Plumbers, Pipe Fitters & Mechanical Equipment Service Local Union No. 392

Health and Welfare Fund

Summary Plan Description

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Plan Document

2015 Edition

PLUMBERS, PIPE FITTERS AND MECHANICAL EQUIPMENT SERVICE LOCAL UNION NO. 392 HEALTH AND WELFARE FUND

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(ADMINISTRATOR AS DEFINED BY LAW)

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CERTIFIED PUBLIC ACCOUNTANTS

Kelley Galloway Smith Goolsby

A MESSAGE FROM THE BOARD OF TRUSTEES

We are pleased to provide you with this updated booklet describing your health benefits under the Plumbers, Pipe Fitters and Mechanical Equipment Service Local Union No. 392 Health and Welfare Fund, effective January 1, 2015 unless otherwise indicated. Although this booklet is meant to be an easy-to-understand description of your Plan benefits, it also serves as the Plan Document, which is the Plan's official Rules and Regulations.

This booklet describes the benefits and the Plan's eligibility rules. Important terms used throughout this booklet are capitalized and defined in the Plan. Please keep this booklet with your other important papers and share this information with your family. If you have questions about information in this booklet, you should contact the Fund Office.

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

IMPORTANT REMINDERS

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

PLAN VENDOR INFORMATION AS OF JANUARY 1, 2015

The **Fund Office** is responsible, under the oversight of the Board, for providing various administrative services for the Fund, including maintaining eligibility records, ensuring that Plan provisions are followed on the payment of claims, handling member requests for information and for providing various reports and other services that the Fund requires. At www.local392fringefunds.org, you will receive unique passwords that will allow you to access your personal eligibility/claims history and you are able to view the Plan/SPD 24 hours a day, 7 days a week. The site contains additional links and services you will find valuable in understanding and using your coverage effectively. Please take full advantage of this service. Additionally, the Fund Office is available for any questions members may have regarding Plan benefits in general, as well as questions specific to an individual member's eligibility or claims at (513) 241-0444, Extension 1.

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

The **Pharmacy Benefit Manager ("PBM")** provides access to pharmacies and mail order services offering discounted prices for covered Prescription Drugs in exchange for the Plan's coverage of such services at a higher level than for non-participating pharmacies or mail order providers. ***The Trustees selected Express Scripts to provide the Plan's preferred prescription drug coverage.*** Active and Class C Participants should contact Express Scripts at (877) 605-7235 or www.express-scripts.com for answers to your prescription drug questions. Medicare eligible members on Plan F or Prescription Only Coverage should contact Benistar at (800) 236-4782.

The **Pre-Certification/Utilization Review Organization ("UR")** helps you and the Plan reduce costs and wasteful expenses by reviewing, authorizing and certifying certain medical procedures, admission and other medical expenses. This process is called the Pre-Certification Program (also known as the Utilization Review Program). ***The Trustees selected Med-Care Management to provide Pre-Certification and UR services to the Plan.*** You can contact Med-Care Management for any Pre-Certification questions and/or to request Pre-Certification at (800) 367-1934.

Table of Contents

SECTION 1: SCHEDULES OF BENEFITS

1.01 General Information

A Schedule of Benefits is a list of benefit amounts and exclusions that apply to benefits offered by the Fund. Each specific benefit is described in more detail in the section concerning that particular benefit. When reading the specific benefit section, you should reference the applicable Schedule of Benefits and vice versa. This Section provides information for each type of participant under the Plan.

Section 1.02 provides a Schedule for Active Employee Class A and Class C Retiree Benefits. Section 1.03 provides a Schedule for Class F Retiree Benefits. Section 1.04 provides a Schedule for Class D Retiree Benefits and Section 1.05 provides a Schedule for Class Rx Only Retiree Benefits.

The following Schedule provides a list of the benefits that apply to each type of participant:

	Active Class A Employee	**Class C Retiree**	**Class D Retiree**	**Rx Only Retiree**	**Class F Retiree**
Major Medical; Section 6	✓	✓			
Supplemental Medical; Section 7					✓
Prescription Drug; Section 8	✓	✓		✓	✓
Death Benefits; Section 3	✓	✓*	✓*	✓*	✓*
AD&D; Section 4	✓				
Dental; Section 9	✓	✓			
HRA Account; Section 10	✓	✓*			✓*

* You may be eligible for these benefits if you meet the individual eligibility requirements as provided in the applicable Section.

1.02 Schedule of Benefits for Class A Active Employees and Class C Pre-Medicare Retirees

Class A and Class C Benefits are the following benefits which are subject to the Plan's deductibles, maximums and limitations.

Death Benefit	***Amount and Limitations***
Death Benefit for Class A Active Employees	$10,000
Death Benefit for Class C Pre-Medicare Retirees	$2,000 for Local 59 Retirees $10,000 for all other Retirees whose death occurs after September 25, 2009, but excluding Local 113 retirees who participate in this Plan solely because of their union's merger with Local 392 on or after May 1, 1988.
AD&D Benefit for Class A Active Employees	***Amount and Limitations***
For Loss of:	
Life	$10,000
Both Hands, Feet or Eyesight in Both Eyes	$10,000
One Hand and One Foot, One Hand and Sight in One Eye or One Foot and Sight in One Eye	$10,000
One Hand, Foot or Sight in One Eye	$5,000
Weekly Disability Benefit for MES & Commercial Plumber Active Employees	***Amount and Limitations***
Weekly Amount for MES Participants	A percentage of weekly earnings based on the A&S Percentage in effect under the SUB Plan*
Weekly Amount for Commercial Service Plumbers	66 2/3% of weekly earnings up to $561/week
Maximum Number of Weeks of Benefits	52 during a 60-month period (26 for each continuous period of disability)

* The A&S Percentage of the SUB Plan is adjusted periodically pursuant to Section 6.01(A) of the SUB Plan. As of August 1, 2014, the A&S Percentage is 52% and the Weekly Disability Benefit amount for the MES Active Employees under the Plan is 52% of weekly earnings.

Major Medical Benefit	
Plan Deductibles	
Calendar Year Deductible	$350 per person $1,050 per family
Non-PPO Hospital Deductible	$200 for each non-Emergency inpatient confinement of at least one day $25 for each non-Emergency outpatient visit
Emergency Room Deductible	$100 for each Emergency room visit during the calendar year (after the first visit) that does not result in an inpatient admission
Out-of-Pocket Maximum for Medical Benefits	
Out-of-Pocket Maximum per Calendar Year Does not include: Non-PPO Deductibles (except for Emergency Deductible), Non-PPO Co-insurance Payments, Prescription Drug Co-Payments and Non-Essential Health Benefit Dental Expense Payments	$2,000 per person $3,000 per family Once you reach the Out-of-Pocket Maximum, the Plan pays 100% of Allowable Expenses for the calendar year (subject to any other limitations as provided in the Plan).
Maximum Benefits Payable under the Plan	
Chiropractic care (excluding laboratory tests)	12 visits per calendar year
Private Duty Nursing	60 days per confinement
Skilled Nursing Care	100 days per confinement
Speech Therapy	120 visits per calendar year
Occupational & Physical Therapy	50 visits per calendar year (combined total, visits over limit subject to medical review)
Treatment or Surgery related to Obesity	One treatment per lifetime
Wig in connection with radiation or chemotherapy	One per Sickness
Non-Medical Expenses for Organ Transplant	$5,000 for the donor & $5,000 for the recipient
Non-Essential Health Benefit Genetic testing	$5,000 per lifetime
Hearing Aid	$3,000 per ear once every 48 months

Major Medical Benefit Continued		
Covered Medical Expenses Paid by the Fund up to the UCR Charges	**PPO Charges**	**Non-PPO Charges**
Physician, Hospital/Facility (Inpatient and Outpatient Services for Medical, Mental Health & Chemical Dependency)	80%	70%
Emergency Services	80%	80% of the greater of the following amounts: (a) the median of the amount negotiated with each PPO provider, (b) the PPO negotiated rate or (c) the Medicare rate (subject to Emergency Deductible)
Annual Physical Examinations	100% (not subject to Deductible)	
Annual Vision Examination	100% up to $100 per calendar year (Dependent children under the age of 19 are not subject to the $100 maximum)	
Annual Hearing Examination	100% for Dependent children under age 19	
Preventive Services	100% (not subject to Deductible)	70%
Hearing Aid	80% up to $3,000 per ear (does not apply to bone anchored hearing aids (osseointegrated auditory implants) for Dependent children under the age of 19)	

Prescription Drug Benefit		
Minimum Co-Payment Amount	**Retail (34 day supply)**	**Mail (90 day supply)**
Generic	$10	$20
Formulary brand name	$20	$40
Non-formulary brand name	$30	$60
Out-of-Pocket Maximum for Prescription Drugs		
Out-of-Pocket Maximum per Calendar Year	$4,600 per person $10,200 per family Once you reach the Prescription Drug Out-of-Pocket Maximum, the Plan pays 100% of Prescription Drug Expenses for the calendar year (subject to any other limitations as provided in the Plan).	

Dental Expense Benefit	
Calendar Year Maximum	$700 per person (does not apply to expenses incurred by Dependent children under age 19 for Preventive and Diagnostic services)
Calendar Year Deductible	$100 per person (does not apply to Preventive or Diagnostic services)
Preventive & Diagnostic Services	80%
All Other Dental Services	50%

1.03 Schedule of Benefits for Class F – Medicare Supplement Retirees

Class F Benefits are the following benefits subject to the Plan's applicable deductibles, maximums benefits and limitations.

Benefit	Benefit Amount or Limitation
Death Benefit	$2,000 for Local 59 Retirees $10,000 for all other Retirees whose death occurs after September 25, 2009, but excluding Local 113 retirees who participate in this Plan solely because of their union's merger with Local 392 on or after May 1, 1988.
Medicare Supplemental Medical Benefit	
Calendar Year Deductible	$2,250 per individual
Hospital Services:	
Room and board	100% of semi-private room rate
Other Services & Supplies	100%
Physician Services:	
Office Visits	100%
Diagnostic Tests	100%
Outpatient Surgery Expenses	100%
Emergency Care & Local Ambulance Service	100%
Hospice care	100%
Outpatient Physical Therapy	100%
Home Health Care	100%
Medical Supplies, Prosthetic Appliances & DME	100%

Prescription Drug Benefits		
Minimum Co-Payment Amount	**Retail (34 day supply)**	**Mail (90 day supply)**
Generic	$8	$16
Formulary brand name	$15	$30
Non-formulary brand name	$20	$40

1.04 Schedule of Benefits for former Class D Retirees

Benefit	Benefit Amount or Limitation
Death Benefit	$2,000 for Local 59 Retirees $10,000 for all other Retirees whose death occurs after September 25, 2009, but excluding Local 113 retirees who participate in this Plan solely because of their union's merger with Local 392 on or after May 1, 1988.

1.05 Schedule of Benefits for Rx Only Retirees

Benefit	Benefit Amount or Limitation	
Death Benefit	$2,000 for Local 59 Retirees $10,000 for all other Retirees whose death occurs after September 25, 2009, but excluding Local 113 retirees who participate in this Plan solely because of their union's merger with Local 392 on or after May 1, 1988.	
Prescription Drug Benefit		
Minimum Co-Payment Amount	**Retail (34 day supply)**	**Mail (90 day supply)**
Generic	$8	$16
Formulary brand name	$15	$30
Non-formulary brand name	$20	$40

SECTION 2: ELIGIBILITY

2.01 Eligibility for Active Employee Benefits (Class A Benefits)

If you are eligible for Class A Benefits, you and your Dependents are eligible for Major Medical, Prescription Drug, and Dental Benefits. Additionally, you are eligible for the Death, AD&D and HRA Account Benefits as provided herein.

A. Qualification Period and Eligibility Periods

A Qualification Period is the time period during which you accumulate Credited Hours to qualify for Continued Eligibility for Class A Benefits under the Plan. An Eligibility Period is a period of time during which you are eligible for Class A Benefits under the Plan. The Qualification Periods and corresponding Eligibility Periods for each calendar year are as follows:

Qualification Period	Corresponding Eligibility Period
If you are credited with 720 hours during the period of January 1 through June 30	You are eligible for Class A Benefits for the period of August 1 through the following January 31
If you are credited with 720 hours during the period of July 1 through December 31	Your are eligible for Class A Benefits for the period of the following February 1 through July 31

B. Initial Eligibility

Initial Eligibility is how you become covered under the Plan for Class A Benefits. The following are the two ways you may attain Initial Eligibility under the Plan:

1. <u>120 Credited Hour Method</u>

   If you are: an approved applicant, an apprentice, a Non-Bargaining Unit Employee or a newly organized Employee, you will become eligible for benefits under this Plan on the first day of the month following the first month in which you work 120 hours for which Contributions are made to the Fund. The rules governing this method of Initial Eligibility are as follows:

   (a) The Union must notify the Fund Office of your status.

   (b) This early eligibility provision will be available to you only once in your lifetime, even if you change status from one of the categories listed above to another.

   (c) In order to maintain your eligibility under this provision, you must continue to work at least 120 hours per month until you have satisfied the Plan's Continued Eligibility Requirements.

   (d) You may only remain eligible under this provision without satisfying the Plan's Continued Eligibility Requirements for up to nine consecutive months during which you must work at least 120 hours each month.

(e) If you fail to work at least 120 hours in a month after becoming eligible under this provision, your eligibility will terminate at the end of the month following the month in which you worked less than 120 hours and you will not be eligible Extended Eligibility provisions in 2.01(G).

(f) If your eligibility under this provision terminates before you satisfy the Plan's Continued Eligibility Requirements, you will not be entitled to any extended coverage except for COBRA Continuation Coverage.

(g) You are not entitled to the Weekly Disability Benefits under this Plan while you are eligible under this provision prior to satisfying the Plan's Continued Eligibility Requirements.

2. 670 Credited Hour Method

If you lose eligibility under the Plan, your eligibility for Class A Benefits will begin on the first day of the calendar month following a consecutive period during which you accumulate 670 Credited Hours. These 670 Credited Hours must be earned within a period of no longer than six consecutive months.

C. Continued Eligibility

Continued Eligibility Requirements are how you keep coverage for Class A Benefits. Once you meet the Initial Eligibility requirements, your Class A Benefits will continue for subsequent Eligibility Periods if you were credited with at least 670 Credited Hours during the preceding Qualification Period.

