Plumbers and Steamfitters Local Union No. 33 Health and Welfare Plan

SUMMARY PLAN DESCRIPTION

Effective January 1, 2017

Plumbers and Steamfitters Local Union No. 33 Health and Welfare Plan

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This booklet, which replaces and supersedes any prior Summary Plan Description (SPD), serves as the Plan's official rules and regulations that establish the Plan. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

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Dear Participant:

We are pleased to provide you with this updated Summary Plan Description (SPD) booklet, which describes the Health and Welfare Plan "the Plan" for Plumbers and Steamfitters Local Union No. 33 Welfare Fund (the Fund) as of January 1, 2017.

The Fund offers a comprehensive benefits program designed to protect you and your covered Dependents. Whether you are beginning a new job, having a child or adopting one, getting married or divorced, battling an illness or disability, or looking forward to retirement, the Plan offers health care coverage that is designed to help meet your and your family's needs.

This booklet describes your benefits completely and in everyday language. We also have tried to organize the SPD to be useful to you. Please read this booklet carefully as it is important that you understand your benefits and the protection they provide. If you are married, be sure to share it with your Spouse.

This SPD replaces and supersedes all prior booklets pertaining to benefits under the Plan. The Plan may be amended from time to time either to revise the benefits or to bring the Plan into compliance with changes in the laws. If this occurs, you will be provided with written notification explaining the change(s).

Only the Board of Trustees is authorized to interpret the Plan. While you may receive information about the Plan from the Union or your Employers, only communication sent to you in writing and signed on behalf of the Board of Trustees is considered official Plan information.

We recommend that you keep this SPD with your important papers so you can refer to it when needed. The Fund Office can answer any questions you or your family may have about the Plan.

Sincerely,

Board of Trustees

Schedule of Benefits

MEDICAL PLAN		
	Network	**Non-Network**
Your annual Deductible		
Individual Coverage	$750	$1,500
Family Coverage	$1,500	$3,000
Coinsurance		
You Pay	20%	30%
Plan Pays	80%	70%
Your annual out-of-pocket maximum (includes deductibles)		
Individual Coverage	$2,750	$5,500
Family Coverage	$5,500	$11,000
Preventive Services		
Coinsurance	**In-Network**	**Out-of-Network**
The Plan pays 100% of services, including flu shots and major medical services such as treatment for strep throat; you receive in a 'retail clinic' or County Health Department.	Annual Deductible and Coinsurance do *not* apply.	Annual Deductible and Coinsurance do apply. Out of network office visits are not covered.
You Pay	0%	30%
Plan Pays	100%	70%

Other Services Covered by the Medical Plan

Annual Deductible, Coinsurance, and Annual Out-of-Pocket Maximum apply.

- Alcoholism and Substance Abuse Care
- Dental Care
- Home Health Care
- Hospice Care
- Mental Health Care
- Surgical Care

ADDITIONAL COVERAGE

Annual Deductible, Coinsurance, and annual Out-of-Pocket Maximum apply.

Physical, Speech & Occupational Therapy Coverage

Coinsurance	**In-Network**	**Out-of-Network**
You Pay	20%	30%
Plan Pays	80%	70%

Once combined therapy visits exceed 20 visits in a calendar year, you must submit a letter of medical necessity and a treatment plan for additional visits to be covered. A determination will be made as to a reasonable medical expectation of significant functional improvement with additional visits.

Durable Medical Equipment Coverage

Coinsurance	**In-Network**	**Out-of-Network**
The Plan will pay once per item, up to the purchase price, for the procurement and/or maintenance of an item.		
You Pay	20%	30%
Plan Pays	80%	70%

Emergency Room Coverage		
Coinsurance	You pay $100 per visit, unless you are admitted to the Hospital within 24 hours, in addition to the coinsurance.	
You Pay	20%	
Plan Pays	80%	
Ambulance Service		
Coinsurance	**In-Network**	**Out-of-Network**
You Pay	20%	30%
Plan Pays	80%	70%
Foot Orthotics		
The Plan will pay a maximum of $400 per year per Covered Person		
Sleep Treatment Coverage		
The Plan will pay a maximum of $1,200 per lifetime of each Covered Person		
Organ Transplant Coverage		
Coinsurance	**In-Network**	**Out-of-Network**
You Pay	20%	30%
Plan Pays	80%	70%
TMJ Appliance Coverage		
The Plan will pay a maximum of $500 in a calendar year per Covered Person; after that, up to $1,000 per Covered Person can be reimbursed from the member's HRA annually.		
Chiropractic Expenses		
The Plan will reimburse a maximum of $1,000 per year for each Covered Person from the member's HRA.		

PRESCRIPTION DRUG BENEFIT[1]	
You are responsible for the full cost of your prescription if you do not show your prescription drug card at the time of purchase.	
Your annual out-of-pocket maximum[2]	
Individual Coverage	$3,850
Family Coverage	$7,700
Coinsurance: Generic drug and brand name drug when generic drug *is not* available	
You Pay	20%
Plan Pays	80%
Coinsurance: Brand name drug when a generic drug is available	
You Pay	20% of the generic drug cost *plus* the difference between the cost of the brand name and generic drug.
Plan Pays	80% of the generic drug cost

[1] See page 47 for any prescription drug exclusions.

[2] Out-of-pocket expenses for prescription drugs do not count towards the medical annual out-of-pocket maximum and vice versa.

DENTAL BENEFIT	
The Plan pays 100% of preventive dental services.	
Restorative procedures Plan Pays	100% of the Usual and Customary Allowance
Annual maximum paid by the Plan (Does not apply to covered persons under age 19)	$1,000
Orthodontia Coverage (Dependents, up to 19th birthday, of Active Employees)	
Lifetime maximum paid by the Plan Lifetime HRA reimbursement	$500 $1,500
Coinsurance	
You Pay	50%
Plan Pays	50%

VISION BENEFIT

- The Plan will pay $150 per calendar year for each covered person.
- There is a $1,000 annual maximum per person for vision expenses paid in a calendar year under the HRA.

HEARING AID BENEFIT

The Plan will pay $350 per ear, per four-year period, for hearing aid expenses[1] for each covered person. (The Medical Plan, not the Hearing Aid Benefit, covers expenses related to diagnostic testing.)

DEATH BENEFIT (Active Employees Only)

Your designated Beneficiary will receive a one-time payment of $5,000

WEEKLY INCOME/SHORT-TERM DISABILITY BENEFIT (Active Employees Only)	
Weekly benefit	$225
Maximum benefit period	26 weeks
For injury, payment begins	On the first day you are injured
For illness, payment begins	On the eighth day you are ill

[1] For services other than the fitting and purchase of a hearing aid, if required, which includes expenses for the manufacture of ear molds by an otologist or otorhinolaryngologist or a licensed audiologist.

NON-MEDICARE ELIGIBLE RETIREES

You have the SAME benefits as Active Employees for covered expenses related to:

- Medical Plan
  - Preventive care
  - Mental health
  - Alcohol and substance abuse
  - Hospital
  - Surgical
  - Home health
  - Hospice
  - Dental
- Additional Coverage
  - Physical therapy
  - Durable medical equipment
  - Emergency room
  - Foot orthotics
  - Ambulance service
  - Sleep treatment
  - Organ transplant
  - TMJ Appliance
- Prescription Drug Plan
- Dental Plan
- Vision Plan
- Hearing Plan

These are the benefits for which you are not eligible:

- Death Benefit
- Weekly Income/Disability Benefit

MEDICARE ELIGIBLE RETIREES

As a Retiree eligible for Medicare, you will receive a Medicare Advantage and Prescription Drug Plan. Contact the Fund Office to receive more information about these plans.

