility or provider after you are stabilized. This can occur if you are notified by the Out-of-Network Provider that the provider does not participate with the Plan and you provide informed consent to be treated by the provider and waive the protections.

If you give informed consent to be treated by the Out-of-Network provider, then the Plan will treat these services as Out-of-Network. This means the provider can bill you for the balance directly and the provider can balance bill you for the difference between what the provider charges and the amount paid by the Plan and the cost-sharing amounts paid by you.

You may not waive No Surprises Act protections for ancillary services provided by an Out-of-Network Provider in a Network Health Care Facility. Ancillary services include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services,

including radiology and laboratory services; and items and services provided by an out-of-network Provider if there is no in-network Provider who can furnish such item or service at such facility.

E. Payments to Out-of-Network Providers at Network Facilities, Out-of-Network Air Ambulance Providers, and Out-of-Network Emergency Facilities

For claims subject to the No Surprises Act from Out-of-Network Providers at Network Health Care Facilities, Out-of-Network Air Ambulance Providers, and Out-of-Network Emergency Facilities, the Plan will pay the provider or facility the Out-of-Network Rate minus any cost-sharing amounts (Co-payments, Coinsurance, and/or amounts paid towards deductible) you paid.

F. Continuing Care

If you are receiving care from a network provider that becomes out-of-network, you may have certain rights to continue your course of treatment if you are a "continuing care patient."

A continuing care patient is a patient that

a. is undergoing a course of treatment for a serious and complex condition from the provider or facility;

b. is undergoing a course of institutional or inpatient care from the provider or facility;

c. is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;

d. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

e. is or was determined to be terminally ill (as determined under Social Security Act) and is receiving treatment for such illness from such provider or facility.

A serious and complex condition means a condition that

a) in the case of an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

b) in the case of a chronic illness or condition, a condition that

   i) is life-threatening, degenerative, potentially disabling, or congenital; and

   ii) requires specialized medical care over a prolonged period of time.

If the Plan terminates its contract with your Network provider or facility or your benefits are terminated because of a change in terms of the providers' and/or facilities' participation in the Plan, you will be notified of the change and informed of your right to elect to receive transitional care from the provider. You may choose to continue your course of treatment under the same terms and conditions as would have applied for an in-network provider for up to 90 days after the notice is provided or until you no longer qualify as a continuing care patient (whichever is earlier). These providers cannot balance bill you during this time. Termination of a contract includes the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

ARTICLE NINE: STATEMENT OF RIGHTS UNDER EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

Section 9.01 – 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:

A. 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 and Coinsurance.

B. 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.

C. Prudent Actions by Plan Fiduciaries

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

D. Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of 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 "Right to Bring Legal Action" subsection in Section 8.19 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.

Section 9.02 – 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.

ARTICLE TEN: OTHER IMPORTANT INFORMATION

Section 10.01 – Name of Plan
The name of the Plan is the Pipe Trades Industry Health and Welfare Plan

Section 10.02 – Plan Sponsor and Plan Administrator
The Plan is administered by a joint Board of Trustees, one-half of whom are appointed by the Union and one-half of whom are appointed by the Employers. The Board of Trustees is also the Plan Administrator.

The Trustees have hired a salaried Administrative Manager to perform the day-to-day operations of the Plan. The Administrative Manager is:

Stephanie Morgan
P.O. Box 3040
Terre Haute, IN 47803-0040
(812) 877-2581

Section 10.03 – 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.

Section 10.04 – 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.

Section 10.05 – 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.

Section 10.06 – Board of Trustees

Union Trustees
Troy Bennett
Plumbers and Steamfitters
Local Union #157
8801 East Milner Avenue
Terre Haute, IN 47803

Derek Sanderson
Plumbers and Steamfitters
Local Union #184
1332 Broadway
Paducah, KY 42001

John Bates
Plumbers and Steamfitters
Local Union #136
2300 St Joseph Industrial Park Drive
Evansville, IN 47720

Management Trustees
Mark Unger
c/o Freitag-Weinhardt, Inc.
5900 North 13th Street
P.O. Box 5177
Terre Haute, IN 47805

Keith Murt
c/o Murtco Mechanical, Inc.
815 Abell Street
Paducah, KY 42003

Keith Kolb
1330 N. Metro Ave.
Evansville, IN 47715

Section 10.07 – Plan Service Providers

Administrative Manager
Stephanie Morgan
P.O. Box 3040
Terre Haute, IN 47803-0040
(812) 877-2581

Actuarial Consultants
United Actuarial Services, Inc.
11590 North Meridian Street, Suite 610
Carmel, IN 46032-4529
(317) 580-8670

Legal Counsel
Ledbetter Partners LLC
429 N. Pennsylvania Ave., Suite 409
Indianapolis, IN 46204

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

Section 10.08 – 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

Section 10.09 – 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.

Section 10.10 – 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.

Section 10.11 – 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