D. Excess Credited Hours

If you accumulate more than 670 Credited Hours in a Qualification Period, any hours above the 670 may be carried over and used as part of the 670 required hours for the next Qualification Period. However, if you do not use those excess hours in the next Qualification Period, they will be canceled and cannot be used in the future.

E. Eligibility during Periods of Disability or Family Leave Lasting Less than 13 Weeks for Which You are Receiving SUB Plan Benefits

For each week that you are on a family leave or you are Disabled as defined in the Plan, and are receiving SUB Plan benefits or Weekly Accident and Sickness Benefits under this Plan, you shall receive eight Credited Hours per day, up to 40 Credited Hours per week for up to: (1) 13 weeks for each disability leave period and (2) 12 or 26 weeks for a Family Leave Period, as applicable.

F. When Coverage under Class A Benefits Terminates

1. Apprentices and Bargaining Unit Employees

Once you meet the Continued Eligibility Requirements, your coverage under the Plan will generally end at the end of the Eligibility Period corresponding to the Qualification Period in which you do not accumulate 670 Credited Hours (including any excess Credited Hours).

However, in the event that you work in Industry Employment, your coverage will end on the last day of the month in which you work for a Contributing Employer and you will not be eligible for the Extended Eligibility Provisions in 2.01(G) or for COBRA Continuation Coverage.

2. Non-Bargaining Unit Employees.

Coverage under the Plan will generally terminate on the last day of the month in which a Non-Bargaining Unit Employee works for a Contributing Employer. However, if you are a Non-Bargaining Unit Employee who became eligible under the Plan under the 670 Credited Hour Rule (previously the 720 Rule), your coverage will terminate at the end of the Eligibility Period corresponding to the Qualification Period in which you do not accumulate 670 Credited Hours (including any excess Credited Hours).

Non-Bargaining Unit Employees are not eligible for the Extended Eligibility Provisions in 2.01(G). Accordingly, if you are a Non-Bargaining Unit Employee, your sole method for extending coverage under the Plan upon termination of employment is under COBRA Continuation Coverage.

G. Methods of Extending Eligibility

There are five methods (not including COBRA Continuation Coverage) under which you may be able to extend your eligibility under the Plan in the event that you fail to accumulate at least 670 hours during a Qualification Period.

1. General Eligibility Requirements

In addition to the specific eligibility conditions listed for each of the five methods provided below, you must meet all of the following general requirements:

(a) You are not a Non-Bargaining Unit Employee;

(b) Your eligibility under the Plan did not terminate due to work in Industry Employment.

(c) You previously satisfied the Plan's Continued Eligibility Requirements for at least one Eligibility Period; and

(d) You are Disabled, you are employed in Covered Employment or available for work on the Local Union No. 392's out-of-work list during the entire period you are unemployed.

2. One Free Six Month Period of Extended Eligibility

The One Free Six Month Period is where you receive coverage free of charge for one period of six months. You may be eligible for One Free Six Month period of eligibility per lifetime if all of the following conditions are satisfied:

(a) You are Disabled or are involuntarily unemployed;

(b) You worked at least five years for Contributing Employers and have accumulated at least 1,440 Credited Hours each year during that five year period. A year in this context is any 12 month period starting on the date you began working for a Contributing Employer. **Any hours accumulated due to Self-Payments will not count towards eligibility for this One Free Six Month Period**;

(c) You were eligible for Class A Benefits during the Eligibility Period immediately preceding the Eligibility Period for which you elect to use the One Free Six Month Period; and

(d) If you want to use your One Free Six Month Period, you must indicate your choice on the notice that you receive from the Fund Office. You must sign the notice and return it to the Fund Office within 60 days of the date of the letter.

3. SUB Plan Payments

If you are eligible for SUB Plan Benefits, you may choose to have the SUB Fund make payments for you if the following conditions are satisfied:

(a) You were registered with the Union as available for work during all of the Qualification Period due to involuntary unemployment within the jurisdiction of the Union; or

(b) You were unable to work during part or all of the Qualification Period because you were Disabled.

The SUB Fund may only make two payments on your behalf in your lifetime. If you want the SUB Fund to make a payment on your behalf, you must indicate your choice on the notice that you receive from the Fund Office. You must sign the notice and return it to the Fund Office within 60 days of the date of the letter. Please note that this benefit is only available to you during your lifetime and will not be available for your Dependents in the event of your death.

4. Total Disability Extension

After you have exhausted the Plan's free methods of extending your eligibility (One-Free Six Month Period and two SUB Plan Payments) on your behalf, your eligibility for Class A Benefits may be extended for a period of up to 12 or 24 months at no cost to you if you are Disabled as follows:

(a) 12-Month Disability Coverage

You will receive 12 consecutive months of extended eligibility if you had 60 months of eligibility within the 84 month period preceding the onset of your disability.

(b) 24-Month Disability Coverage

You will receive 24 consecutive months of extended eligibility if you had 120 months of eligibility within the 144 month period preceding the onset of your disability.

Once your Disability Extension is exhausted, you will be entitled to Class C or Class F Benefits if you meet the applicable eligibility requirements. Additionally, if you die while you are on a Disability Extension, your surviving Dependents may exhaust the balance of your coverage under this provision prior to being required to make the Surviving Dependent Self-Payments under Section 2.07(D).

5. Automatic HRA Self-Payment Deductions

If you have a balance in your HRA Account, the Fund will automatically deduct the required Self-Payment from your account to maintain coverage until your account is exhausted. In the event that your HRA balance is not sufficient to cover the full amount of the required Self-Payment, the Fund Office will send you a Self-Payment notice and you must pay the difference. If you do not wish to have your HRA Account deducted automatically, you must notify the Fund Office in writing.

However, failure to make a required Self-Payment will result in the termination of your eligibility under the Plan and the forfeiture of your HRA account balance.

6. Class A Benefit Self-Payments

If you receive a notice from the Fund Office which states that you are eligible to make Self-Payments, you may make Self-Payments to continue your eligibility for Class A Benefits subject to the following rules.

(a) The Fund Office will only send a notice for Self-Payments if you were eligible for Class A Benefits during the period immediately preceding Eligibility Period.

(b) The Self-Payment needed to continue eligibility for the Eligibility Period must be paid by check or money order within 60 days from the date the Fund Office sends you the notice. The amount of the required Self-Payment is determined by the Trustees and is based on the current contribution rate as set by the collective bargaining agreement for the minimum number of hours needed to maintain your eligibility for the Eligibility Period.

(c) There is no limit to the number of Self-Payments you can make to continue your Class A Benefits because you have Insufficient Hours; however, if **all** of your accumulated hours are the result of Self-Payments, you may only continue eligibility through Self-Payments for a maximum of two consecutive Eligibility Periods.

(d) If you fail to make a timely Self-Payment, your eligibility for Class A Benefits will terminate on the last day of the month for which you made a timely Self-Payment.

H. Effect of Military Service on Eligibility

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

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

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

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

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

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

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

Option 1

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

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

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

Option 2

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

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

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

Option 3

If you elect Option 3 (continue active coverage), you and your Dependents will receive active coverage for as long as you remain eligible under the Plan's Continued Eligibility Requirements or Extended Eligibility Provisions. Thereafter you will be offered COBRA coverage for up to 24 months. The standard election and payment deadlines under COBRA apply.

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

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

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

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

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

During your absence, you will be credited with the number of hours you normally worked per week prior to the commencement of your leave. If you return to work for a Contributing Employer within the FMLA guidelines, you will continue to receive coverage if you otherwise meet the Plan's eligibility requirements.

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

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

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

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

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

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

1. You may qualify for up to 12 weeks (during any 12-month period) of unpaid leave for your own serious illness, the birth or adoption of a child, to care for a seriously ill spouse, parent or child or qualifying exigency to deal with the affairs of your spouse, child, or parent because he or she is called to Duty. A qualifying exigency includes short-notice deployment, military events and related activities, childcare and school activities, financial and legal arrangements, counseling, rest and recuperation, post-deployment activities and additional activities as defined under the FMLA in 29 CFR Part 825.

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

2.02 Eligibility for Pre-Medicare Retiree Benefits (Class C Benefits)

Once you retire and are no longer eligible for Class A Benefits but are not yet eligible for Medicare due to your age, this Plan offers Class C Pre-Medicare Retiree Benefits (Class C Benefits). If you are eligible for Class C Benefits, you and your Dependents are eligible for the following benefits: Major Medical,

Prescription Drug, Dental and Hospice Benefits. Additionally, you may eligible for the Death Benefit and the HRA Account Benefit provided you meet the additional eligibility requirements of those specific benefits.

A. Eligibility for Class C Benefits

You may be eligible for Class C Benefits under this Plan if you:

1. Are not eligible for Medicare due to your age;

2. Are receiving benefits from the Pension Fund;

3. Make the required Class C Self-Payments in a timely manner; and

4. Meet one of the following age and service requirements:

   (a) Previously worked under a Collective Bargaining Agreement with Local 392, did not lose eligibility under the Plan due to work in Industry Employment, are at least 55 years old and have at least 25 Years of Service; or

   (b) Have been eligible for benefits under this Plan during at least 36 out of the 60 months immediately preceding the month for which you first receive pension retirement benefits from the Pension Plan, and you:

      i. Are at least 55 years old and have at least 15 Years of Service; or

      ii. Are at least 60 years old and have at least 10 Years of Service.

B. When Class C Benefits Begin

If you are eligible for Class C Benefits, your coverage will begin on the first day of the first Eligibility Period after you exhaust your Class A Benefit eligibility under the 670 Rule.

C. Class C Self-Payments

If you are eligible for Class C Benefits, a timely Class C Self-Payment is required to maintain coverage under the Plan. You must make Self-Payments for all persons you intend to cover under the Plan. If you have a balance in your HRA Account upon your retirement, the Fund Office will automatically deduct the required monthly Self-Payment from your HRA Account until the balance in your account is exhausted. If there is an insufficient balance to cover the full amount of the required Self-Payment, the Fund Office will automatically deduct the difference from your Pension check. Once your HRA is exhausted, the Self-Payments will automatically be deducted from your Pension Plan check each month.

If you are eligible for Class C Benefits and you elect NOT to make Class C Self-Payments for you and/or your Dependents when you first are required to do so or at any time during which you are eligible for Class C Benefits, you and/or your Dependents will not be permitted to opt back into Class C Benefits or into Class F Benefits when you are eligible for Medicare due to your age unless you satisfy the Retiree Opt-In requirements under Section 2.06.

1. <u>Amount of Class C Self-Payment</u>

There are two separate categories of Class C Self-Payments and what category you are in depends on when you retire.

(a) **If you retired and began receiving Pension Plan benefits before June 1, 2009**, the amount of your Class C Self-Payments is determined by your age, Years of Service and whether you elect family or single coverage. This amount is determined by the Trustees and is subject to change at any time. Please contact the Fund Office for the current rates.

(b) **If you retire and begin receiving Pension Plan benefits on or after June 1, 2009**, your Class C Self-Payment is based on the age at which you begin receiving Pension Plan benefits, your Years of Service, and a percentage of the Fund's cost for providing this coverage. These rates are "indexed" to the Fund's actual cost for coverage, which means they will generally adjust each June 1st based on those costs, subject to Trustee approval.

As illustrated in the following table, the age at which you begin receiving Pension Plan benefits **significantly** impacts your monthly Class C Self-Payment amount.

Class C Retiree Self-Payment Rates for Retirement Dates On or After June 1, 2009				
	30 or More Years of Service	***25-29 Years of Service***	***20-24 Years of Service***	***Less than 20 Years of Service***
Age at Retirement	**Percentage of Plan Cost You Pay Each Month**	**Percentage of Plan Cost You Pay Each Month**	**Percentage of Plan Cost You Pay Each Month**	**Percentage of Plan Cost You Pay Each Month**
57 & Under	55%	60%	70%	100%
Single				
Family				
58-59	15%	25%	30%	100%
Single				
Family				
60 & Over	5%	12.5%	15%	100%
Single				
Family				

As you can see in the example on the following page, **you will not move to a lower Self-Payment category as you get older – the age at which you begin receiving Pension Plan benefits will determine your Class C Self-Payment rate until you are eligible for Medicare due to your age.**

Tom is married and will be 55 years old when he will be eligible to retire on January 1, 2015, with 29 Years of Service. Table I shows Tom's monthly Self-Payment amount for Class C coverage as well as an estimate of his monthly pension benefit if he retires at age 55. Tables II and III show the impact on Tom's monthly Self-Payments, pension and average net annual income if he chooses to defer his retirement date.

		• TABLE I • *If Tom, who is married, retires at age **55 with 25-29 years of service** . . .*			• TABLE II • *If Tom defers his retirement until he is **age 58 with 30+ years of service** . . .*			• TABLE III • *If Tom defers his retirement until he is **age 60 with 30+ years of service** . . .*		
Date	Tom's Age	Monthly Self-Payment[1]	Gross	Net[2]	Monthly Self-Payment[1]	Gross Monthly Pension[3]	Net Monthly Income[2]	Monthly Self-Payment[1]	Gross Monthly Pension[3]	Net Monthly Income[2]
1/1/2015	55	$795	$1,782	$631	still working			still working		
1/1/2016	56	$835	$1,782	$591						
1/1/2017	57	$877	$1,782	$549						
1/1/2018	58	$921	$1,782	$505	$229	$3,205	$2,191			
1/1/2019	59	$967	$1,782	$459	$240	$3,205	$2,180			
1/1/2020	60	$1,015	$1,782	$411	$252	$3,205	$2,168	$84	$3,690	$2,868
1/1/2021	61	$1,066	$1,782	$360	$265	$3,205	$2,155	$88	$3,690	$2,864
1/1/2022	62	$1,119	$1,782	$307	$278	$3,205	$2,142	$92	$3,690	$2,860
1/1/2023	63	$1,175	$1,782	$251	$292	$3,205	$2,128	$97	$3,690	$2,855
1/1/2024	64	$1,234	$1,782	$192	$307	$3,205	$2,113	$102	$3,690	$2,850
1/1/2025	65	Medicare-eligible			Medicare-eligible			Medicare-eligible		
Avg. Net Annual Income		$5,107			$25,846			$34,313		

[1] *The monthly Self-Payment amounts above, which are indexed to the Fund's actual costs of providing this coverage, are estimated to increase at 5% per year. This is only an estimate for the purpose of this example; the actual rate used will be different.*

[2] *"Net income" means the Retiree's pension income after deducting Self-Payments for Class C Benefits and estimated income taxes of 20%.*

[3] *The example assumes that Tom works at least 1500 hours during 2015, 2016, 2017 and 2018 at the current Pension Plan Accrual Rate of $67.*

D. Returning to Work & the Full Cost Premium

If you are a Retiree who is eligible for Class C Benefits (Class C Retiree) and you decide to return to work after you retire, ***regardless of the date of your retirement,*** your Self-Payment rate will be adjusted to the Full Cost Premium if you work in Disqualifying Employment.