You have the SAME benefits as Active Employees for covered expenses related to:

- Dental
- Vision
- Hearing

Plan Participation

Initial Eligibility

The Plan provides coverage to Employees, Retirees, and their Eligible Dependents, as well as to Surviving Spouses and their Eligible Dependents. No Employee may refuse coverage under this Plan based on other health benefit coverage, or for any other reason. This section describes the eligibility requirements for Employees and defines Dependents eligible for coverage under the Plan.

On your first day of work in covered employment with a Contributing Employer, you will become eligible for Plan coverage.

Covered employment is work performed by an Employee, for a Contributing Employer who contributes to the Fund. A Contributing Employer includes:

- Any person, firm, Association, partnership, or corporation that enters into a Collective Bargaining Agreement with the Union requiring contributions to be made to the Fund on behalf of full-time Employees;
- The Union, which is required to make contributions to the Fund for its full-time Employees under the terms of a participation agreement; and Plumbers and Steamfitters Local Union No. 33 Fund Office with respect to its full-time Employees.

Although the Plan covers you from the first day of work, your claims for care and services will be pending until your Employer contributes to your Dollar Bank the amount necessary to cover one month of Dollar Bank Charge.

Continuing Eligibility

Eligibility for coverage continues on a month-by-month basis. As long as you are working in covered employment and have sufficient contributions made on your behalf to cover the Dollar Bank Charge, your benefits will continue.

For your coverage to continue for the next benefit month you must continue to work in covered employment and your Employer must make sufficient contributions on your behalf in the corresponding work month to cover the Dollar Bank Charge.

The Trustees determine the Dollar Bank Charge based on the actual cost of providing benefits. The Trustees, in their sole discretion, reserve the right to modify this amount periodically. The Fund Office will notify you in advance of a change in the Dollar Bank Charge.

If contributions made on your behalf in a work month are:

- Less than the Dollar Bank Charge for the corresponding benefit month, the additional amount needed will be deducted from your Dollar Bank, if available; or
- Accrue to more than six months' worth of eligibility in your Dollar Bank; the additional amount will be credited to your Health Reimbursement Account.

If your Dollar Bank becomes depleted, and you have exhausted your right to self-pay or chosen not to self-pay, then you are eligible to enroll in COBRA Continuation Coverage.

Dollar Bank

Dollar Bank Funding for Active Employees

The Dollar Bank program is designed so that the more you work, the more your Dollar Bank may grow. Contributions that your Employer makes on your behalf are based on the number of hours you work each month and are credited to your Dollar Bank.

After your Dollar Bank has reached the six-month capacity, future employer contributions will be deposited into your HRA.

If contributions made on your behalf in a work month are less than the Dollar Bank Charge for the corresponding benefit month, the additional amount needed will be deducted from your Dollar Bank, if available. If the amount credited to your Dollar Bank does not cover the Dollar Bank Charge, you may be eligible to make self-payment contributions for the difference. If your Dollar Bank becomes depleted, you may be eligible to enroll in COBRA Continuation Coverage.

The Dollar Bank is the recordkeeping system the Fund uses to keep track of employer contributions. The Dollar Bank is an accounting system and not a savings account. No Employee ownership or vesting of any benefits is created in the Dollar Bank.

Dollar Bank Funding for Apprentices

Prior to each September 1, the apprenticeship coordinator must certify that the apprentice is in good standing. If the apprentice is in good standing, then on September 1, the Fund will offer the apprentice a credit to the Dollar Bank of 250 times the hourly rate.

At the end of each Plan year, the Fund will collect surplus credits from the apprentice's Dollar Bank until the Fund recaptures all credit provided to the apprentice. If the apprentice stops working for an Employer while relying on the credit for coverage, the apprentice must pay the Fund back the balance plus interest from the date of credit.

Self-Paying for Coverage

If you do not have the amount necessary to cover one month of Dollar Bank Charge, you may self-pay the cost of coverage. The Plan will provide you with a self-pay notice and you will have 30 days from the date of that notice to pay. However, you may not self-pay for your first month of eligibility.

You may continue to self-pay to maintain Plan coverage for up to eight full months and one partial month so long as you remain ready, willing, and available for work. You will be considered ready, willing, and available for work so long as you remain on the out-of-work list at the Union.

If the Plan does not receive your payment within 30 days of the self-pay notice, the Plan will issue a COBRA Notice. You may elect COBRA Continuation Coverage, but you may pay a higher cost for this coverage. More information on COBRA Continuation Coverage may be found in the *COBRA Continuation Coverage* section of this SPD.

Reinstatement of Coverage

If you become employed by a non-contributory employer, you will immediately lose coverage under the Plan and forfeit your Dollar Bank and Health Reimbursement Account. Your coverage will terminate at 12:01 a.m. on the date you are first employed by a non-contributory employer.

Your eligibility will be reinstated at 12:01 a.m. on the first day of the month following the date the Plan receives employer contributions sufficient to pay the cost of the Plan. Reinstatement in the Plan is done on a prospective basis only.

The Plan will not retroactively rescind Employee eligibility unless an act of fraud has occurred.

MAINTENANCE OF HRA ACCOUNT FOR CERTAIN NON-COVERED EMPLOYMENT

Generally, when you become employed by a non-contributory employer your eligibility under the Plan will be terminated and your Health Reimbursement Account will be forfeited.

Notwithstanding the above, your Health Reimbursement Account will not be forfeited, but instead will be frozen, and access to the amount therein available upon being reinstated into the Plan, in a limited number of circumstances. Those circumstances where your HRA will be frozen are limited to the following:

- You are a retiree who exercised the one-time opt-out option, and are subsequently applying for retiree coverage pursuant to the terms of the Plan;
- You go to work for an Employer signatory to a Collective Bargaining Agreement with the Union, but in a non-bargained position not covered by the Collective Bargaining Agreement;
- You go to work for a signatory employer who is prohibited by law to contribute to the Plan;
- You go to work as an inspector or other similar position for a municipality within the geographic jurisdiction of the Union; or
- You are performing work as a voluntary union organizer for a non-signatory employer pursuant to a directive from the Union.

In all circumstances listed above, the Plan will only freeze your HRA for up to five (5) years. Therefore, if you do not become eligible under the terms of the Plan within five (5) years of losing your eligibility then your HRA will be permanently forfeited.

During the time your HRA account is frozen, you will not be permitted to access the HRA under any circumstances. Furthermore, during the freeze period your HRA will not accrue interest or any other monetary value. You have no vested right to the HRA.

Dependent Eligibility

Your Dependents become eligible for coverage on the same date you become eligible, or if later, on the date you acquire an Eligible Dependent. When you acquire a new Eligible Dependent, you must contact the Fund Office within 30 days of the qualifying event to update your personal information and provide documentation showing your relationship to the Dependent. If you notify the Fund Office and provide documentation within 30 days of the qualifying event, benefits for that Dependent will begin on the date of the qualifying event. If you do not notify the Fund Office of a new Dependent within 30 days, benefits for that Dependent will begin on the date of notification.

In addition, you must notify the Fund Office of a change in your address.

Your Eligible Dependents include:

- Your Spouse: the lawful spouse as recognized by the law of the state in which you live, or in which the marriage was performed. In addition, your spouse must reside with you in your permanent place of residence.
- Your child, whether single or married, who is younger than age 26 unless disabled, and who received uninterrupted coverage under the plan since eligible.
- Your child includes any of the following:
  - Natural child;
  - Legally adopted child, including a child placed with you for adoption;
  - Foster child; or
  - Stepchild who is the natural or adopted child of your spouse.
- Your child for whom you have legal guardianship, provided the child is younger than age 26. You must provide documentation of legal guardianship;
- Your unmarried child age 26 or older who is Disabled due to a mental or physical Disability. Initially, you must provide written proof of your child's Disability within 31 days of the Fund's request for proof. Thereafter, you need to provide documentation of the continued Disability annually. The Disabled child must:
  - Meet the Plan's definition of child or be a child for whom you have legal guardianship;
  - Have become Disabled due to mental or physical Disability before age 26;
  - Be incapable of self-sustaining employment and continue to be incapable of such employment;
  - Be dependent on you for more than one-half of his or her financial support and maintenance; and
  - Maintain his or her principal place of residence with you for more than one-half of the calendar year.