1. Disqualifying Employment

   For the purpose of the Full Cost Premium, Disqualifying Employment is defined as follows:

(a) **Work for a Non-Signatory Contractor.** A Class C Retiree will be charged the Full Cost Premium for the calendar year in which he is employed in any capacity by a Non-Signatory Contractor.

(b) **Work for a Signatory Contractor.** A Class C Retiree will be charged the Full Cost Premium for the calendar year in which his annual earnings exceed the annual Social Security Limit (SS Limit) as a result of work performed in any capacity for a Signatory Contractor.

(c) **Work for an employer that is neither a Signatory Contractor nor a Non-Signatory Contractor**. A Class C Retiree will be charged the Full Cost Premium for the calendar year in which his annual earnings exceed the annual SS Limit as a result of work performed within the territorial jurisdiction of the Union: 1) in the Trade or 2) using a Related Skill.

Exceptions:

(i) To the extent that the Class C Retiree establishes that any portion of the earnings he received from a Signatory Contractor resulted from work performed outside the Union's territorial jurisdiction, those earnings will be excluded for purposes of determining whether he exceeded the SS Limit.

(ii) In the event that the Class C Retiree's earnings exceed the SS Limit for a calendar year and he accumulates sufficient Credited Hours, including hours credited to this Plan pursuant to a Reciprocal Agreement, to satisfy the Continued Eligibility Requirements for Class A Benefits under the Plan, he will be charged the standard Class C Self-Payment in Section 2.03(C)(1) for the months in which he worked to establish Continued Eligibility.

(iii) The Full Cost Premium will not be charged for any months for which the Class C Retiree demonstrates that he did not receive any compensation.

2. Enforcement

(a) As a condition to the payment of benefits, prior to each calendar year and at such other times as determined by the Trustees, Class C Retirees will be required to submit written authorization to the Plan in order for the Fund Office to obtain periodic earnings statements from the Social Security Administration (SSA). The Trustees may require the production of specific information and documents, including W-2 forms and tax withholding documents and income tax returns, in order to verify employment. The Trustees may also require each Class C Retiree to certify under oath that he is not engaged in Disqualifying Employment described in this Section of the Plan. **The failure to provide such authorization, requested documentation and/or certification will result in the Fund Office withholding your benefits until such documentation is received.**

(b) Upon receipt of earnings information from SSA, the Fund Office will make a determination of whether the Class C Retiree has engaged in Disqualifying Employment and whether the SS Limit has been reached (if applicable).

(c) If the Fund Office makes a determination that the Class C Retiree worked in Disqualifying Employment during the calendar year(s) in review, the Class C Retiree will be presumed to have worked one or more hours in Disqualifying Employment during each month of the

affected calendar year and through the present time. Such presumption will apply until such time as the Class C Retiree provides proof that he did not work during a particular month.

(d) If, upon receipt of the SSA information, it is determined that an adjustment is appropriate, the Fund Office will send a notification letter. The notification will state that the Class C Retiree's work in Disqualifying Employment resulted in an underpayment of Class C Self-Payments and accordingly, the amount of the underpayment will be charged to the Class C Retiree based on 1/24 of the aggregate underpayment during the 24-month period following the determination.

For Example:

Pete retired at age 55 and is now a 60 year old retired plumber receiving benefits under the Local 392 Pension and Welfare Plans. He accepted a position at Joe's Plumbing in January 2014 performing supervisory work and office work for which Contributions are not required. After 2014 ends, the Fund Office receives Pete's Social Security Earning Statement which shows that he earned $17,000 during 2014 from his work at Joe's Plumbing which exceeded the 2014 SS Limit of $15,480. Accordingly, Pete's Class C Self-Payment rate would adjust to the Full Cost Premium amount for the entire 2014 calendar year, through the present time until he terminates employment with Joe's Plumbing.

The Fund Office sends a notification letter on August 30, 2015, stating that Pete's work in Disqualifying Employment during 2014 resulted in a Self-Payment underpayment for the 2014 calendar year through the present time.

- Pete's Class C Self-Payment is $795 and the Full Cost Premium amount is $1,325 (Pete is married and therefore charged the family rate). Accordingly, Pete's underpayment for each month of the 2014 calendar year through the present time is $530 ($1,325 monthly Full Cost - $795 monthly Self-Payment) and his total underpayment is $10,600 ($530 per month x 20 months from 1/1/14 through 8/1/15).

- Therefore, Pete will be charged $442 ($10,600 x 1/24) per month for the 24-month period immediately following the notice. This amount is in addition to the $1,325 Full Cost Premium payment necessary to maintain coverage under the Plan until Pete provides evidence that he has terminated his disqualifying employment.

Note: If Pete turns age 65 and becomes eligible for Medicare while he is paying any amount of underpayment, he will be charged the 1/24 of the amount of the underpayment per month in addition to any Class F Self-Payments necessary to maintain Class F eligibility under the Plan.

E. When Class C Benefits End

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

1. The date you stop meeting the Retiree general eligibility requirements under the Plan;

2. The date the Trustees discontinue Retiree Benefits;

3. The last day of the last month for which you made a timely Retiree Self-Payment; or

4. The date of your death.

Additionally, your Class C Benefits will end on the first day of the month you are eligible for Medicare due to your age. Please be aware that if you: (a) are retired, (b) are receiving Class C Benefits and (c) you become eligible for Medicare due to your age, you will be required to elect Class F benefits under Section 2.04 or elect no coverage under the Plan. If you elect Class F Benefits, they will begin on the date you are eligible for Medicare. If you elect no coverage under the Plan, you will not be allowed to change your election at a later date.

2.03 Eligibility for Medicare Supplement Retiree Benefits (Class F)

Once you retire and are no longer eligible for Class A Benefits and are not eligible for Class C Benefits because you are eligible for Medicare due to your age, this Plan offers Class F Medicare Supplement Retiree Benefits (Class F Benefits). If you are eligible for Class F Benefits, you and your Dependents are eligible for the following benefits: Medical Benefits Supplemental to Medicare, Prescription Drug, and Hospice Benefits. Additionally, you may eligible for the Death Benefit and the HRA Account Benefit provided you meet the additional eligibility requirements of those specific benefits.

A. Eligibility for Class F Benefits

1. General Eligibility Requirements

   You may be eligible for Class F Benefits under this Plan if you:

   a. Are eligible for Medicare due to your age;

   b. Are receiving benefits from the Pension Fund;

   c. Make the required Class F Self-Payments in a timely manner; and

   d. Meet one of the following age and service requirements:

      (i) Previously worked under a Collective Bargaining Agreement with Local 392, did not lose eligibility under the Plan due to work in Industry Employment, are at least 55 years old and have at least 25 Years of Service; or

      (ii) Have been eligible for benefits under this Plan during at least 36 out of the 60 months immediately preceding the month for which you first receive pension retirement benefits from the Pension Plan, and you:

         (a) Are at least 55 years old and have at least 15 Years of Service; or

         (b) Are at least 60 years old and have at least 10 Years of Service.

2. Special Eligibility due to Disability

If you are not eligible for Class A Benefits or Class C Benefits under the Plan, you will be eligible for Class F Benefits and your Dependents will be eligible for Class C or Class F Benefits as applicable if you:

a. Have exhausted all other forms of continuation coverage (except COBRA);

b. Retired due to a disability with either a lump sum distribution or a disability retirement benefit from the Pension Plan;

c. Are under the age of 65;

d. Are determined to be Disabled by the Social Security Administration; and

e. Make the Class F Disability Self-Payment.

B. When Class F Benefits Begin

Please be aware that if you: (a) are retired, (b) are receiving Class C Benefits and (c) become eligible for Medicare due to your age, you will be required to elect Class F benefits or elect no coverage under the Plan. If you elect Class F Benefits, they will begin on the date you are eligible for Medicare. If you elect no coverage under the Plan, you will not be allowed to change your election at a later date.

C. Class F Self-Payments

If you are eligible for Class F Benefits, a timely Class F Self-Payment is required to maintain coverage under the Plan. You must make the appropriate Self-Payments for all persons you intend to cover under the Plan. If you have a balance in your HRA Account upon your eligibility for Class F Benefits, the Fund Office will automatically deduct the required monthly Self-Payment from your HRA Account until the balance in your account is exhausted. If there is an insufficient balance to cover the full amount of the required Self-Payment, the Fund Office will automatically deduct the difference from your Pension check. Once your HRA is exhausted, the Self-Payments will automatically be deducted from your Pension Plan check each month.

The amount of the Class F Self-Payment and Class F Disability Self-Payment for Class F Benefits is determined by the Trustees and is subject to change at any time.

D. When Class F Benefits End

When your Class F Benefits end depends on whether you (1) are eligible for Medicare due to your age or (2) eligible due to a Disability.

1. <u>Eligible for Medicare Due to Age</u>

   If you are eligible under Class F Benefits because you are entitled to Medicare due to your age, your Class F Benefits will end on the first of the following dates to occur:

   a. The final day of the last month for which you make a timely and correct Class F Self-Payment;

   b. The date the Trustees discontinue this benefit; or

   c. The date of your death.

2. Eligible Due to a Disability

   If you are eligible under Class F Benefits because you are Disabled, your Class F Benefits will end on the first of the following dates to occur:

   a. The final day of the last month for which you make a timely and correct Class F Disability Self-Payment;

   b. The date on which you are no longer Disabled;

   c. The date you become eligible under the Plan for Class C Benefits or Class F Benefits as a result of your entitlement to Medicare due to your age;

   d. The date the Trustees discontinue this benefit; or

   e. The date of your death.

2.04 Eligibility for other Retiree Benefits (Class D or Rx Only)

A. Class D Benefits.

If you were enrolled under the former Class D Benefits as of December 31, 2010, you are eligible for the Class D Benefits which consist solely of the Death Benefit; provided that you meet the additional eligibility requirements thereunder. Your Dependents are not eligible for benefits under the Plan.

No Self-Payment is required for Class D Benefits and your eligibility will end in the event that the Trustees discontinue the Death Benefit or the Plan.

B. Retiree Prescription Drug Only Coverage (Rx Only Benefits)

If you are eligible for Class F Benefits under Section 2.04 of the Plan because you are eligible for Medicare due to your age, you may elect Rx Only Coverage, provided you make the required timely Rx Only Self-Payment ($180 as of January 1, 2015 but subject to change by the Trustees at any time). If you elect Rx Only coverage, you will be eligible for the Prescription Drug Benefit under the Plan and you may be eligible for the Death Benefit; provided that you meet the additional eligibility requirements thereunder.

Once you elect this Rx Only coverage, you may only rescind this coverage once and re-enter Class F Benefits. If you re-enter Class F Benefits, you may not make a subsequent election of the Rx Only coverage. Additionally, your Rx Only coverage will end on the first of the following dates to occur:

1. The final day of the last month for which you make a timely and correct Rx Only Self-Payment;

2. The date the Trustees discontinue this benefit; or

3. The date of your death.

2.05 Retiree Opt-In and Opt-Outs Due to Other Coverage

As stated in 2.03(E) and 2.04(B), once you opt-out of coverage under the Plan for Class C or Class F Benefits you will not be eligible to opt-in at a later date (except as provided under 2.05(B) for Rx Only coverage).

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

1. There is no gap in coverage;

2. The other employer sponsored coverage is lost by reason of termination of employment, termination of plan, death, or divorce; and

3. The application to opt-in is made within 30 days of the termination of the other employer sponsored coverage and is accompanied with satisfactory proof of the termination and its effective date.

In the event that you are eligible to opt-in under this subsection, the amount of the Class C or Class F Self-Payment will depend on the date you begin receiving benefits from the Pension Plan.

2.06 Dependent Eligibility

A. Dependents' Initial Eligibility

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

1. The date you are eligible for coverage; or

2. The date he/she meets the definition of Dependent under the Plan.

B. Dependent Eligibility for Class A, Class C and Class F Benefits

Your Dependent's eligibility for a particular class of Benefits (A, C or F) depends on what class you are covered under and if you are retired, their age. For example, you may be eligible for Class F Benefits, but your Dependent spouse may be eligible for and elect Class C Benefits because he/she is not yet entitled to Medicare due to his/her age.

1. Class A Benefits

   Your Dependents will be eligible for Class A Benefits as long as you are covered under the Plan's Class A Benefits, subject to the Dependent termination provisions.

2. Class C Benefits

   Your Dependents are eligible for Class C Benefits (subject to the Dependent termination provisions) if the following conditions are met:

   (a) You are covered under Class C or Class F Benefits;

   (b) He/she is not entitled to Medicare due to his/her age; and

   (c) The applicable Class C Self-Payments are made in a timely manner.

3. Class F Benefits

   Your Dependents are eligible for Class F Benefits (subject to the Dependent termination provisions) if the following conditions are met:

   (a) You are covered under Class C or Class F Benefits or you died while covered under such benefits;

   (b) He/she is entitled to Medicare; and

   (c) The applicable Class F Self-Payments are made in a timely manner.

C. When Dependent Eligibility Ends

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

1. The date your eligibility ends;

2. The date he/she no longer meets the definition of a Dependent under the Plan;

3. The date the Trustees discontinue Dependent Benefits;

4. The date he/she enters active military service; or

5. The date the Trustees terminate the Plan

D. Extension of Dependent Eligibility in the Event of Your Death

Generally, once you lose eligibility for any reason under the Plan, your Dependent(s)' eligibility will end when your coverage ends and COBRA Continuation Coverage will be the sole method available for the continuation of their coverage. However, in the event of your death, your Dependents may have other options available to continue their coverage, provided they are otherwise eligible under the terms of the Plan.

1. Continuation of Coverage due to Credited Hours

   If you die while you are covered under Class A Benefits, your Dependents will continue to be covered under the Plan until the end of the Eligibility Period for which you were credited with sufficient hours during the corresponding Qualification Period.

2. Use of the One Free Six Month Period

   If you die while you are covered under Class A Benefits and you have earned but not used your One Free Six Month Period, your surviving Dependents may use that One Free Six Month Period at the end of the last Eligibility Period you earned prior to your death.

3. Continuation of Coverage under the Disability Extension

   If you die while you are exhausting a Disability Extension under Section 2.01(G)(4), your surviving Dependents may continue their coverage for the balance of the Disability Extension, if any.

4. Self-Payments by Surviving Dependents

After your Surviving Dependents exhaust the above listed methods of continuing coverage under the Plan, they will be eligible to either make Dependent Self-Payments to continue eligibility **OR** to elect COBRA Continuation Coverage.

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

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

(b) Your surviving spouse is eligible to make Self-Payments for your Dependents until your surviving spouse remarries.

(c) If your surviving spouse dies while covered under these Self-Payment rules, any surviving Dependent children may continue to make Self-Payments until they no longer meet the definition of Dependent under the Plan.

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

(e) The coverage provided for your surviving Dependents is the same coverage for which they were eligible before your death. When your surviving spouse becomes eligible for Medicare due to age, he/she will be eligible for Class F Benefits; provided that he/she makes the required self-payments.

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

A Qualified Medical Child Support Order (QMCSO) is a court order regarding medical coverage for your children (called Alternate Recipients) in situations involving divorce, legal separation or a paternity dispute. The Fund will honor the terms of a QMCSO regarding communication with the custodial parent of a Dependent and with regard to which plan is primary when a Dependent is covered by more than one group health plan as described in the Plan's Coordination of Benefits rules.

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

2.07 COBRA Continuation Coverage

A. COBRA Continuation Coverage in General

When you and/or your covered Dependents lose coverage because of a Qualifying Event, coverage may be temporarily continued at your own expense as required under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Qualifying Events are defined as death, a reduction of hours, loss of employment (except due to gross misconduct), entitlement to Medicare benefits, a Dependent losing their Dependent status under the Plan and separation or divorce. However, if your Dependents lose

coverage due to your death or if you elect Retiree coverage and elect to make Self-Payments to continue coverage under the Plan instead of electing COBRA Continuation Coverage, COBRA Continuation Coverage will not be available once your eligibility due to Self-Payments terminates.

For Example:

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

If you elect COBRA Continuation Coverage under this Plan, you are entitled to the benefits you were eligible for on the day before the Qualifying Event including Major Medical, Prescription Drug, and Dental benefits. However, COBRA Continuation Coverage does not include the following benefits: Death, AD&D and Weekly Disability Benefits.

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

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

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

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

B. Eligibility

1. <u>18-Month COBRA Continuation Coverage</u>

   You are eligible to elect COBRA Continuation Coverage when you lose eligibility for benefits because of a Qualifying Event. In such event, you and your eligible Dependents may elect up to

18 months of COBRA Continuation Coverage when your coverage terminates because of the loss of employment, lay-off, retirement or a reduction in your hours of work. Under these circumstances, the Qualifying Event will result in loss of coverage on the first day of the new Eligibility Period where you did not meet the Continued Eligibility Requirements under the Plan.

2. Disability Extension of 18-Month COBRA Continuation Coverage

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

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

3. 36-Month COBRA Continuation Coverage

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

(a) Your death;

(b) Your divorce or legal separation;

(c) You become eligible for Medicare; or

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

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

C. COBRA Premiums, Payments and Due Dates

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

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

If a COBRA premium payment is not postmarked by the Fund Office within the time limits specified above, COBRA Continuation Coverage will be terminated retroactive to the first day of the month in which a

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

D. The Notification Responsibilities of the Fund Office

When the Fund Office is notified of a Qualifying Event, the Fund Office will send a COBRA Election Notice and COBRA Election Form to you and your Dependents who would lose coverage due to the Qualifying event. The Fund Office will send the notice within 14 days of the time it receives notice of a Qualifying event. The Election Notice tells you about your right to elect COBRA Continuation Coverage, the due dates for returning the election form, the amount of the payment for COBRA Continuation Coverage and the due dates for COBRA payments.

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

E. Electing Continuation Coverage

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

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

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

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

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

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

F. When the COBRA Continuation Coverage Period Begins

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

G. When COBRA Continuation Coverage Ends

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

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

2. The required premium is not timely paid;

3. The Trustees terminate the Plan;

4. You or your Dependent reaches the end of the 18-month, 29-month or 36-month applicable Continuation Coverage period;

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

6. Your Dependent becomes entitled to Medicare.

SECTION 3: DEATH BENEFITS

3.01 Death Benefit for Active Employees

If you are eligible for Class A Benefits, the Plan provides for a Death Benefit to be paid to your beneficiary in the event of your death. The amount of the applicable Death Benefit is provided in the Schedule of Benefits.

3.02 Death Benefit for Retirees

The Plan will pay a Death Benefit to your beneficiary in the event of your death if you are eligible for Class C Benefits, Class D Benefits, Class F Benefits or Rx Only Coverage and either your death occurs after September 25, 2009, or you are a Local 59 Retiree. No death benefits are provided for Local 113 Retirees who participate in the Plan solely because of the merger of Local 113 with Local 392 on or after May 1, 1988.

The amounts of the Death Benefits are provided in the Schedules of Benefits.

3.03 Continuation of Death Benefit During Total Disability

Additionally, if you become Disabled while you are covered under Class A Benefits, your eligibility for Death Benefits will continue for as long as you are Disabled or until you retire. The conditions for receiving this continuation are as follows:

A. You must become Disabled prior to your 60th birthday;

B. You must be totally and completely unable to perform any and all work in any occupation or business for wage, compensation or profit;

C. Your total disability must last for at least nine months (or up to the date of your death if death occurs within nine months from the date you became Disabled);

D. You must provide the Trustees with acceptable medical proof that your disability has lasted for at least nine months. The proof must be furnished after you have been Disabled for at least nine months and before your disability has lasted for 12 months. If the Trustees so request, you must agree to be examined periodically (but not more often than is reasonable) by a Physician chosen by the Trustees;

E. Annually thereafter, you must provide proof that you remain Disabled, if requested by the Trustees.

3.04 Designating Your Beneficiary

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

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

A. Your spouse;

B. Your children;

C. Your parents;

D. Your brothers and sisters; or

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

The designation of a spouse as beneficiary of Death Benefits is void upon divorce, and submission of the Universal Beneficiary Designation Form will be required in order to name a new beneficiary(ies) or to re-name a former spouse as beneficiary. This form includes designation for death benefits under both the Pension Fund and the Welfare Fund. Please be aware that if you do not request and properly submit this form, and the beneficiary is void pursuant to this subsection, the Welfare Fund will pay Death Benefits in the order of survivorship as listed above.

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

4.01 AD&D Benefits for Active Employees Only

If you are eligible for Class A Benefits, your coverage includes the Accidental Death and Dismemberment (AD&D) Benefit. This benefit is payable to you if you sustain a Loss within 90 days of an Accident. For the purposes of this Section, Loss means loss of a limb, sight or life.

The types of losses covered under the AD&D Benefits and the benefit amounts are provided in the Schedule of Benefits. This amount is in addition to any other benefits you may receive under the Plan. If you die as a result of an Accident, this Benefit is paid to your beneficiary.

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

4.02 Limitations on AD&D Benefits

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

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

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

C. Suicide or attempted suicide;

D. Intentional self-inflicted injuries;

E. Participation in, or as a result of participation in, the commission of a felony, riot or a civil promotion;

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

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

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

I. An accidental overdose; or

J. Any of the circumstances listed under the Plan Exclusions.

SECTION 5: WEEKLY DISABILITY BENEFITS

5.01 Eligibility for Weekly Disability Benefits

If you are a mechanical equipment serviceman or a commercial service plumber and you are eligible under the Plan for Class A Benefits through the 670 Hour Rule, you may be eligible for Weekly Disability Benefits if you are Disabled under the Plan and you were covered under the Plan on the date your disability began. For the purposes of weekly disability benefits only, mechanical equipment serviceman also includes a Participant who became a mechanical equipment service journeyman within the immediately preceding twelve month period and has not yet established eligibility for Accident and Sickness (A&S) Benefits under the SUB Plan.

If you are entitled to any unemployment benefit under any state unemployment laws or entitled to disability benefits under any state workers' compensation law, employers' liability law or similar laws, then you are not entitled to Weekly Disability Benefits under the Plan.

Please be aware that if you are eligible for A&S Benefits under the SUB Plan, you must exhaust your available SUB Plan Benefits prior to receiving Weekly Disability Benefits under the Plan.

5.02 Payment of Weekly Disability Benefits

The amount of the Weekly Disability Benefit payable is provided in the Schedule of Benefits. If you are Disabled for part of a week, you will receive one-seventh (1/7) of the weekly benefit for each day of disability. As a special benefit to Participants, the Trustees are authorized to withhold and pay both the Employer and Employee portions of FICA and FUTA taxes, and withhold federal income tax upon written request, from any amounts you receive as a Weekly Disability Benefit.

Your disability must continue for at least seven consecutive days before you become eligible to receive Weekly Disability Benefits. If your disability is due to an Accident and continues for eight or more consecutive days, Weekly Disability Benefits shall retroactively be paid for the first seven days of disability. If your disability is due to Sickness and continues for 15 or more consecutive days, Weekly Disability Benefits shall retroactively be paid for the first seven days of your disability. This Benefit is payable for up to 26 weeks for any one continuous period of disability (less the number of weeks you received A&S Benefits under the SUB Plan).

Successive periods of disability resulting from or contributed to the same or related causes and are separated by less than two weeks of full-time work in Covered Employment, will be considered one continuous period of disability.

If the second period of disability is due to an Accident or Sickness entirely unrelated to the cause of the first disability and it begins after you have returned to work in Covered Employment or are available for work with Local Union No. 392 for at least one full work-week, then the second disability will be considered as a new period of disability and you will be eligible for a new 26-week period of Weekly Disability Benefits. Benefits will be paid for no more than two periods of disability during any 60-month period.

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

If you are eligible for Weekly Disability Benefits and participate in a course of treatment for Chemical Dependency, you may receive Weekly Disability Benefits once your Physician has certified your Disabled status, as well as, your status as a patient in a treatment program. Weekly Disability Benefits during a course of treatment for Chemical Dependency are limited to the period of time in which you are in the treatment program and the two (2) weeks following your discharge from the program. However, Benefits will not be payable beyond the date on which you have already received weekly benefits for the maximum 26-week period for any one period of disability.

5.04 Limitations on Your Weekly Disability Benefits

No Weekly Disability Benefits will be paid:

A. For any period for which your disability is not certified by a Physician and you are not under the care of a Physician; or

B. If your loss is caused by any of the items listed in the Plan Exclusions.

SECTION 6: COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFIT FOR ACTIVE EMPLOYEES AND CLASS C RETIREES

6.01 The Deductible

The deductible is the amount of Covered Medical Expenses that you and each of your eligible Dependents pay each calendar year before Plan benefits are paid.

The deductibles are listed in the Schedule of Benefits of this booklet.

The deductible applies to each eligible individual in your family (includes you and your eligible Dependents only) every calendar year. However, if two or more eligible members of your family are injured in the same Accident, only one deductible will be applied to the total expenses resulting from the Accident.

Also, once you meet the family deductible, no further deductible will be applied to any eligible member of your family during the remainder of the calendar year.

If you incur Covered Medical Expenses during October, November and/or December of a calendar year that are used to satisfy your deductible, those Covered Medical Expenses will also be applied toward your deductible for the next calendar year.

6.02 Non-PPO Hospital Deductible

If you or your eligible Dependents use a non-PPO Hospital for non-emergency inpatient care, even if such care is approved by the Plan's UR company, that treatment will be subject to an additional non-PPO Hospital deductible. The amount of this deductible is provided in the Schedule of Benefits.

Additionally, this deductible will be waived if your Dependent has other coverage that is the primary payor and your Dependent follows the primary plan's rules requiring use of a Hospital that does not participate in the Plan's PPO network.

6.03 Percentage of Benefits Payable

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

6.04 Out-of-Pocket Maximum

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

6.05 Maximum Benefit Payable

The maximum benefits payable are listed in the applicable Schedule of Benefits. If you change classification from one class of benefits (Class A or Class C) to the other, the prior classification will be used in determining your remaining maximums available under the Plan.

6.06 Preferred Provider Organization (PPO)

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

To minimize your out-of-pocket costs, contact the PPO for information about which Hospitals and providers are in the Plan's PPO network. When you use PPO Hospitals and providers rather than non-PPO Hospitals and providers, you can reduce costs for both you and the Fund.

6.07 Hospital Preadmission Certification Program

The Welfare Fund contracts with a review organization to help reduce costs and wasteful expenses by reviewing and certifying Hospital admissions. This process is called Utilization Review (UR).

In order for benefits to be paid under the Plan, you and your Dependents ***should*** comply with the following procedures for all Hospital admissions, including for inpatient treatment of Chemical Dependency or Mental and Nervous Disorders. These procedures are as follows:

A. Non-Emergency Admissions – You or someone calling on your behalf should call the Fund's review organization before your admission or at the time of admission. The review organization will then contact your treating provider for detailed information and along with your treating provider they will determine if your admission is Medically Necessary. The review organization will then send you a notice certifying that you provided notification about your admission and informing you about the number of days certified.

B. Emergency Admissions – If an admission is due to an emergency, you or someone on your behalf should call the review organization within forty-eight (48) hours after admission.

Please note that treatment in a Hospital's emergency room is not considered an Emergency Admission and does not require a call to the Fund Office or the review organization unless the covered person is admitted to the Hospital as an Inpatient.

6.08 Covered Medical Expenses and Exclusions

A. Expenses Covered Under the Plan

The Plan covers up to the UCR Charges for Medically Necessary services and supplies listed in this subsection that you and/or your Dependents receive for the treatment of a non-occupational Accident or Sickness which are provided by an individual or organization that is licensed to provide the covered services or supplies in the state or jurisdiction where the services are rendered and where such individual is acting within the scope of his or her license. All benefits payable under this section are subject to the Plan maximums and limitations noted in the Schedules of Benefits and the exclusions noted in Section 6.08(B) and Section 11.

1. Hospital services and supplies for:

(a) Room and board fees up to:

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

ii. The Hospital's regular daily rate for a private room when required for contagious or communicable diseases.