- Your child covered under a Qualified Medical Child Support Order (QMCSO). In addition to the above Dependent children, the Plan covers children who are required to be covered under a Qualified Medical Child Support Order (QMCSO). A QMCSO is generally a court order that directs a medical plan covering a parent to provide benefits to the parent's children. The Plan will provide benefits in accordance with such an order. A child covered by a QMCSO is called an Alternate Recipient and is treated as a Dependent under the Plan if he or she meets the criteria specified in the law governing QMCSOs. If you think this law may apply to you, you should contact legal counsel. You may contact the Fund Office if you have questions about the Plan's QMCSO procedures, or if you need a copy of those procedures.
- Coverage provided pursuant to QMCSOs cannot be greater in length, type, and amount of benefits than that provided to other Eligible Dependent children under Plan terms. The contents of QMCSOs and their administration are governed by both ERISA and written procedures adopted by the Fund. You will be required to provide legal documentation, such as a certified birth certificate, for your child.

When Eligibility Ends

When your coverage or your Eligible Dependent's coverage ends, you or they may be eligible to continue coverage by electing COBRA Continuation Coverage and making monthly payments.

End of Eligibility for You

Your eligibility for coverage under the Plan will end on the earlier of the:

- First day of the month for which you do not meet the Plan's continuing eligibility requirements;
- First day on which you perform work in the plumbing and steamfitting industry in the jurisdiction of the Fund for an employer that does not contribute to the Fund;
- First day of a benefit month for which you do not make the required self-payment contribution by the due date;
- Date you commit an act of fraud, omission, or an intentional misrepresentation of material fact, including employment with a non-contributing employer;
- Date your election period for COBRA Continuation Coverage ends;
- Date of your death; or
- Date this Plan ends.

End of Eligibility for Your Dependent

Your Eligible Dependent's eligibility for coverage will end on the earlier of the:

- First day of the month for which you do not meet the Plan's continuing eligibility requirements;
- First day on which you perform work in the plumbing and steamfitting industry in the jurisdiction of the Fund for an employer that does not contribute to the Fund;
- Date a Dependent no longer meets the Plan's definition of an Eligible Dependent;
- First day of a benefit month for which the required self-payment contribution is not made by the due date;
- Date coverage would terminate in accordance with other provisions of the Plan;
- Date your Eligible Dependent's election period for COBRA Continuation Coverage ends;
- Date specified in a Qualified Medical Child Support Order (QMCSO) for an Alternate Recipient receiving coverage under the QMCSO;
- Date that a legal separation order or decision of the court is entered;
- Date you and your spouse no longer share a permanent residence; or
- Date that the court enters and finalizes a divorce decree.

In the event of your death, your Surviving Spouse may continue coverage for himself/herself and any Eligible Dependents under either COBRA Continuation Coverage or the Surviving Spouse Program.

Rescission of Coverage

The Plan may rescind your coverage for fraud, intentional misrepresentation of a material fact, or material omission after the Plan provides you with 30 days' advance written notice of that rescission of coverage. The Trustees have the right to determine, in their sole discretion, whether there has been fraud, an intentional misrepresentation of a material fact, or a material omission. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you should not have been covered by the Plan. However, the following situations will not be considered rescissions of coverage and do not require the Plan to give you 30 days' advance written notice:

- The Plan terminates your coverage back to the date of your loss of employment when there is a delay in administrative recordkeeping between your loss of employment and notification to the Plan of your termination of employment.
- The Plan retroactively terminates your coverage because of your failure to timely pay required Dollar Bank Charge or contributions for your coverage.
- The Plan retroactively terminates your former spouse's coverage back to the date of your divorce.

For any other unintentional mistakes or errors under which you and your Dependents were covered by the Plan when you should not have been covered, the Plan will cancel your coverage prospectively – for the future – once the mistake is identified. Such cancellation will not be considered a rescission of coverage and does not require the Plan to give you 30 days' advance written notice.

Life Events

Different events can affect your benefits coverage. Your benefits can adapt to your needs at different stages of your life. The following are considered life events:

- Getting married;
- Adding a child;
- Becoming separated or divorced;
- Your child no longer meets the Plan's definition of a Dependent;
- Taking a leave of absence;
- Taking military leave;
- Becoming Disabled; and
- Retiring.

Getting Married

When you get married, notify the Fund Office within 30 days and your spouse is automatically eligible for Dependent coverage under the Plan. Once you provide the required information, coverage for your spouse begins on the date of your marriage. When you do not notify the Fund Office within 30 days, your spouse's Plan coverage will begin on the day you notify the Fund. At this time, you also may want to consider updating your Beneficiary information for your Death Benefit.

You must report to the Fund Office your spouse's coverage under another group medical plan. The Fund Office will coordinate coverage with the two plans and pay benefits as the secondary plan. You must send the Fund Office relevant documents such as birth certificates, marriage certificates, any court decrees, orders, or any other document determined necessary by the Trustees to verify the eligibility of your Dependents.

Adding a Child

The Plan will cover your new Dependent child as of 12:01 a.m. on the date of birth, adoption, marriage, or date of the court order establishing financial responsibility for the child, so long as you notify the Fund Office within 30 days of the event.

If you do not notify the Fund Office of a new Dependent within 30 days, benefits for that Dependent will begin on the date of notification.

You must send the Fund Office relevant documents such as birth certificates, marriage certificates, any court decrees, orders, or any other document determined necessary by the Trustees to verify the eligibility of your Dependents.

BECOMING SEPARATED OR DIVORCED

Your spouse is not eligible for coverage through this Plan when you legally separate, divorce or no longer share a permanent residence. Your spouse can elect COBRA Continuation Coverage for up to 36 months. You or your spouse must notify the Fund Office within 60 days of the legal separation or divorce for your Spouse to receive an enrollment form for COBRA benefits.

This Plan recognizes Qualified Medical Child Support Orders (QMCSOs) and provides benefits for your Dependent child(ren), as determined by a court order. You may obtain a copy of the Plan's procedures for handling QMCSOs, at no charge, by contacting the Fund Office.

CHILD LOSING ELIGIBILITY

If your child loses Plan coverage because he or she ceases to meet the Plan's definition of a Dependent, he or she can receive benefits through COBRA Continuation Coverage for up to 36 months.

TAKING A LEAVE OF ABSENCE

Under the Family and Medical Leave Act (FMLA), you can take up to 12 weeks of unpaid leave during any 12-month period due to:

- The birth of a child or placement of a child with you for adoption;
- The care of a seriously ill spouse, parent, or child;
- Your serious illness; or
- You have an urgent need for leave because your spouse, son, daughter, or parent is on active duty in the armed services in support of a military operation.

In addition, under the FMLA, you may be able to take up to 26 weeks of unpaid leave during any 12-month period to care for a service member. The service member must:

- Be your spouse, son, daughter, parent, or next of kin;
- Be undergoing medical treatment, recuperation, or therapy, for a serious illness or injury incurred in the line of duty while in military service; and
- Be an outpatient, or on the temporary Disability retired list of the armed services.
- During your leave, you will maintain all of the coverage offered through the Fund. The Fund will continue eligibility for a family medical leave and maintain your prior eligibility status until the end of the leave, provided your Employer properly grants the leave under federal law and receives the required notification. No contributions of any kind shall be required to continue coverage, and no amount will be deducted from your Dollar Bank to pay for coverage during FMLA leave. Only your Employer determines your eligibility for FMLA leave and grants such leave.

MILITARY LEAVE

If you are called into uniformed services, you may elect to continue your health coverage (medical, prescription drug and hearing), in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Your health care coverage will continue under the Plan if you serve for up to 31 days. If you serve for more than 31 days, you may continue your coverage at your own expense until the earlier of:

- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- 24 consecutive months after coverage ended.