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

(c) Outpatient Hospital services, including fees incurred for:

i. Outpatient surgical procedures; and

ii. Emergency treatment for an Accident or Sickness.

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

2. Medical care and treatment, including surgery.

3. Pre-admission tests performed on an outpatient basis at a Hospital performed prior to and in connection with inpatient or outpatient surgery. The tests must be expected to shorten the covered person's Hospital stay and the results of the tests must be valid at the time of the surgery. If the tests become medically invalid due to postponement of the admission because a Hospital bed was unavailable or a condition was revealed that required treatment prior to admission, the charges for the tests will still be Covered Medical Expenses.

4. Services performed in a Hospital, Outpatient Surgical Center or Physician's office for the administration of anesthetics.

5. Private duty professional nursing services under the supervision of a Physician.

6. Second and, if necessary, third surgical opinions.

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

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

9. Eye exercise administration when ordered by a Physician for the correction of an injury or muscle imbalance of the eye and when performed within 90 days prior to or following eye surgery.

10. Preventive Services in accordance with federal law.

11. Routine physical exams and necessary diagnostic tests that are not deemed Preventive Services under federal law. However, if the exam reveals symptoms or conditions that require further testing or treatment, benefits for the additional tests and/or treatment are paid the same as any other Accident or Sickness.

12. Transfer by local ambulance to:

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

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

    (c) Local ambulance service for transportation of the covered person from the Hospital to his/her home upon discharge provided the person's condition requires ambulance transportation and pursuant to the treating Physician's instructions.

13. Transportation for medical purposes where:

    (a) The transportation is within the continental limits of the United States and Canada;

    (b) The covered person utilizes a regularly scheduled commercial aircraft, railroad or automobile*; and

    (c) The transportation is from the location in which the Accident or Sickness was first diagnosed and/or treated to and from a Hospital or Physician in another geographic location that offers special equipment and/or special skills necessary to the diagnosis and/or treatment of the covered person's Accident or Sickness.

    The transportation is limited to two round trips per period of disability per calendar year.

    *The maximum Covered Medical Expense for transportation by automobile will not exceed the amount allowed per mile by the Internal Revenue Service for medical transportation during the year in which the cost is incurred, and such allowable amount may not exceed the amount that would have been allowed if the person had traveled by commercial aircraft.

14. Care provided in a Skilled Nursing Care Facility subject to the limitations provided in the Schedule of Benefits when:

    (a) Your confinement begins within 14 days after a Hospital admission of at least three (3) days duration;

    (b) Your care and treatment are for the Sickness or Accident that caused the Hospital confinement immediately before admission to the Skilled Nursing Care Facility; and

    (c) You are under the regular care of a Physician.

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

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

17. Diagnostic infertility testing for Active Employees and Dependent spouses, if such tests are performed for a Physician to make an initial diagnosis.

18. Radiation therapy and chemotherapy.

19. Dental services and supplies provided for ONLY the following types of care and treatment:

    (a) Reduction of fractures of the jaw or facial bones;

    (b) Surgical correction of harelip, cleft palate or protruding mandible;

    (c) Removal of stones from salivary ducts;

    (d) Excision of impacted teeth, bony cysts of the jaw, torus palatinus, leukoplakia or malignant tissues;

    (e) Freeing of muscle attachments; and

    (f) Repair of sound natural teeth due to Accident when the expense is incurred within 365 days of the Accident.

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

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

    (b) Part-time or intermittent home health aide services;

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

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

    (e) Medical services of interns and residents in training under an approved teaching program of a Hospital with which the Home Health Agency is affiliated.

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

22. Chiropractic care.

23. Asbestos testing for Active Employees and Retirees.

24. Treatment or surgery for one occurrence of obesity or an overweight condition per lifetime if the covered person:

    (a) Has a BMI of 45 or greater;

(b) Faces a threat to his/her life due to diabetes, hypertension or cardiac disease;

(c) Completes a six-month nutritional counseling program under the supervision of the UR company approved by the Trustees; and

(d) Is not a Dependent child.

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

26. Casts, splints, trusses, braces, crutches, artificial limbs and/or artificial eyes.

27. Purchase and/or rental of Durable Medical Equipment, provided advance authorization is obtained from the review organization. The Fund reserves the right to purchase the equipment instead of paying for rental, if purchase would cost less than UCR rental amount.

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

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

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

(c) Prostheses and physical complications of all stages of mastectomy including lymphedemas.

28. Charges for oxygen and its administration.

29. Surgical stockings.

30. One wig per Sickness if necessary due to hair loss as a result of radiation therapy or chemotherapy.

31. Examinations and eyeglasses required to correct impairment caused by an ocular Accident or by intra-ocular surgery where such expenses are incurred no later than six (6) months after the injury is sustained or the surgery is performed.

32. Hospital and anesthesia charges related to dental procedures for children below the age of nine, persons with serious mental or physical conditions and persons with significant behavioral problems, where the Dentist treating the covered person or the admitting Physician certifies that because of the patient's age, condition or problem, such treatment is required in order to safely and effectively perform the procedures.

32. Non-experimental or non-investigative organ or tissue transplants.

33. Inpatient treatment provided by a Hospital for Mental and Nervous Disorders and Outpatient treatment, family therapy or group therapy where: the patient is a covered person and is a participant in the therapy session.

34. Inpatient treatment provided by a Hospital or Chemical Dependency Treatment Facility for Chemical Dependency and Outpatient treatment, family therapy or group therapy where the patient

being treated is a covered individual (for family or group therapy where the patient is not a Dependent child under the age of 19, the patient must be a participant in the therapy session).

35. Charges incurred for covered pregnancy expenses provided by a licensed midwife, pursuant to pre-certification by the Plan's review organization.

36. Testing for Hepatitis A, B and C for covered persons who are believed to have been exposed.

37. Diabetic training and education.

38. Genetic testing where:

    (a) The result of the test will directly impact the treatment delivered to the covered person;

    (b) The test is performed on the genes of the covered person with the symptoms of risk and not on a relative or embryo;

    (c) The purpose of the test is not for the medical management of another person who is not covered under this Plan; and

    (d) The purpose of the test is not for directing a reproductive decision in a prenatal setting.

39. Nutritional counseling for cardiovascular disease, malnutrition, cancer, cerebral vascular disease and kidney disease.

40. Non-surgical and surgical routine foot care treatment for a covered person under active treatment for a metabolic or peripheral vascular disease such as diabetes. This includes the treatment or removal, in whole or in part, of corns, callosities, hypertrophy or hyperlasias of the skin or any subcutaneous tissue, or for the cutting or trimming of the toenails. Open cutting, such as for the removal of bunions or bone spurs, is also a Covered Medical Expense.

41. Services and supplies provided for obtaining a routine colonoscopy.

42. Hearing examinations for Dependent children under the age of 26.

43. Hearing devices (aids) where an examination indicates the need for a hearing aid and the examination and the hearing aid are both furnished by a Physician or by an audiologist who is certified by the American Speech-Language Hearing Association.

44. TMJ Treatment.

B. Medical Expenses Not Covered

No benefits shall be payable under this benefit for charges incurred which are in excess of the UCR or any maximum benefit or limitation specified in the Schedule of Benefits or this Article. No benefits will be payable which are not specifically included under the terms of the Plan or which are specifically excluded from coverage. Specifically, the Comprehensive Major Medical Benefit does not cover the following:

1. Services or supplies received from a physician, hospital, chemical dependency treatment facility or outpatient surgical center which does not meet the Plan's definition of such person, facility or organization.

2. Services, supplies, treatments or procedures which are not rendered for the treatment or correction of, or in connection with, a specific non-occupational Accident or Sickness, unless specifically provided.

3. A pregnancy or pregnancy related condition of a Dependent child.

4. Abortion procedures.

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

    (a) Hormone therapy;

    (b) Surgically induced fertility;

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

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

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

7. Pre-admission tests performed prior to admission to a Hospital if the results of the tests become medically invalid except as specifically provided.

8. Home health care except as specifically provided.

9. Any type of employment, pre-employment or premarital physical examination.

10. Services, supplies, treatments or surgical procedures rendered in connection with obesity or an overweight condition except as specifically provided.

11. Non-emergency plastic or cosmetic surgery except as specifically provided.

12. Eye refractions, eye examinations or contact lenses except as specifically provided.

13. Any care or treatment of teeth, gums or the alveolar process except as specifically provided.

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

15. Treatment or removal, in whole or in part, of corns, callosities, hypertrophy or hyperplasias of the skin or any subcutaneous tissue, or for the cutting or trimming of toenails except as specifically provided.

16. Travel or transportation except as specifically provided.

17. Duplicate or spare artificial limbs or eyes, teeth, eyeglasses, hearing aids or braces.

18. Orthopedic shoes or orthopedic prescription devices to be attached to shoes.

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

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

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

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

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

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

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

26. Charges that are payable by Medicare Part A or Medicare Part B where the claimant is eligible for Medicare.

27. Any charges that are incurred for a treatment for Chemical Dependency which is ordered by a court.

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

29. Any physical therapy or speech therapy services designed to adapt and/or develop a physical function.

30. Expenses which would have been covered by another plan but which are not covered because the person failed to take the action required under the other plan's rules.

31. Any charges in connection with medical services rendered to a surrogate or surrogate fees. This exclusion applies, but is not limited to, the medical or other expenses of a surrogate who carries and delivers a child on behalf of a person covered under the Plan or a covered person acting as a surrogate mother.

32. Durable Medical Equipment that serves as a comfort or convenience item, is used for environmental control or used to enhance the environmental setting or surroundings of an individual.

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

SECTION 7: SUPPLEMENTAL MEDICAL BENEFITS FOR RETIRED EMPLOYEES ELIGIBLE FOR MEDICARE – CLASS F MEDICAL BENEFITS

7.01 General Provisions

If you are eligible for and elect Class F Benefits and make timely Class F Self-Payments or if your Dependents are eligible for Medicare, the benefits under the Major Medical Benefit for the all person(s) covered by Medicare are replaced with these benefits designed to supplement Medicare.

Once you and/or your eligible Dependents are **eligible** for Medicare, the Fund pays benefits as if you were enrolled in both Parts A and B of Medicare regardless of whether you actually are enrolled in both Parts A and B of Medicare. **Therefore, you should contact your local Social Security Administration Office for information on how to enroll for Medicare Parts A and B when you retire.**

If you and/or your Dependents are covered under another plan in addition to Medicare, this Plan will always pay after the other plan and Medicare. That means that this Plan will always pay its benefits AFTER Medicare and all other plans and insurance coverage have paid their benefits.

7.02 Class F Benefits

The Class F Medical Benefits provide benefits to supplement Medicare.

7.03 Covered Expenses

The Plan pays the following expenses:

A. Hospital expenses you actually incur while confined in a Hospital as an Inpatient for room and board and for medical care and treatment (exclusive of professional services), subject to the Plan's maximums during any one continuous period of Hospital Confinement as listed in the Schedule of Benefits.

B. 100% of the amount of the Medicare Part B deductible.

C. 20% of Medicare Part B expenses based on Medicare's Limiting Charge or Medicare's Approved Charge as applicable.

D. A portion towards the Medicare deductible as stated in the Schedule of Benefits for charges actually incurred for treatment provided in a skilled nursing care facility as defined under the Medicare guidelines from the 21st through the 100th day of any period of confinement.

A **Hospital Confinement** is considered one continuous period of Hospital Confinement unless you have a period of at least 60 consecutive days between confinements.

Your **Lifetime Reserve** days are 60 days that Medicare will pay for when you are in a Hospital for more than 90 days in a benefit period. These 60 reserve days can be used only once during your lifetime. For each reserve day, Medicare pays all covered costs except for Medicare's daily coinsurance amount.

Medicare's Approved Charge is the fee Medicare sets as reasonable for a covered medical service based on payment being assigned directly to the provider. It may be less than the actual amount charged by a

doctor or supplier. Medicare pays 80% of Medicare's Approved Charge after the deductible is paid. Benefits are assigned directly to your Physician, so Medicare sends the reimbursement to your Physician. The Fund pays the other 20% of the Medicare Approved Charge.

Medicare's Limiting Charge is the highest amount of money you can be charged for a covered service by doctors and other health care providers who do not accept assignment. The limit is 15% over Medicare's Approved Charge. The limiting charge only applies to certain services and does not apply to supplies or equipment. Medicare pays 80% of Medicare's Limiting Charge and the Fund pays the other 20%.

7.04 Expenses Not Covered.

The Plan does not provide for payment of any the following expenses:

A. Not Medicare-approved;

B. Above Medicare's Limiting Charge or Medicare's Approved Charge; or

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

SECTION 8: PRESCRIPTION DRUG BENEFITS

8.01 Eligibility of Active Employees and Retired Employees

The Prescription Drug Benefit applies to you if you are eligible for and covered under Class A Benefits, Class C Benefits, Class F Benefits or Rx Only Coverage. The benefit amounts and applicable co-payments are shown in the Schedule of Benefits. The Prescription Drug Benefit also applies to your Dependents, and is subject to the Plan's Coordination of Benefits rules. Dependents that have primary coverage through another group plan should use those Prescription Drug benefits first, and the Plan will provide secondary coverage.

8.02 General Information

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

The Fund Office provides the PBM with eligibility data including primary and secondary coverage information. Where the coordination of benefits does not take place at the point of purchase, a claim will need to be submitted directly to the Fund Office.

If you have secondary coverage through another prescription drug plan and you choose to use that plan as primary coverage for prescriptions, you may submit a claim for your co-payment amount to this Plan and it may be used to satisfy any of the individual and family deductibles under this Plan.

Under the Prescription Drug Benefit, you have two programs available to you: 1) the Drug Card Program; and 2) the Mail Order Program.

8.03 The Drug Card Program

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

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

A. Go to a participating pharmacy;

B. Show the pharmacist your Prescription Drug I.D. card; and

C. Pay the pharmacist the applicable co-payment per prescription.

8.04 The Mail Order Program

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

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

To order maintenance drugs by mail, follow the directions in your packet of materials. You will be responsible for paying only the co-payment listed in the Schedule of Benefits for each prescription ordered.

8.05 Coverage of Over-the-Counter Medications

Generally, the Plan does not cover over-the-counter medications. However, from time to time the Trustees may decide to cover an over-the-counter drug and will provide you with notice of such coverage through a Summary of Material Modification (SMM). As of the date of this Plan Restatement, Prilosec OTC is the only over-the-counter medication covered under the Plan.