Uniformed service includes service in the United States Armed Forces, the Army National Guard, the Air National Guard, 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. Service means the performance of duty on a voluntary or involuntary basis under competent authority and includes active duty, active duty training, initial active duty for training, inactive duty training, full-time National Guard duty and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

You must give advance notice of your military service and provide a copy of your call to uniformed service orders to the Fund Office, unless you are unable to do so because of military necessity, advance notice is impossible, or it is unreasonable under the circumstances.

Coverage under USERRA will run concurrently with COBRA Continuation Coverage. The cost of continuation coverage under USERRA will be the same cost as COBRA Continuation Coverage. The procedures for electing coverage under USERRA will be the same procedures described in the COBRA Continuation Coverage section of this booklet, except that only the Employee has the right to elect USERRA coverage for himself or herself and his/her Dependents, and that coverage will extend to a maximum of 24 months.

Generally, if you return to work within five years after you are called to service, you will be reinstated for Plan benefits as if you had not left for military service if:

- You notify the Fund Office that you were called to service;
- You leave service under conditions that are not dishonorable; and
- You report for work or apply for reemployment within the period specified in the following chart after you complete your active duty.

Length of Military Service	Reemployment 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

If you are hospitalized or otherwise incapacitated by a service-related illness or injury, your reemployment deadline may be extended up to two years.

Your coverage will continue until the last day of the month that you enter service. After that, to continue coverage, you or your Eligible Dependent must make the required self-payment

contribution for coverage. However, if you have an unused amount in your Dollar Bank, it may be used toward continuing coverage for you and/or your Eligible Dependents before you begin making self-payment contributions for coverage or you may freeze your Dollar Bank until you return from service. Your USERRA coverage may be terminated if:

- You do incur the required Dollar Bank charge for continuation of coverage;
- You exhaust the 24-month coverage period;
- The Plan ceases to provide group health coverage;
- You lose your rights under USERRA (for instance, for a dishonorable discharge); or
- You fail to return to work or apply for reemployment within the time required under USERRA.

However, your coverage will end at midnight on the earliest of the day:

- Your coverage would otherwise end as described above;
- Your former Employer ceases to provide any health plan to any Employee;
- Your self-payment contribution is due and unpaid; or
- You are again covered under the Plan.

Your Eligible Dependents may continue coverage under the Plan during your term of service by using any unused amounts in your Dollar Bank. However, if you elect to freeze your Dollar Bank until your return from service, your Eligible Dependents may continue coverage by self-paying for COBRA Continuation Coverage.

You need to notify the Fund Office in writing when you enter the uniformed services. For more information about continuing coverage under USERRA, contact the Fund Office.

When You Do Not Continue Coverage under USERRA

If you do not continue coverage under USERRA, your coverage will end on the last day of the month in which you enter active uniformed service. Your Eligible Dependents will have the opportunity to elect COBRA Continuation Coverage.

Reinstating Your Coverage

In accordance with USERRA, once you are discharged from uniformed service, you may be eligible to apply for reemployment with your former Employer.

Upon honorable discharge or release, your eligibility will be reinstated if you make yourself available for work in the jurisdiction of the Union by the reemployment deadlines specified. If your Dollar Bank has been depleted, you will be required to make self-payment contributions to maintain your eligibility. It is your responsibility to inform the Fund Office (in writing) of your return from service by the reemployment deadline.

Disability – Weekly Income Benefit

If a Sickness or accident causes you temporary disablement, you are entitled to the Weekly Income Benefit.

You are eligible for the Weekly Income benefit when you are:

- Wholly and continuously Disabled because of a non-work related injury or Sickness;
- Unable to perform the duties of your occupation;
- Not engaged in any other occupation for wage or profit; and
- Under the care of a physician for the injury or Sickness that caused the Disability.

You can receive up to 26 weeks for any one period of Disability.

The weekly income benefit is calculated on a five calendar day period beginning with the first day of Disability due to injury or the eighth day of Disability due to an illness. The first day of any period of Disability will never be more than three calendar days prior to the date on which you were first seen by a physician, physician's assistant, or nurse for the injury or Sickness causing the Disability.

You may have a second period of Disability if you work for at least three months or if you are subsequently Disabled by a second and separate physical or mental health condition unrelated to the first.

The Weekly Income benefit is not available to Retirees or Employees entitled to Workers Compensation. You cannot receive the Weekly Income Benefits when your Dollar Bank has a negative balance.

In the Event of Death

If you are an active Employee and eligible for coverage on the date of your death, your Beneficiary will receive a $5,000 Death Benefit.

In the event of your death, your spouse and/or Eligible Dependents may continue health care coverage by electing coverage under the Surviving Spouse Program or by electing COBRA Continuation Coverage.

DESIGNATE A BENEFICIARY

You may designate a Beneficiary in writing on the Plan's Beneficiary designation form. You may change or revoke this designation at any time prior to your death. A Beneficiary designation is only effective when filed with and received by the Plan.

You may designate multiple beneficiaries. If you do not designate the amount to distribute to each Beneficiary, the benefit will be split equally among all beneficiaries.

If you die without designating a Beneficiary, or if your Beneficiary dies before you, the Death Benefit will be paid to your Spouse. If you do not have a Spouse, the Death Benefit will be paid to your natural or adopted children in equal shares. If you have no legal spouse and no living children, the Death Benefit will be paid to your natural parents. If you have no legal spouse, no living children, and no living natural parents, then your Death Benefit will be paid in a single lump sum to the executor of your estate.

Retiree Plan

When you retire, the Plan will automatically enroll you in the Retiree Plan. You must contact the Fund Office if, for any reason, you decide to waive your Retiree Plan coverage. The Fund Office will send a form that allows you to waive this Retiree Coverage. Complete and return the form as soon as possible.

Included in the Retiree Plan are:

- Medical Plan;
- Prescription Drug Benefit; and
- Dental, Vision and Hearing Benefits.

ELIGIBILITY

To be eligible for Retiree coverage:

- You must be age 55 or retired due to Disability;
- You must be receiving benefits under the Plumbers and Steamfitters Local Union No. 33 Retirement Trust or the Plumbers and Pipefitters National Pension Plan;
- You must pay the appropriate Retiree Self-Pay amount; and
- For at least 16 out of the last 20 calendar quarters preceding the year in which you retire you must have been either:
  - Covered under the Plan as an Employee (not under COBRA Continuation Coverage); or
  - Working in covered employment under a Collective Bargaining Agreement with the Union.

In order to receive Retiree health coverage, you must elect this coverage at the time of your retirement. If you do not make this election, you, your spouse, and any Dependents will not be allowed to begin participation at a later date.

ONE TIME TEMPORARY WAIVER OF COVERAGE FOR RETIREES

If your spouse maintains coverage under an employer-sponsored group health plan, then you may waive coverage under this Plan at the time of your retirement. If coverage is waived, then you may become covered under this Plan again if you notify the Fund Office within 31 days of the date coverage under your spouse's health plan is terminated. You and your spouse are only eligible for this temporary waiver one-time at the time of your retirement.

Requirements to remember regarding this one-time temporary waiver of coverage:

- You may only elect to waive coverage one time;
- You may only exercise this option at the time of your retirement or after the depletion of your dollar bank, if later;
- At the time you opt-out of coverage you must provide proof that you and your spouse have coverage under your spouse's group health plan;
- You may only opt back in to coverage under this Plan if your other health coverage is lost through retirement, termination of employment (voluntary or involuntary), reduction in work hours or by becoming Medicare eligible;

- You may also opt-in to this Plan if you no longer satisfy the requirement of being a dependent as a result of divorce or legal separation. If you opt-in to the Plan based on divorce or legal separation only you, the retiree, are eligible for coverage, and not the former spouse;
- You must give timely notice to the Fund Office to elect coverage after your initial waiver. Timely notice means you have notified the Fund Office within 31 days of the date coverage under your Spouse's health plan is terminated; and
- Your self-payments must be made on time each month.