Please note that in order for any over-the-counter medication to be covered under the Plan, the following must occur:

A. The Trustees must specifically identify the medication as a covered over-the-counter medication under the Plan; and

B. You must obtain a written prescription from your Physician for the medication.

8.06 Pre-Authorizations and Step-Therapy

A. PBM Administration

The PBM will administer the Prescription Drug pre-authorization and Step-Therapy program for the following medications:

1. Drugs with over-the-counter equivalents, such as proton pump inhibitors (like Prevacid or Nexium) and non-sedating antihistamines (like Clarinex or Allegra);

2. Brand name drugs with generic equivalents;

3. COX-II drugs (such as Celebrex); and

4. CNS stimulants (such as Adderall or Ritalin).

You should contact the PBM before you have any of the above types of prescriptions filled. To contact the PBM, call the phone number on the back of your I.D. card or contact the Fund Office for contact information.

B. Over-the-Counter Equivalents and Generic Equivalents

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

Prescription Drugs with over-the-counter equivalents and brand name drugs with generic equivalents are not normally covered under the Plan. If your Physician prescribes a drug with an over-the-counter equivalent or a brand name drug with a generic equivalent, ask if you can use the generic or over-the-

counter version instead. If you are unsure if there is an over-the-counter equivalent or generic equivalent for a brand name drug, please contact your Physician or pharmacist.

If you have unsuccessfully tried over-the-counter and/or generic versions of a brand name Prescription Drug, and if the PBM determines, in consultation with your Physician that the Prescription Drug is Medically Necessary, the Plan will make an exception to its exclusion and will consider it as a covered Prescription Drug and will pay the normal Prescription Drug Benefits. However, if the PBM determines that the drug is not Medically Necessary, and you choose to have the prescription filled anyway, you will have to pay the entire cost of the prescription yourself without reimbursement from the Plan.

C. COX-II Inhibitors

COX-II inhibitors must be pre-authorized by the PBM before the prescription is filled. A COX-II inhibitor is a non-steroidal anti-inflammatory drug used to treat pain and is frequently prescribed for arthritis and arthritis-like conditions.

The pre-authorization program for COX-II inhibitors is a Step-Therapy program. Step-Therapy is a program in which a patient with a chronic condition first tries a less costly medication (first-line drug) before using a more expensive drug (second-line drug). Another form of Step-Therapy involves the initial use of the second-line drug to relieve the immediate symptoms, followed by maintenance therapy with a first line-medication. In either case, the goal is to ensure that the patient receives an appropriate medication for a condition.

D. CNS Stimulants

A CNS stimulant is a drug that helps to speed up the mental processes and is frequently prescribed for conditions such as ADD/ADHD, MS, narcolepsy or depression.

You must get prior authorization from the PBM to obtain coverage for CNS stimulants. Examples of such drugs include, but are not limited to: Adderrall, Focalin, Dexadrine, Desoxyn, Ritalin, Metadata, Concerta, Methylin and Strattera.

8.07 Excluded Drugs

The following medications are not covered under the Plan:

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

B. Dietary or nutritional supplements;

C. Smoking cessation drugs in excess of two attempts per year, unless specifically required under federal law as a Preventive Service;

D. Weight loss drugs except as required by federal law as a Preventive Service;

E. Prescription Drugs with a generic or over-the counter equivalent except as specifically provided;

F. Nexium;

G. The Plan does not cover drugs for male impotence (including Viagra). Drugs for male impotence will only be covered if the drugs are determined by the Fund Office to be Medically Necessary. Medically Necessary in this circumstance means that the impotence is caused by an underlying physical condition such as diabetes, a physical injury or a circulatory or neurological disorder. If you obtain pre-approval, you may obtain the quantity of drugs prescribed, up to a maximum of six (6) tablets per month.

SECTION 9: DENTAL EXPENSE BENEFIT

9.01 Eligibility

You and your Dependents are eligible for Dental Benefits under this Article if you are covered under Class A or Class C Benefits.

9.02 Covered Dental Expenses

Subject to the maximums and limitations listed in the Schedule of Benefits, covered dental expenses shall be the UCR Charge incurred for the following services and supplies provided by a Dentist in accordance with accepted standards of dental practice (cleaning and fluoride application may be provided by a licensed dental hygienist):

A. Diagnostic and Preventive Services

1. Routine oral examinations and prophylaxis (scaling/cleaning of teeth), up to two (2) of such services per calendar year;

2. For Dependent children under age 19, topical application of fluoride and space maintainers that replace prematurely lost teeth;

3. Emergency treatment for pain relief;

4. Dental x-rays, including full mouth x-rays (once in 36 consecutive months), supplementary bitewing x-rays (twice per calendar year), and other dental x-rays as are required in connection with the diagnosis of a specific condition requiring treatment; and

5. For Dependent children under age 19 only, sealants on the six-year and twelve-year molars only.

B. Other Covered Dental Expenses

1. Extractions and oral surgery;

2. Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased teeth or accidentally broken teeth which were not caused by an injury;

3. General anesthetics when Medically Necessary and administered in connection with oral or dental surgery, and injection of antibiotic drugs by the attending Dentist;

4. Treatment of periodontal and other diseases of the gums and tissues of the mouth;

5. Endodontic treatment, including root canal therapy;

6. Repair or cementing of crowns, inlays, on lays, bridgework or dentures, or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, limited to one relining or rebasing in 36 consecutive months;

7. Inlays, on lays, gold fillings or crown restorations to restore diseased or accidentally broken teeth, but only when the tooth cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain or composite filling restoration;

8. Initial installation of fixed bridgework (including inlays and crowns as abutments);

9. Initial installation of partial or full removal dentures (including precision attachments and any adjustments during the six month period following installation);

10. Dental (tooth) implants. Laboratory services for preparation of dental restoration and dental prosthetic devices if the Dentist includes the cost of such services or devices in the charges for these services; and

11. Replacement of an existing partial or full removal denture, fixed bridgework or single crown by new denture, by new bridgework, or by a new single crown, or the addition of teeth to an existing partial removable denture or to bridgework, but only if satisfactory evidence has presented that:

    (a) The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture bridgework was installed;

    (b) The existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within 12 months from the date of initial installation of the immediate temporary dentures; or

    (c) The existing denture, bridgework or single crown cannot be made serviceable and, if it was installed and paid for under this dental expense benefit, at least five (5) years have elapsed prior to its replacement.

    Dentures will generally be replaced by dentures. However, if a professionally adequate result can be achieved only with bridgework, charges for such bridgework will be considered covered dental expenses.

9.03 Exclusions and Limitations

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

A. Treatment by persons other than a licensed Dentist, except that scaling or cleaning of teeth and topical applications of fluoride may be performed by a licensed dental hygienist, if the treatment is rendered under the supervision and guidance of a Dentist;

B. Veneers or similar properties of crowns and pontics placed on or replacing teeth, other than the ten upper and lower anterior teeth;

C. Cosmetic services and supplies;

D. Any duplicate prosthetic device or any other duplicate appliance or the replacement of a lost, missing or stolen prosthetic device, unless no benefits were paid under the Plan for that prosthetic device;

E. Any type of orthodontic services or supplies;

F. Sealants, except for Dependent children under age 19 as described in Section 9.02(A)(5);

G. Oral hygiene, dietary instructions or a plaque control program;

H. Splints or appliances such as nightguards used to control harmful habits;

I. Treatment for opening of vertical dimensions;

J. Treatment of conditions related to the temporomandibular jaw joint (TMJ);

K. Services or supplies received as a result of dental disease, defect, or injury due to war, declared or undeclared, or any act of war or aggression;

L. Dental care or services paid for or furnished by or at the direction of any governmental agency, but only to the extent paid for or furnished;

M. Dental procedures that are included as Covered Medical Expenses under the Comprehensive Medical Benefit;

N. Prosthetic devices (including bridges and crowns), and the fitting of such devices, that are ordered while a person is not eligible for dental benefits;

O. Prosthetic devices (including bridges and crowns), and the fitting of such devices, which are ordered while the person is eligible for dental benefits, but which are finally installed or delivered to the person more than 90 days after termination of eligibility; and

P. Expenses incurred for dental services provided while a person is not eligible for dental benefits. Treatment is considered to begin:

    1. For full or partial dentures, when the impression is taken for the appliances;

    2. For root canal therapy, when the tooth is opened; and

    3. For fixed bridgework, crowns and other gold restorations, when the tooth is first prepared.

9.04 Extension of Dental Benefits

If a covered person's eligibility for Dental Benefits terminates while that person is receiving dental treatment that started while that person was eligible, Dental Benefits shall continue to be paid for that person for treatment completed within 90 days after the date of the covered person's eligibility terminates for covered dental expenses incurred for:

A. Fillings, bridgework, crowns or gold restorations, provided the tooth was prepared while the person was eligible for Dental Benefits;

B. Full or partial dentures, provided the impression for the appliance was taken while the person was eligible for Dental Benefits; or

C. Endodontic treatment, provided the tooth was opened for root canal therapy while the person was eligible for Dental Benefits.

SECTION 10: HEALTH REIMBURSEMENT ARRANGEMENT

10.01 General Provisions

The Trustees have established a Health Reimbursement Arrangement (HRA) as approved in Treasury Department Notice 2002-45 and Revenue Ruling 2002-41. Eligible Employees and Eligible Retirees can withdraw amounts from their individual HRA accounts to cover specified expenses that are related to, but not payable under the regular provisions of the Plan.

10.02 HRA Accounts

A. If you worked in Covered Employment after June 1, 2001, you have an HRA account. HRA accounts are only bookkeeping entries and are not funded and no interest is credited. These accounts are credited in the amount specified in the applicable collective bargaining agreement for each hour worked in Covered Employment after June 1, 2001.

B. If you work under a Reciprocal Agreement, your account is credited the portion of the hourly contribution rate payable to the Fund under the Reciprocal Agreement that is in excess of the non-HRA portion of the hourly contribution rate up to the HRA amount specified in the applicable collective bargaining agreement. As of the date of this Plan Restatement, the HRA amounts specified in the collective bargaining agreements were $0.55 per hour, $0.45 per hour and $0.35 per hour depending on the job classification.

C. If an Employer Contribution is incorrectly calculated, your HRA account is credited as if the correct contribution had been made.

D. If the Fund Office issues you a HRA reimbursement check, your HRA account balance will be reduced by the amount of such reimbursement. Any remaining balance at the end of a calendar year is carried forward from year to year, except as specified below.

10.03 Automatic Deduction from an HRA Account to Maintain Coverage

In the event that you are going to lose eligibility under the Plan and have a balance in your HRA Account, the Fund Office will automatically deduct the amount of self-payment necessary to maintain your coverage under the Plan until the balance of your HRA Account is exhausted. If you do not wish to have your HRA Account deducted automatically, you must notify the Fund Office in writing.

10.04 Forfeiture of HRA Account Balance

The remaining balance in your HRA will be forfeited in the following situations:

A. Your HRA account has a balance of less than $100 and no allocations have been made into your account or you have made no reimbursement requests for a period of two calendar years.

B. Your account has a balance of $100 or more and no allocations have been made into your account or no reimbursement requests have been made for a period of four (4) calendar years.

C. You opt-out of the HRA in writing at any time.

D. If you die and there is no surviving spouse or Dependent.

E. The first day of the month in which you work in Industry Employment.

10.05 Payment of Benefits upon your Death

If you die and there is a balance in your HRA account, your surviving spouse or Dependent may use your account balance while they remain covered under Class A or Class C Benefits. Any remaining HRA account balance not reimbursed to your surviving spouse or Dependent will be forfeited as follows:

A. The HRA account has a balance of less than $100 and no reimbursement requests have been made for a period of two calendar years.

B. The HRA account has a balance of $100 or more and no reimbursement requests have been made for a period of four (4) calendar years.

Additionally, the balance will be forfeited if your surviving spouse and all Dependents lose coverage under the Plan (including COBRA Continuation Coverage), unless they are able to establish that they are covered under another employer sponsored group health plan that meets the Patient Protection and Affordable Care Act of 2010 (ACA) requirements of minimum essential coverage.

10.06 HRA Account Reimbursements

A. Entitlement to Reimbursement

Your entitlement to reimbursement and the amount of any such reimbursement made by the Fund Office will be based on your account balance at the time the reimbursement check is requested. You may receive reimbursement from your HRA account for the types of expenses specified in Paragraph B below, provided the expense is:

1. Incurred on or after June 1, 2001;

2. Is a qualified medical expense under Section 213(d) of the Internal Revenue Code (IRC) that you are required to pay; and

3. Is not payable under another Section of the Plan (i.e. medical, prescription drug, dental or hospice).

B. Covered Expenses

Covered Expenses are "qualified medical expenses" under Section 213(d) of the IRC. Examples of such covered expenses may include the following:

1. Self-Payments, including regular and COBRA Continuation Coverage Self-Payments and Dependent Self-Payments made for widow or spouse coverage under the Plan;

2. Major Medical Benefit deductibles and the individual's out-of-pocket co-payment percentage shares of charges considered Covered Medical Expenses under the Major Medical Benefit;

3. Medical expenses not covered by or in excess of the benefits provided under the Major Medical Benefit;

4. Guide dogs for blind or deaf persons;

5. Certain travel expenses of the patients when necessary to receive essential medical care, and the travel and lodging expenses of another family member whose presence is necessary for the treatment. The patient's Physician must certify that the family member's presence is necessary for the treatment;

6. Special telephone and television equipment for hearing-impaired persons;

7. Smoking cessation programs;

8. Expenses for dental treatment, including orthodontia;

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

10. Hearing aids and examinations;

11. Healthcare insurance premiums, including those for a Dependent child's college healthcare plan;

12. Schooling for the mentally impaired or physically Disabled;

13. Acupuncture;

14. Prescriptions and over-the-counter medications; provided that such items are accompanied by a written prescription and generally accepted as medicine and drugs. Such items shall not include toiletries, sundries or cosmetics; and

15. Weight loss programs, but not food or dietary supplements.

C. Exclusions

No reimbursement will be made from your account for expenses that are not listed as "qualified medical expenses" in Section 213(d) of the IRC. Examples of expenses that are not covered include the following:

1. Cosmetic surgery and treatment;

2. Child and elder care;

3. Household help;

4. Health club memberships and expenses;

5. Maternity clothes;

6. Expenses for which reimbursement can be made by some other source, including, but not limited to, benefits provided by another benefit or insurance plan; and

7. Expenses not listed in Paragraph B above or that are excluded under the provisions of Paragraph A above.

10.07 Submitting Reimbursement Requests

Reimbursements from your HRA account are subject to the following provisions:

A. HRA reimbursement requests may be submitted at any time; however, such request must be received by the Fund Office no later than two (2) years following the date on which the expense was incurred.