Returning to Work after Retirement

Your Retiree health coverage will terminate when you regain coverage as an Employee. If you return to work, you may continue your coverage by self-paying until you have enough employer contributions to cover your Dollar Bank Charge. Your self-pay rate will be the rate that applies to those on the out-of-work list rather than the Retiree rate.

Retiree Coverage and Medicare

Once you or your Dependents reach age 65 or any other age requirement set under Medicare laws and regulations, the Plan will enroll you in the Medicare program available at that time. You must enroll in Medicare parts A and B to be eligible for the Fund's Medicare program. Please contact the Fund Office for more information about the plans and benefits available for Medicare eligible Retirees.

Termination of Retiree Coverage

Your coverage through the Plan will terminate if you fail to pay the required Retiree Self-Pay amount. You may not return to the Plan after you lose coverage.

In the Event of Death During Retirement

In the event of your death during the period that coverage is postponed or suspended for you and/or your Dependents, your Eligible Dependents can begin or resume surviving spouse coverage either immediately or when their other coverage ends. Surviving spouse coverage is available to your eligible surviving Dependents according to the same Plan rules that apply to surviving Dependents of Retirees who had not postponed or suspended coverage, as well as the other provisions outlined in the previous section.

To begin or resume coverage, your eligible surviving Dependents must apply for Surviving Spouse coverage within 60 days following the later of the date the other coverage ends, as described in the previous section, or the date of your death. If your surviving Eligible Dependents do not apply for coverage by this deadline, they will have no future rights to coverage under the Plan.

Surviving Spouse Program

Your Surviving Spouse may continue coverage so long as your Surviving Spouse was covered as a Dependent under this Plan on the date of your death.

If, at your death, there are contributions in your Dollar Bank, the monthly payment for your Surviving Spouse's coverage will be deducted from your Dollar Bank. Once the Dollar Bank is exhausted, your Surviving Spouse may purchase Surviving Spouse coverage. This coverage will require your Surviving Spouse to self-pay by the first day of each month.

Coverage for your Surviving Spouse will end at midnight on the day in which the Surviving Spouse remarries, when the Surviving Spouse fails to pay the required self-payment, or at midnight on the day in which the Surviving Spouse dies.

A Surviving Spouse may not regain coverage following a coverage lapse. If your Surviving Spouse's coverage terminates for non-payment, your Surviving Spouse will be sent a COBRA Notice and have the opportunity to elect COBRA Continuation Coverage. Similarly, coverage for your dependent children can be continued through self-payments until they no longer meet the Plan's definition of dependent children – usually at age 26. However, the Dollar Bank is only available to the Surviving Spouse or if there is no Surviving Spouse to the children in equal shares as necessary to continue coverage.

COBRA Continuation Coverage

In certain situations, where your coverage would otherwise end under the Plan, the Plan provides an opportunity for a temporary extension of health care coverage. The law that requires this coverage is the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA. Health care coverage under COBRA is called COBRA Continuation Coverage. You do not have to show that you are insurable for COBRA Continuation Coverage. It is offered to you at rates (set by the Trustees) in specific instances (called qualifying events) where coverage under the Plan would otherwise end. If you are eligible for continuing coverage under both USERRA and COBRA, USERRA continuing coverage will run concurrently with COBRA Continuation Coverage.

Qualifying Events

If you or your Eligible Dependents lose coverage because of a qualifying event, you are entitled to elect COBRA Continuation Coverage. Qualifying events include your:

- Reduction in hours or termination of employment (including layoff, strike, Disability, medical leave of absence or retirement);
- Death;
- Legal separation or divorce;
- Entitlement to Medicare (eligible for and enrolled in Medicare); or
- Eligible Dependent child ceasing to qualify as a Dependent child under the Plan.

Notifying the Fund Office

You or your Dependent must inform the Fund Office of a divorce, separation, or a child losing Dependent status under the Plan within 60 days of the occurrence. If you do not notify the Fund Office in a timely manner, you or your Dependent will lose the right to elect COBRA Continuation Coverage.

By law, your Employer is required to notify the Fund Office of your death, termination of employment or reduction in hours or entitlement to Medicare within 45 days of its occurrence. However, because Employers contributing to multiemployer funds may not be aware of these events, we urge you or a family member to notify the Fund Office of all qualifying events as soon as the qualifying event occurs.

When the Fund Office is notified that one of these events has occurred, and you lose coverage under the Plan, you and your Eligible Dependents will be notified within 14 days of your right to elect COBRA Continuation Coverage. Your Eligible Dependents have the option to elect COBRA coverage whether you elect COBRA coverage or not.

You must also notify the Fund within 60 days of a Social Security Disability award and before the normal COBRA expiration date. In addition, if you are eligible for the 11-month Disability extension of COBRA Continuation Coverage, and receive a notice that you are no longer eligible for the Social Security Disability award, you must notify the Fund within 30 days of receiving the notice that you are no longer eligible.

Once you receive a COBRA notice, you have 60 days to respond if you want to elect COBRA Continuation Coverage. Your Eligible Dependents have the option to elect coverage independently from you if you choose not to elect COBRA Continuation Coverage.

If COBRA Continuation Coverage is elected, the Plan will provide coverage that is identical to the health coverage (excluding Weekly Disability, Death Benefit, and AD&D Benefit) provided to similar Employees and their Dependents.

COBRA Continuation Coverage will be offered to you and all of your Eligible Dependents who were covered under the Plan on the day before the day of the qualifying event. You and such covered Eligible Dependents are known as qualified beneficiaries for purposes of COBRA Continuation Coverage. If you have a newborn child, adopt a child or have a child placed with you for adoption (for whom you have financial responsibility) while your COBRA Continuation Coverage is in effect, you may add this child to your coverage, and that child will be treated as a qualified Dependent under COBRA. You must notify the Fund Office, in writing, of the birth or placement for adoption to add the child to your coverage.

Periods of Coverage

The maximum period of COBRA Continuation Coverage is 36 months from the qualifying event.

- Coverage continues for a maximum of 18 months if your coverage ends due to your termination of employment or your reduction in hours.
- Coverage continues for a maximum of 29 months if you or an Eligible Dependent qualifies for a Social Security Disability Award at the time you lose eligibility, or within 60 days after that, provided you notify the Fund within 60 days of the award and before the normal COBRA expiration date. Other members of your family who have elected COBRA Continuation Coverage are also eligible to continue COBRA coverage for the extended 29-month period.
- Coverage continues for a maximum of 36 months if your spouse or other Eligible Dependents' coverage ends because of your:
  - Death;
  - Legal separation or divorce;
  - Entitlement to Medicare; or
  - Dependent child no longer qualifying for Dependent coverage under the Plan.
- Coverage continues for up to a maximum of 36 months if your spouse or other Eligible Dependent experiences a second qualifying event during an 18-month COBRA Continuation Coverage period because of your:
  - Death;
  - Legal separation or divorce;
  - Entitlement to Medicare; or
  - Dependent child no longer qualifying for Dependent coverage under the Plan.

Loss of Continued Coverage

The period of COBRA Continuation Coverage for you or your Eligible Dependents may end if:

- You or your Eligible Dependents do not make the required self-payment contributions on a timely basis;
- You or your Eligible Dependents first become covered under any other group health care plan, including Medicare (provided such plan does not contain any exclusions or limitations with respect to any pre-existing conditions) after electing COBRA Continuation Coverage;

- The Fund ceases to provide any group health benefits;
- You or your Dependent reaches the end of the 18-month, 29-month, or 36-month COBRA Continuation Coverage period and you are not eligible for additional continuation coverage under the rules described above;
- You exhaust the Plan's maximum benefits;
- You become entitled to (eligible for and enrolled in) Medicare; or
- Your Dependents become entitled to (eligible for and enrolled in) Medicare.

Once your COBRA Continuation Coverage ends, it cannot be reinstated. When your COBRA Continuation Coverage ends, you will be provided with certification of your length of coverage under this Plan. This may help reduce or eliminate any pre-existing condition limitation under a new group medical plan.

Paying for COBRA Continuation Coverage

The Fund Office will notify you of the cost of your COBRA Continuation Coverage when it notifies you of your right to coverage. The cost for COBRA Continuation Coverage is determined by the Trustees on an annual (12-month) basis. The amount may not exceed 102% (or, in the case of an extension of Continuation Coverage due to a Disability, 150%) of the cost to the Plan (including both Employer and Employee contributions).

Your first payment for COBRA Continuation Coverage must include payments for any months retroactive to the day your coverage and/or your Eligible Dependents' coverage under the Plan ended. The Fund Office will notify you of the due date for the first payment; subsequent payments are due the first of the month. If a payment is late, coverage will be terminated.

First Payment for Continuation Coverage

If you elect Continuation Coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for Continuation Coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for Continuation Coverage in full within 45 days after the date of your election, you will lose all Continuation Coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the Fund Administrator to confirm the correct amount of your first payment.

Monthly Payments for Continuation Coverage

After you make your first payment for Continuation Coverage, you will be required to make monthly payments for each subsequent coverage period. Payment is due on the first day of each month for that month's coverage. If you make a monthly payment on or before the first day of the month to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send any notices of payments due.

Grace Periods for Monthly Payments

Although monthly payments are due on the first day of the month to which the coverage period applies, you will be given a grace period of 30 days after the first day of the payment due date to make each payment. Your Continuation Coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you make a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the coverage,

your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that payment, you will lose all rights to Continuation Coverage under the Plan.

Loss of Other Group Health Plan Coverage or Other Health Insurance Coverage

If, while you are enrolled in COBRA Continuation Coverage, your spouse or Dependent child loses coverage under another group health plan, you may enroll the spouse or Dependent child for coverage for the balance of the period of COBRA Continuation Coverage. The spouse and/or Dependent child must have been eligible but not enrolled for coverage under the terms of this Plan and declined coverage when enrollment was previously offered under this Plan. In addition, the spouse and/or Dependent child must have been covered under another group health plan or had other health insurance coverage.

You must enroll the spouse and/or Dependent child within 31 days after the termination of the other coverage.

The loss of coverage under the other plan must be due to one of the following:

- Exhaustion of COBRA Continuation under another plan;
- Loss of eligibility; or
- Employer contributions towards the other plan decline or are eliminated.

Loss of eligibility does not include a loss due to failure of the individual or participant to pay on a timely basis or termination of coverage for cause.

Confirmation of Coverage to Health Providers

Under certain circumstances, the Fund may need to inform your health care providers as to whether you have elected and/or paid for COBRA Continuation Coverage. This rule is applicable under the following three circumstances:

- If a health care provider requests confirmation of coverage during the COBRA election period and you, your spouse, or your Dependent children have not yet elected COBRA Continuation Coverage, then the Fund Office will give a complete response to the health care provider about your and your Dependents' COBRA continuation rights during the election period.
- The Fund cancels your and your Dependents' coverage as of the date coverage ends under the Plan. However, the Fund retroactively reinstates your coverage once COBRA Continuation Coverage is elected. If you have not yet elected COBRA, the Fund Office will inform the health care provider that you do not currently have coverage, but that you and your Dependents' will have coverage retroactively to the date coverage was lost if you elect COBRA Continuation Coverage and make the payment on time.
- If after you have elected COBRA Continuation Coverage, a health care provider requests confirmation of coverage for a period for which the Fund Office has not yet

received payment, then the Fund Office will give a complete response to the health care provider about your and your Dependents' COBRA continuation rights during that period.

Special Enrollment Rights

In addition, if you have a life-changing event, you may request special enrollment. Such an event includes acquiring a new Dependent because of marriage, birth, adoption, or placement for adoption. You may be able to enroll yourself and your Dependents due to such an event. However, you must request special enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Fund Office.

Under federal law, an individual has the special right to enroll in any other group health plan for which he or she may be eligible (such as a plan sponsored by a spouse's employer) within 30 days after his or her regular coverage under this Plan terminates due to a qualifying event. The individual will not have to wait until that other plan's next open enrollment period. If that individual elects COBRA Continuation Coverage under this Plan, he or she will have that same special right to enroll in another group health plan at the end of the COBRA coverage if he or she keeps the COBRA coverage for the maximum period it is available.

CHIPRA (the Children's Health Insurance Program Reauthorization Act of 2009) created two new special enrollment events if you are eligible for the Plan but are not enrolled in the Plan. First, if you or your Dependents were covered under Medicaid or a state CHIP plan and lose that coverage, you or your Dependents are entitled to a special enrollment period in this Plan. Second, if you or your Dependents become eligible for the state's health plan assistance program you are entitled to a special enrollment period. You have 60 days to notify the Plan of the event, and 31 days to provide proof of eligibility and enroll. To request Special CHIPRA Enrollment or obtain more information, contact the Fund Office.

Health Reimbursement Account (HRA)

The Health Reimbursement Account (HRA) will reimburse your eligible health care expenses, on a tax-free basis. The Fund will establish a separate HRA for each employee or family.

HRA FUNDING

After your Dollar Bank has reached the six-month capacity, future employer contributions, in excess of the dollar bank charge, will be deposited into your HRA. Your HRA account will be credited at the end of each month. If your Dollar Bank becomes less than the six-month capacity due to debiting for continued eligibility, future employer contributions will be deposited into the Dollar Bank until the six-month capacity is restored. Once again, after the six-month capacity has been restored, employer contributions will then be deposited into the HRA.

Your individual account does not earn interest, nor is it charged with administrative expenses. The balance remaining in your HRA at the end of the year is carried over to the next year.

HRA ELIGIBILITY DURING COBRA

If your Dollar Bank does not have the contribution amount required to pay for your monthly cost of coverage, you may use your HRA to pay COBRA costs and continue your eligibility. If, at any time, your eligibility for the health Plan is terminated for more than one month, it is considered a qualifying event and you will receive a COBRA notice form.

You may use your HRA to pay COBRA costs only if you elect COBRA within 60 days of receiving the notice and authorize the payment of your COBRA cost from the HRA within 45 days of your COBRA election. If you do not have enough in your HRA to pay your COBRA cost, you must self-pay the remaining amount. Failure to make a timely payment will result in the termination of COBRA coverage.

If you do not elect COBRA within 60 days of receiving the COBRA election notice or do not pay within 45 days of your COBRA election, your HRA balance will be forfeited.

The HRA is a reimbursement mechanism, which means that only the amounts remaining in your family's account on the day of the COBRA event are available for reimbursement. The Plan leaves it to you and your family to decide how the money in the account will be used.

If a divorce occurs, you will need to arrange for the divorce decree to specify who can submit claims to the account. If you do not, the Plan will continue to allow your former Spouse to submit for reimbursement from the HRA account. For HRA expenses to be eligible for reimbursement, they must have been incurred while you or your spouse were eligible for coverage in the Plan, and submitted within 1 year from the date when incurred.

Eligible Expenses

You may use your HRA to pay the following types of expenses incurred by you, your Spouse and eligible Dependents:

- Medical care Deductibles and Coinsurance;
- Dental expenses (except for excluded items or frequency overages);
- Up to $1,500 per lifetime per dependent under age 19 for Orthodontia expenses;
- Covered Vision or hearing out of pocket expenses (limited to $1,000 calendar year maximum per person for vision expenses);
- Up to $1,000 per year per person for Chiropractic expenses;
- Up to $1,000 per year per person for TMJ appliance expenses after the $500 annual medical benefit has been reached;
- Expenses related to exercise or weight-loss programs and educational classes, including gym or health club membership fees, if your physician has diagnosed you with a disease and the program or class is prescribed as treatment for that disease. (Note that in the absence of both a diagnosis or a disease and a prescribed treatment program, gym membership fees are not reimbursable.)
- Retiree Self-Pay requirements; and
- COBRA costs.