B. HRA reimbursement requests for Self-Payment amounts must be accompanied by the Self-Payment billing issued by the Fund Office.

C. You must submit a HRA account reimbursement request with a properly completed request form to the Fund Office. Reimbursement requests must include a copy of the explanation of benefits (EOB), itemized bills or any other documentation as required by the Trustees.

D. HRA reimbursement requests can only be submitted by you or by your spouse pursuant to your written authorization on file at the Fund Office or in the event you are deceased, by your surviving spouse or Dependent. HRA reimbursement requests may not be submitted by a former spouse and an HRA account balance is not subject to division pursuant to a domestic relations order under the preemption provisions of ERISA Section 514.

10.08 Reimbursements

Upon receipt of a HRA reimbursement request for a HRA Covered Medical Expense that has been submitted in accordance with the provisions of this Section, the Fund Office will issue you a reimbursement check. This check will be issued within 30 days of your request for the amount of the Covered Medical Expense, up to, but not to exceed the amount of your account balance. Once the check has been issued, the Fund Office will deduct the amount of such reimbursement from your HRA account balance.

10.09 There is no Vesting of HRA Accounts

HRA accounts are not savings accounts from which you can withdraw at will. You and your Dependents are not vested in your HRA account balances. Amounts accumulated in your HRA account can only be used for HRA account Covered Medical Expenses, subject to the rules and provisions set forth in this Section.

The Trustees reserve the right to eliminate or modify this program at any time and in their sole discretion.

Benefits payable under the HRA shall not be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment or encumbrance of any kind.

SECTION 11: PLAN EXCLUSIONS

11.01 Specific Exclusions

The Plan does not pay for the following:

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

2. Care, treatment, procedures, services or supplies provided to a person who is not covered under the Plan, except as may be provided for live organ donors or under the Extension of Benefits rules with respect to the Comprehensive Major Medical Expense Benefit and the Dental Benefit.

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

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

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

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

7. Any expenses or charges incurred while in the military service of any country, or civilian non-combatant unit serving with such forces. However, the Plan will cover expenses as required under USERRA as provided under Section 2.

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

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

10. Any expenses or charges for services or supplies:

    (a) not provided in accord with generally accepted professional medical standards;

    (b) not Medically Necessary; or

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

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

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

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

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

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

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

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

11.02 General Exclusions

The preceding list is not an all-inclusive listing of the Plan's limitations and excluded procedures, services, supplies and types of treatment. It is only representative of the types of services and supplies for which charges may be incurred which are not payable by the Plan. The Plan will not pay benefits for any charges not specifically listed as a Covered Medical Expenses under the Plan.

SECTION 12: COORDINATION OF BENEFITS

12.01 Benefits Are Coordinated

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

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

12.02 Another Group Plan Defined

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

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

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

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

D. Any coverage under governmental programs;

E. Any coverage required or provided by statute; and

F. This Plan when you are covered as:

   1. An Employee and as a Dependent; or

   2. A Dependent child of more than one Employee.

12.03 How Benefits are Paid

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

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

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

The combined payments of both plans will not be more than the primary plan's contract calls for if the primary plan has a contract with the provider through an HMO or PPO arrangement. Moreover, if this Plan

and the other plan have a contract with the same provider, the Allowable Expense will be the lower of the two contracted or negotiated fees.

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

12.04 Order of Benefit Payment

For coordination with other plans the following rules apply:

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

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

C. The plan that covers a person as an Employee, who is neither laid off nor retired, is primary. The same would hold true if a person is a Dependent of a person covered as a retiree and an Employee. However, coverage provided an individual as a retired worker and as a Dependent of an actively working spouse will be determined under B above.

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

E. For claims on behalf of Dependent children whose parents are divorced or separated, the following rules apply:

    1. If there is a court decree that establishes financial responsibility for medical expenses, the plan covering the parent who has such financial responsibility or had financial responsibility prior to the child attaining age of majority will be primary.

    2. If there is no court decree and the parent with custody has not remarried, the plan that covers the parent with custody or will be primary. The Plan who covers the parent who had custody at the time the child reached age of majority will be primary.

    3. If there is no such court decree and the parent with custody (or who had custody at the time the child reached the age of majority) has remarried, the order of benefit coordination will be as follows:

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

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

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

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

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

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

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

I. If a person who has COBRA Continuation Coverage is also covered under another plan as an employee, retiree or Dependent, the COBRA Continuation Coverage is secondary unless the COBRA Continuation Coverage under this Plan is being used because he/she has a preexisting condition. In that circumstance, this Plan will pay primary benefits on only the claims related to the condition defined as a preexisting condition under the other plan.

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

K. If a Class C or Class F Retiree or Dependent is covered under any other group health plan or other type of medical insurance coverage or Medicare, the Plan will always pay its benefits after all other plans and insurance coverage and Medicare have paid their benefits.

12.05 Coordination of Benefits Implementation Rules

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

A. Release or obtain information considered necessary;

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

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

12.06 Coordination of Benefits with Medicare

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

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

B. When You are Entitled to Medicare due to Age

If you retire, you are entitled to Medicare due to age and are eligible for Class F Retiree Benefits. Even if you are exhausting some form of extended eligibility for coverage under Class A Benefits, if you are eligible for Medicare due to your age, Medicare will have primary responsibility and this Plan will pay second.

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

C. End Stage Renal Disease (ESRD)

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

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

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

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

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

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

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

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

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

SECTION 13: SUBROGATION AND REIMBURSEMENT

13.01 Reimbursement to the Plan.

The Fund's right of subrogation and reimbursement arises when benefits are paid on behalf of you or your Dependent as a result of an injury or illness for which another party may be responsible. If the Fund pays any benefits that arise out of the injury or illness which results or could result in a claim against a Third

Party, acceptance of these benefits under the Plan means you agree to reimburse the Fund for all expenses paid on your or your Dependent's behalf.

13.02 Third Parties Defined.

A Third Party is defined as a person or a business entity and shall include, but is not limited to:

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

B. Other benefit plans;

C. An insurance company, including but not limited to the party at fault's insurance;

D. Workers' compensation; or

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

13.03 Your Responsibilities.

By accepting benefits under this Plan, your responsibilities include, but are not limited to the following:

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

B. You and/or your Dependent must cooperate with the Fund by providing, among other things, information requested by the Fund concerning subrogation or reimbursement. You must provide the Fund Office with:

    1. A signed *Subrogation and Reimbursement Agreement*;

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

    3. Accident reports; and

    4. Any other information the Fund Office requests.

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

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

13.04 If You Are Reimbursed by a Third Party.

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

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

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

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

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

You and/or your Dependents shall be responsible for compliance with these provisions and the provisions of any Subrogation and Reimbursement Agreement. You will also be responsible for compliance by your or your Dependents' agents, representatives and attorneys.

Furthermore, if you and/or your Dependent receive payment from a Third Party for Plan benefits already received and you do not reimburse the Fund as stated above, the Fund may take any action to recover 100% of the benefits paid. Such action includes, but is not limited to:

A. Initiating a claim to compel compliance with these terms or the terms of the Subrogation and Reimbursement Agreement;

B. Withholding benefits payable to you or your Dependents until you or your Dependents comply; or

C. Initiating such other equitable or legal action it deems appropriate.

D. The Fund reserves the right to be reimbursed for its court costs and attorney's fees necessary to recovery payment.

SECTION 14: CLAIMS AND APPEALS

14.01 General Information

A. Exhaustion of Remedies

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

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

B. Discretionary Decision Making Authority of the Trustees

Subject to the provisions of the Trust Agreement, the Trustees have full and exclusive authority to determine all questions of coverage and eligibility, methods of providing or arranging for benefits and all other related matters. They have full power to construe the provisions of this Summary Plan Description/Plan Document and the terms used in this booklet. Any such determination and any such construction adopted by the Trustees will be binding upon all of the parties and beneficiaries of this Plan. No determinations involved in or arising under the Trust Agreement or this Summary Plan Description/Plan Document will be subject to the grievance or arbitration procedure established in any Collective Bargaining Agreement between the Association and the Union. However, this provision will not affect the rights and liabilities of any of the parties under any of such Collective Bargaining Agreements.

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

14.02 Filing Your Initial Claim for Benefits

A. What is a Claim?

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

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

A claim may fall into one of the following categories:

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

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

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

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

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

B. How to File a Claim

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

1. Hospital, Physician and Medical Claims

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

   (a) Employee's name;

   (b) Patient's name;

   (c) Patient's date of birth;

   (d) Social Security number of Employee or Retiree;

   (e) Date of service;

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

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

   (h) Billed charge;

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

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

(k) Billing name and address.

2. Prescription Drug Claims

Express Scripts
Attn: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872
Toll Free: (877)389-5398

3. All other Benefits

You should contact the Fund Office about how to file a claim for Dental, Weekly Sickness and Disability, HRA, Death or AD&D Benefits.

C. Where to File a Claim

To request a claim form and submit claims for all Benefits, please contact the Fund Office.

Plumbers, Pipe Fitters and Mechanical
Equipment Service Local Union No. 392
Health and Welfare Fund
1228 Central Parkway, Room 100
Cincinnati, OH 45202

14.03 Initial Claim Determination Timeframes

A. Claim Filing Deadline

You must file your claim for benefits as soon as possible following the date you incurred the charges. **You must submit a completed claim form within 365 days from the date that the service for the charge is rendered.** A claim is considered to have been filed on the day it is received by the Fund Office, even if it is incomplete.

B. Claim Processing Timeframes

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

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

1. Post-service claims

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

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

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

2. Weekly Disability Claims

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

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

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

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

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

3. Pre-Service Claims

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

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

(c) If an extension is needed because the Fund needs additional information from you to process your claim, the extension notice will specify the information needed. In that case you will

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

4. Urgent Care Claims

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

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

5. Concurrent Care Claims

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

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

14.04 Notice of Initial Decision

The Fund Office must provide you with a notice of the initial determination about your claim within certain timeframes after they receive your claim. The notice must provide the following information:

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

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

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

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

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

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

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

14.05 Internal Appeal Procedures

A. Internal Appeal Filing Deadline

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

B. Internal Appeal Process

The appeal process works as follows:

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

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

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

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

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

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

3. Before the plan can issue a final internal Adverse Benefit Determination based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is required to be provided to give you a reasonable opportunity to respond prior to that date.

4. A different person will review your claim than the one who originally denied the claim. The reviewer will not give deference to the initial Adverse Benefit Determination. You have the right to present evidence and testimony as part of your appeal. The decision will be made on the

basis of a full and fair review of the record, including such additional evidence and testimony that you may submit.

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

C. Timing of Notice of Decision on Internal Appeal

1. Urgent Care Claims

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

2. All Non-Urgent Pre-Service Care Claims

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

3. Weekly Disability Claims and Post-Service Care Claims

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

4. Death Benefit and AD&D Claims

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

14.06 Notice of Decision on Internal Appeal

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

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

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

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

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

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

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

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

14.07 External Review Procedures

A. External Review Filing Deadline

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

B. External Review Process

The external review process works as follows:

1. Determination of Eligibility for Review.

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

   (a) you are or were covered under the Plan at the time of service or requested service;

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

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

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

   Within one business day after the completion of this review, the Plan must notify you (or your authorized representative) whether the request is complete and is eligible for review. If the request is not complete, the Plan must provide notice of what information or materials are needed and allow

you to perfect the request within the four-month filing period or 48 hours following receipt of the notification, whichever is later. If the request is not eligible for external review, the notice must include the reason(s) for ineligibility and contact information for the Employee Benefits Security Administration.

2. Referral to an Independent Review Organization (IRO).

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

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

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

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

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

      (1) the claimant's medical records;

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

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

      (4) the terms of the Plan;

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

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

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

3. Request for an Expedited External Review.

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

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

C. Timing of Notice of Decision on External Review

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

D. Content of Notice of Decision on External Review

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

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

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

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

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

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

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

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

14.08 Physical Examination

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

14.09 Payment of Claims

The Fund will make payments due under the Plan as they accrue, immediately upon receipt by the Fund Office of proper written proof of loss.

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

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

A. Your spouse;

B. Your Dependent children, including legally adopted children;

C. Your parents;

D. Your brothers and sisters; or

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

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

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

14.10 Authorized Representatives

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

14.11 Benefit Payment to an Incompetent Person

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

A. Directly to such person;

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

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

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

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

14.12 Misstatement by Plan Participant

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

SECTION 15: DEFINITIONS

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

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

2. **Active Employee** means a person who meets the definition of Employee, is actively at work or available for work for a Contributing Employer, and who is not a Retiree.

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

   (a) A determination of an individual's eligibility to participate in a plan or health insurance coverage;

   (b) A determination that a benefit is not a covered benefit;

   (c) The imposition of a pre-existing condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or

   (d) A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

4. **Board of Trustees and/or Trustees** means the Trustees and Board of Trustees designated in the Trust Agreement, together with their successors designated and appointed in accordance with the terms of the Trust Agreement for the Plumbers, Pipe Fitters and Mechanical Equipment Service Local Union No. 392 Health and Welfare Fund. The Board of Trustees is the administrator of this Plan as that term is used in the Employee Retirement Income Security Act of 1974.

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

6. **Contributions** are payments made by Contributing Employers to the Fund on behalf of their Employees.

7. **Contributing Employer** means any person, firm, association, partnership or corporation which is signatory to a collective bargaining agreement which requires Contributions to this Fund. Contributing Employer also means the Union, the Fund Office, the Local Union No. 392 Training Fund and any other entity that has entered into a participation agreement with the consent of the Trustees which does in fact make Contributions to the Fund as provided for in the Fund's Trust Agreement and has agreed in writing to be bound by such Trust Agreement.

8. **Covered Employment** means employment of an Employee by an Employer for which Contributions to this Fund are required.