Expenses that are not included in this list are not eligible for reimbursement through your HRA.

An expense is eligible for reimbursement based on the date of service, not when you are billed or pay the bill. You have a full calendar year, from the date of the service, to submit a claim for the expense.

Eligible expenses do not include expenses covered by any other plan. You may not claim an expense for which you already have been reimbursed. Expenses incurred before your HRA was established are not eligible for reimbursement.

Filing Claims

You may apply for reimbursement by mailing a claim form and applicable receipts to the Fund Office. The minimum reimbursement claim amount you can submit is $25 for the same patient and provider. Claim payments may never exceed the balance remaining in the HRA. Charges excluded by the Plan are also excluded from HRA reimbursement. Medical providers will be paid directly, unless you submit proof of payment with your claim.

The Medical Plan

Your medical benefits cover a wide range of services and supplies, including physician charges, diagnostic testing, prescription drugs, Hospital charges, and surgery. These benefits can pay a large part of your health care expenses and are designed to pay benefits for medical expenses related to medically necessary non-occupational Sickness or injury.

How the Medical Plan Works

- **In-Network providers typically submit claims** on your behalf. You do not have to pay your portion of the bill at the time you receive services. The In-Network provider discounts your bill and, after processing, the Fund Office will notify you of your share of the bill.
- **Before benefits are payable under the Plan**, you must satisfy an annual Deductible. The *Schedule of Benefits* lists your annual Deductible amount.
- **Once you meet the annual Deductible**, you and the Plan share expenses – Coinsurance. The Plan pays a higher percentage for expenses incurred In-Network. The Plan pays less for expenses incurred Out-of-Network. The *Schedule of Benefits* lists your annual Deductible and Coinsurance rates.
- **Once your Out-of-Pocket expenses reach the annual Maximum**, the Plan pays 100% of benefits. The *Schedule of Benefits* lists your annual Out-of-Pocket Maximum.

You save money by using In-Network providers. The Fund has contracted with certain providers of products and services to provide you and your Dependents health care at preferred prices. However, you have the right to see any provider you choose.

Annual Deductible

The annual Deductible is the dollar amount you pay each year before the Plan pays benefits. The annual Deductible applies to each covered person each calendar year. For a family, once the family has combined expenses equal to the family maximum, no further Deductibles are required for that year. Your Deductible does count toward your out-of-pocket maximum.

Coinsurance

Coinsurance, generally expressed as a percentage, is the amount you pay for covered services after you meet the Plan's annual Deductible, if applicable.

How Using a PPO Hospital Can Save You Money

Rich is admitted to the Hospital for non-emergency medical treatment. The following is a comparison of what Rich might pay if he uses a network Hospital and a non-network Hospital.

The deductible is $750 when Rich uses in-network providers. When Rich goes out of the network, the deductible is $1,500.

For this example, assume Rich met the $750 in network deductible payments earlier in the year.

The In-Network PPO Hospital provides a 30% discount.

Expenses	PPO Hospital	Non-PPO Hospital
Hospital total covered medical expenses	$10,000	$10,000
PPO provider discount	-30%	-0
Total amount subject to Coinsurance	$7,000	$10,000
Deductible	$0	$750
Percentage Plan pays	-80%	-70%
Amount Plan pays	$5,600	$6,475
Amount Rich pays	$1,400	$3,525

EXPENSES THE MEDICAL PLAN PAYS

The Plan covers the following expenses when they are Medically Necessary for the treatment of a non-occupational injury or Sickness.

Preventive Care

The Plan pays 100% of Preventive Services received In-Network. These services are not subject to the annual Deductible or Coinsurance. In addition, the Plan pays 100% of services, including flu shots and major medical services such as treatment for strep throat, you receive in a 'retail clinic' or County Health Department. You will pay 30% Coinsurance, after your Out-of-Network deductible has been met, if you receive your preventive care out-of-network.

The Preventive Care Benefit includes those items and services described in 26 C.F.R. § 54.9815-2713T, which includes 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 and immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. A list of items and services that are included as Preventive Health Care may be found at http://www.healthcare.gov/what-are-my-preventive-care-benefits/. The list of items and services that are included as Preventive Care is updated from time-to-time by the USPSTF.

The following is a list of benefits that are available under the Fund's Preventive Services Benefit at the time of publication of this SPD.

Covered Preventive Care for Adults

1. Abdominal Aortic Aneurysm one-time screening for men ages 65-75 who have ever smoked.
2. Alcohol misuse screening and counseling, screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.
3. Aspirin use for men and women of certain ages. Aspirin is not payable, nor is counseling for aspirin use, because the service is included in the payment for a physician visit.
4. Blood pressure screening for all adults age 18 and older; blood pressure screening is not payable as a separate claim, as it is included in the payment for a physician visit.
5. Cholesterol screening (Lipid Disorders Screening) for men aged 35 and older; men aged 20-35 if they are at increased risk for coronary heart disease; and women aged 20 and older if they are at increased risk for coronary heart disease.
6. Colorectal cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults beginning at age 50 and continuing until age 75. The test methodology must be medically appropriate for the patient. Removal of polyps during a preventive colonoscopy are covered at 100%.
7. Depression screening for adults.
8. Type 2 Diabetes screening for asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
9. Diet counseling for adults at higher risk for chronic disease.
10. HIV screening for all adults at higher risk.
11. Obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. Screening includes measurement of BMI by the clinician with the purpose of assessing and addressing body weight in the clinical setting.
12. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk.
13. Tobacco use screening, counseling, and behavioral and pharmacological interventions.
14. Syphilis screening for all adults at increased risk of infection.
15. Statins in adults aged 40-75, with cardiovascular disease risk factors.
16. Tuberculin screening for adults at increased risk.

Covered Preventive Care for Women, Including Pregnant Women

1. Anemia screening on a routine basis for pregnant women.
2. Prenatal vitamins for pregnant women, covered only if the woman obtains a prescription.
3. Bacteriuria urinary tract or other infection screening for pregnant women. Screening for asymptomatic bacteriuria with urine culture for pregnant women is payable at 12 to 16 weeks' gestation or at the first prenatal visit, if later.
4. Breast cancer screening mammography for women with or without clinical breast examination and with or without diagnosis, every 1 to 2 years for women aged 40 and older.
5. BRCA genetic testing for breast cancer for women whose family history is associated with an increased risk for BRCA 1 or BRCA 2 genetic mutations; genetic counseling; and BRCA genetic testing.
6. Breast cancer chemoprevention counseling for women at higher risk. The Plan will pay for counseling by physicians with women at high risk for breast cancer and at low risk for

adverse effects of chemoprevention, to discuss the risks and benefits of chemoprevention. Breast cancer risk-reducing medications for women, such as tamoxifen or raloxifene, will also be covered at 100%.