9. **Covered Medical Expenses** means the UCR Charges ordered by a Physician and incurred by a covered person for Medically Necessary services and supplies required for the treatment of a non-

occupational Accident or Sickness. The Plan covers the UCR Charges subject to the Plan maximums and limitations provided in the Schedules of Benefits.

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

11. **Credited Hour** means any hour for which:

    (a) A Contributing Employer pays you wages and for which the Contributing Employer is required to made a Contribution to the Fund on your behalf;

    (b) You make a Self-Payment to the Fund on your own behalf to maintain your eligibility; or

    (c) You are credited with a disability hour under the Eligibility During Disability rules.

12. **Dentist** means a legally qualified Dentist practicing within the scope of his or her license or a legally qualified Physician authorized by his or her license to perform the particular Dental Service rendered.

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

    (a) An Employee's spouse (marriage license required). Spouse includes same sex spouses who were married in a jurisdiction recognizing same sex marriages.

    (b) Each child of an Employee from birth to the end of the month in which such child attains age 26.

    (c) A child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, provided:

        (i) such incapacity began before the end of the month such child attains age 26; and

        (ii) such child is chiefly dependent upon the Employee for financial support and maintenance; and

        (iii) proof of such incapacity is submitted to the Trustees within 31 days of the date such Dependent's eligibility would otherwise terminate.

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

    (e) If the Employee's spouse is divorced, the Employee must provide a certified copy of the spouse's divorce decree. If the spouse is a widow or widower, the Employee must provide the Plan with a certified copy of the death certificate of the former spouse.

14. **Disabled** means:

    (a) **Active Employee** - if, as result of an Accident or Sickness, he is completely unable to perform each and every duty associated with his occupation or employment.

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

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

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

16. **Duty** means serving on a voluntary or involuntary basis in a uniformed service, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and absence from employment for an examination to determine fitness for such duty. The uniformed services include the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the president in time of war or emergency.

17. **Emergency Admission** means an admission as an Inpatient to a Hospital directly from a Hospital emergency room for the sudden and acute onset of a medical condition that the absence of immediate medical treatment would result in serious and permanent medical consequences.

18. **Employee** means a person who is working for a Contributing Employer who is required under a collective bargaining agreement or other agreement to make Contributions to the Fund on his behalf. Also included as Employees are employees of the following organizations (provided that a valid participation agreement is on file with the Fund Office and such employee has accrued sufficient hours to establish and maintain eligibility under this Plan): the Union, the Joint Apprentice Training Committee, the Health and Welfare Trust Fund, the Credit Union, the Greater Cincinnati Building and Construction Trades Council, the Ohio State Association of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry and the AFL-CIO, provided he/she is also a member of the Union.

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

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

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

    (c) Such treatment or procedure, or the patient-informed consent document utilized with such treatment or procedure was reviewed and approved by the treating facility "institutional

review board" or other body serving a similar function, or if federal law requires such review or approval;

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

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

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

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

20. **Full Cost Premium** is the self-pay amount for the Retired Employee and Dependents as applicable based on the expected cost of Class C Retiree Benefits for a calendar year determined by the Fund consultant and adopted by the Trustees.

21. **Fund and/or Welfare Fund** means the Plumbers, Pipe Fitters and Mechanical Equipment Service Local Union No. 392 Health and Welfare Fund.

22. **Fund Office** means the office of the Plumbers, Pipe Fitters and Mechanical Equipment Service Local Union No. 392 Health and Welfare Fund.

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

(a) it is primarily engaged in providing skilled nursing services and other therapeutic services in the homes or places of residence of its patients;

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

(c) it provides for the supervision of its services by a Physician or registered professional nurse;

(d) it is licensed according to all the applicable laws of the state in which it is located; and

(e) it is eligible to participate in Medicare.

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

    (a) be eligible to participate in Medicare;

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

    (c) maintain clerical records on all of its patients;

    (d) meet the standards of the National Hospice Organization; and

    (e) provide, either directly or indirectly or other arrangement, the "core service" listed as Covered Expenses.

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

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

27. **Industry Employment** is work, as indicated by the Union, to be for a Non-Signatory Contractor or use of a Related Skill to perform work for an employer within the territorial jurisdiction of the Union (as defined in the Local 392 Collective Bargaining Agreement) that is not covered by a Collective Bargaining Agreement with the Union.

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

    (a) is consistent with the symptoms of diagnosis and treatment of the person's injury or Sickness;

    (b) is appropriate with regard to standards of good medical practice and recognized by an established medical society in the United States; and

    (c) could not have been omitted without adversely affecting the person's condition or the quality of medical care.

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

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

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

32. **Non-Bargaining Unit Employees** means Employees of the Plumbers, Pipe Fitters and Mechanical Equipment Service Local Union No. 392 Fringe Benefit Funds, the Plumbers, Pipe Fitters and Mechanical Equipment Service Local Union No. 392 Joint Apprenticeship Training Committee, the Plumbers, Pipe Fitters and Mechanical Equipment Service Local Union No. 392 and the Local Union 392 Federal Credit Union.

33. **Non-Signatory Contractor** means any employer that contracts for any work in the plumbing, pipefitting, and/or mechanical service industry in the United States who is not signatory to a collective bargaining agreement with the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada (UA) or any local union affiliated with the UA.

34. **Outpatient Surgical Center** means a health care facility in which surgery is performed on patients on an outpatient basis and that meets all of the following requirements:

    (a) be regularly licensed by the governmental or other agency that has the responsibility for such licensing, and it must keep medical records on all patients;

    (b) employ a licensed anesthesiologist and an R.N., be supervised full time by a Physician and any Physician performing surgery on the premises must also be allowed to perform surgery in a local Hospital;

    (c) have at least two (2) operating rooms and a recovery room, be equipped to take care of emergencies; have an agreement with a local Hospital to take patients who develop problems.

35. **Pension Plan or Pension Fund** means the Plumbers, Pipe Fitters and Mechanical Equipment Service Local Union No. 392 Pension Fund.

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

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

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

39. **Preventive Services** means:

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

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

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

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

40. **Related Skill(s)** are those skills learned in the Trade as well as skills associated with other related trades including, but not limited to, sheet metal workers and operating engineers.

41. **Retiree** is a person who is a former Active Employee, is receiving pension retirement benefits from the Pension Plan and meets the applicable eligibility requirements for Retiree Benefits.

42. **Self-Payments** are any payments made by Employees, Dependents or Retirees for the purpose of maintaining coverage under the Plan.

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

44. **Signatory Contractor** means any employer that contracts for any work in the plumbing, pipefitting, and/or mechanical service industry in the United States who is signatory to a collective bargaining agreement with the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada (UA) or any local union affiliated with the UA.

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

46. **Social Security Limit** is the maximum amount that a Social Security recipient can earn prior to Social Security full retirement age without affecting the amount received from Social Security. The Social Security Limit is determined on a calendar year basis by the Social Security Administration.

47. **Step-Therapy Program** is where a patient with a chronic condition first tries a less costly medication (first-line drug) before using a more expensive drug (second-line drug).

48. **SUB Fund or SUB Plan** means the Plumbers, Pipe Fitters and Mechanical Equipment Service Local Union No. 392 Supplemental Unemployment Benefits Fund.

49. **Trade** means work relating to a skill or skills learned in the Local 392 Apprenticeship Program and any other skills within the work jurisdiction as defined in the Local 392 collective bargaining agreement. Such work includes employment that is based on the application of such skills including, but not limited to, supervisory activities, estimating, sales, and consulting.

50. **Usual, Customary and Reasonable (UCR) Charges** means the Plan's negotiated rate or an amount determined by comparing a particular charge with the charges made for similar services and supplies in the locality concerned to individuals of similar age, sex, circumstances, and medical condition. The result of the comparison will determine the amount that is the maximum allowable charge to be considered a Covered Medical Expense under this Plan. (If a particular charge is more than what the Trustees consider to be UCR, any amount over the UCR charge will not be recognized by the Plan as a Covered Medical Expense.)

51. **Union** means Plumbers, Pipe Fitters and Mechanical Equipment Service Local Union No. 392.

52. **Year of Service** means any calendar year in which the participant had Contributions credited from Contributing Employers to the Fund while working under a Union collective bargaining agreement or collective bargaining agreement of any United Association local union that has been merged or consolidated into the Union.

SECTION 16: ADDITIONAL PLAN INFORMATION

16.01 Plan Name

Plumbers, Pipe Fitters and Mechanical Equipment Service Local Union No. 392 Health and Welfare Fund.

16.02 Board of Trustees

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

Board of Trustees of the Plumbers, Pipe Fitters and Mechanical Equipment Service
Local Union No. 392 Health and Welfare Fund
1228 Central Parkway, Room 100
Cincinnati, OH 45202
(513) 241-0444
(877) 389-5398

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

Labor Trustees	Employer Trustees
Mr. Thomas P. Cheek Plumbers, Pipe Fitters & MES Local Union No. 392 Health and Welfare Fund 1228 Central Parkway, Room 100 Cincinnati, OH 45202	Mr. Rick Driehaus Driekast Piping 11290 Sebring Drive Cincinnati, Ohio 45240
Mr. James B. Harris Plumbers, Pipe Fitters & MES Local Union No. 392 Health and Welfare Fund 1228 Central Parkway, Room 100 Cincinnati, OH 45202	Mr. Bill Flaugher DeBra-Kuempel 3976 Southern Avenue Cincinnati, Ohio 45227
Mr. Cliff Johnson Plumbers, Pipe Fitters & MES Local Union No. 392 Health and Welfare Fund 1228 Central Parkway, Room 100 Cincinnati, OH 45202	Mr. Frank Werk Peck-Hannaford & Briggs Service Corp. 4673 Spring Grove Ave Cincinnati, OH 45232

16.03 Plan Sponsor and Administrator

The Board of Trustees is the Plan Sponsor and Plan Administrator.

16.04 Plan Numbers

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

The Employer Identification Number assigned to the Board of Trustees by the Internal Revenue Service is 31-0561070.

16.05 Agent for Service of Legal Process

Ms. Rinda Hoffman
Plumbers, Pipe Fitters and Mechanical Equipment Service Local Union No. 392 Health and Welfare Fund
1228 Central Parkway, Room 100
Cincinnati, OH 45202
(513) 241-0444

Service of legal process also may be made on the Board of Trustees or any individual Trustee at the above address.

16.06 Source of Contributions

The benefits described in this Welfare Fund booklet are provided through Contributions and Self-Payments. The amount of Contributions and the Employees on whose behalf Contributions are made are determined by the provisions of the collective bargaining agreements. The amount of Self-Payments is determined by the Trustees. The Fund may also receive refunds or fees from its prescription benefit manager.

16.07 Collective Bargaining Agreement

The Plan is maintained in accordance with a collective bargaining agreement between the Plumbers, Pipe Fitters and Mechanical Equipment Service Local Union 392 and the Mechanical Contractors Association of Cincinnati. Other agreements may be in effect from time to time. The agreements specify the Contributions required.

The Fund Office will provide you, upon written request, information as to whether a particular Employer is contributing to this Fund on behalf of participants working under a collective bargaining agreement or a list of participating Employers.

16.08 Trust Fund

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

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

16.09 Plan Year

The records of the Plan are kept separately for each Plan Year. The Plan Year is the calendar year that begins on January 1 and ends on December 31.

16.10 Type of Plan

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

16.11 Gender

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

16.12 Assignment

Assignment of benefits may be made only with the Plan's consent. An assignment is not binding until the Plan receives and acknowledges in writing the original or copy of the assignment before payment of the benefit. The Plan does not guarantee the legal validity or effect of such assignment.

16.13 Amendment and Termination

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

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

16.14 Discretionary Authority

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

16.15 Severability Clause

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

16.16 Worker's Compensation Not Affected

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

16.17 Recovery of Benefits Paid in Error

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

provide, including, but not limited to withholding benefits until the amount of the overpayment is recovered in full.

16.18 Privacy Policy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice. The privacy notice will be available from the Fund Administrator.

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

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

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

A. You need a copy of the Privacy Notice;

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

C. You wish to file a complaint under HIPAA.

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

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

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

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

B. Definition of Payment

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

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

2. Coordination of benefits;

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

4. Subrogation of health benefit claims;

5. Establishing Employee Contributions;

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

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

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

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

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

11. Utilization review, including precertification, preauthorization, concurrent review and retrospective review;

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

13. Reimbursement to the Plan.

C. Definition of Health Care Operations

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

1. Quality assessment;

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

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

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

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

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

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

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

   (b) customer service, including the provision of data analyses for policyholders, Plan sponsors or other customers;

   (c) resolution of internal grievances; and

   (d) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or following completion of the sale or transfer, will become a covered entity.

D. The Plan's Disclosure of Protected Health Information to the Board of Trustees

For purposes of this Section the Board of Trustees is the Plan Sponsor. With respect to PHI, the Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by this Summary Plan Description/Plan Document or as required by law;

2. Ensure that any agents, including a subcontractor to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

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

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

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

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

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

8. Make the information available that is required to provide an accounting of disclosures;

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

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

Adequate separation between the Plan and the Plan Sponsor will be maintained. Therefore, in accordance with HIPAA, only the following Employees or classes of Employees will be given access to PHI:

1. The Plan Administrator; and

2. Staff designated by the Plan Administrator.

The persons described above will only have access to and will only use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this Summary Plan Description/Plan Document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

16.20 Statement of ERISA Rights

As a participant in the Plumbers, Pipe Fitters and Mechanical Equipment Service Local Union No. 392, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to the following rights.

A. Receive Information About Your Plan And Benefits.

You have the right to:

1. Examine, without charge, at the Plan Administrator's office, all documents governing the Plan. These include insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

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

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

B. Continue Group Health Plan Coverage.

You also have the right to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

C. Prudent Actions by Plan Fiduciaries

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

D. Enforce Your Rights

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

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

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a lawsuit in a court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file a lawsuit in court. You must exhaust all of the Plan's claims and appeals procedures before filing a lawsuit. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file a lawsuit. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

E. Receive Assistance With Your Questions.

If you have any questions about your Plan, you should contact the 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 Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or:

The Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also find answers to your Plan questions, your rights and responsibilities under ERISA and a list of EBSA field offices by contacting the EBSA:

1. By calling (866) 444-3272;

2. Sending electronic inquires to www.askebsa.dol.gov; or

3. Visiting the EBSA web site at www.dol.gov/ebsa.