7. Breast feeding interventions to support and promote breast feeding. Breast feeding intervention is not payable as a separate claim, because the service is included in the payment for a physician, gynecologist, or obstetrician visit.
8. Cervical cancer screening for sexually active women who have a cervix at intervals to be determined by the plan based on age and whether the woman has had recent screening with normal Pap results.
9. Chlamydia infection screening for all sexually active non-pregnant young women aged 24 and younger, and for older non-pregnant women who are at increased risk. For all pregnant women aged 24 and younger, and for older pregnant women at increased risk, Chlamydia infection screening is covered as part of the prenatal visit.
10. Folic acid supplements for women who are planning to become pregnant or capable of pregnancy, containing 0.4 to 0.8 mg of folic acid, covered only if the woman obtains a prescription.
11. Gonorrhea screening for all sexually active women, including those who are pregnant, if they are at increased risk for infection (i.e., young or have other individual or population risk factors). The plan will pay for the most cost-effective test methodology only.
12. Hepatitis B screening for pregnant women at their first prenatal visit.
13. Osteoporosis screening for women. Women age 65 and older will be eligible for routine screening for osteoporosis. Routine screening will begin at age 60 for women at increased risk for osteoporotic fractures. The plan will pay for the most cost-effective test methodology only.
14. Rh incompatibility screening for all pregnant women during their first visit for pregnancy related care, and follow-up testing for all unsensitized Rh (D) negative women at 24 – 28 weeks' gestation, unless the biological father is known to be Rh (D) negative.
15. Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users.
16. Syphilis screening for all pregnant women or other women at increased risk.
17. Well-woman visits; screening for gestational diabetes; human papillomavirus (HPV) DNA testing for women age 30 and older; sexually transmitted infection counseling; human immunodeficiency virus (HIV) screening and counseling; FDA-approved contraception methods and contraceptive counseling; breastfeeding support, supplies and counseling; and domestic violence screening and counseling, without charging a Copayment, Coinsurance or Deductible.

Covered Preventive Care for Children

1. Well baby and well child visits from ages newborn through 21 years as recommended for pediatric preventive health care by "Bright Futures/American Academy of Pediatrics." Visits will include the following age-appropriate screenings and assessments:
    a. Developmental screening for children under age three, and surveillance throughout childhood.
    b. Behavioral assessments for children of all ages.
    c. Vision screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than age five years.
    d. Hearing screening.

e. Height, weight and body mass index measurements for children.
   i. Autism screening for children ages 9, 18, and 30 months.
   ii. Alcohol and drug use assessments for adolescents.
   iii. Hematocrit or hemoglobin screening for children.
   iv. Lead screening for children at risk of exposure.
   v. Tuberculin testing for children at higher risk of tuberculosis.
   vi. Dyslipidemia screening for children at higher risk of lipid disorders.
   vii. Sexually transmitted infection (STI) prevention counseling for adolescents at higher risk.
   viii. Cervical dysplasia screening for sexually active females.
   ix. Oral health risk assessment.
2. Newborn screenings:
   a. Hemoglobinopathies or sickle cell screening.
   b. Phenylketonuria (PKU) screening.
   c. Hypothyroidism screening for newborns.
3. Screening for oral fluoride supplementation at currently recommended doses (based on local water supplies) to preschool children older than age 6 months whose primary water source is deficient in fluoride.
4. Screening for iron supplementation for asymptomatic children age 6 to 12 months who are at increased risk for iron deficiency anemia.
5. Oral fluoride supplementation for preschool children older than 6 months whose primary water source is deficient in fluoride.
6. Iron supplementation for asymptomatic children ages 6 to 12 months who are at increased risk for iron deficiency anemia.
7. Obesity screening for children age 6 years and older, and counseling or referral to comprehensive, intensive behavioral interventions to promote improvement in weight status.
8. HIV screening for adolescents at increased risk of infection.

Immunizations

Routine adult immunizations are covered for covered persons who meet the age and gender requirements and who meet the CDC medical criteria for recommendation.

1. Immunization vaccines for adults – doses, recommended ages, and recommended populations must be satisfied:
   a. Diphtheria/tetanus/pertussis (DTP).
   b. Measles/mumps/rubella (MMR).
   c. Poliomyelitis.
   d. Influenza.
   e. Human papillomavirus (HPV).
   f. Pneumococcal (polysaccharide).
   g. Hepatitis A.
   h. Hepatitis B.
   i. Meningococcal.

j. Shingles.

2. Immunization vaccines for children from birth to age 18—doses, recommended ages, and recommended populations must be satisfied:
   a. Hepatitis B.
   b. Rotavirus.
   c. Diphtheria, Tetanus, Pertussis.
   d. Haemophilus influenzae type B.
   e. Pneumococcal.
   f. Inactivated Poliovirus.
   g. Influenza.
   h. Measles/Mumps/Rubella (MMR).
   i. Varicella.
   j. Hepatitis A.
   k. Meningococcal.
   l. Human papillomavirus (HPV).

Physician's Office

Preventive Services are paid for based on the Plan's payment schedules for the individual services. However, there may be limited situations in which an office visit is payable under the Preventive Services benefit. The following conditions apply to payment for in-network office visits under the Preventive Services benefit. Non-network office visits are not covered under the Preventive Services benefit under any condition.

1. If a preventive item or service is billed separately from an office visit, then the Plan will impose cost sharing with respect to the office visit.
2. If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is the delivery of such preventive item or service, then the Plan will pay 100% for the office visit.
3. If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is not the delivery of such preventive item or service, then the Plan will impose cost sharing with respect to the office visit.

Well child annual physical exams recommended in the Bright Futures Recommendations are treated as Preventive Services and paid at 100%.

Preventive Care Limitations and Exclusions

1. Preventive Care is covered when performed for preventive screening reasons and billed under the appropriate preventive services codes. Plural services covered for diagnostic reasons are covered under the applicable plan benefit, not the Preventive Services benefit. A service is covered for diagnostic reasons if the covered person had symptoms requiring further diagnosis or abnormalities found on previous preventive or diagnostic studies that required additional examinations, screenings, tests, treatment, or other services.

2. Care covered as a Preventive Service is not payable under other portions of the Plan.

3. The Plan will use reasonable medical management techniques to control costs of the Preventive Care. The Plan will establish treatment, setting, frequency, and medical

management standards for specific Preventive Services, which must be satisfied in order to obtain payment under Preventive Care.

4. Immunizations are not covered, even if recommended by the CDC, if the recommendation is based on the fact that some other risk factor is present (e.g., on the basis of occupational, lifestyle, or other indications). Travel immunizations, e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus, are not covered.
5. Examinations, screenings, tests, items or services are not covered when they are investigational or experimental, as determined by the Plan.
6. Examinations, screenings, tests, items, or services are not covered when they are provided for the following purposes:
   a. When required for travel, insurance, marriage, adoption, or other non-medical purposes;
   b. When related to judicial or administrative proceedings;
   c. When related to medical research or trials; or
   d. When required to maintain employment or a license of any kind.
7. Drugs, medicines, vitamins, and/or supplements, whether available through a prescription or over-the-counter, are not covered under the Preventive Services benefit. For example, the following drugs, medicines, vitamins, and supplements are not covered:
   a. Aspirin (except for adults of certain ages who are at increased risk of cardiovascular disease and for pregnant women at increased risk of preeclampsia),
   b. Chemoprevention for any indication, including but not limited to for breast cancer; and
   c. Supplements, including but not limited to oral fluoride supplements and folic acid supplements (except for women who are planning to become pregnant or capable of pregnancy, containing 0.4 to 0.8 mg of folic acid, and only if the woman obtains a prescription).

Hospital Care

The Plan will pay for Hospital care when the treatment cannot be provided in a more cost-effective environment, such as an In-Network outpatient surgical center, a doctor's office or other type of outpatient clinic. Expenses from products and services, received in a Hospital must be Medically Necessary and not exceed what is a Reasonable and Customary charge. You are responsible for any amount remaining. In addition, **all non-emergency in-patient expenses at a non-network facility are not covered.** See the definition of an Emergency Medical Condition to see when non-network inpatient expenses are covered.

Mental Health and Substance Abuse Care

Mental Health Care is a benefit of the Medical Plan. The same annual Deductible, Coinsurance, and annual Out-of-Pocket Maximum apply.

Individual practitioners, employed and credentialed by programs accredited by The Joint Commission Accreditation of Healthcare Organizations are considered In-Network providers when performing functions directed by the program and indicated as clinically necessary in the patient's assessment and treatment planning. In addition, you may receive coverage for counseling services provided by an individual therapist certified by the Iowa Board of Substance Abuse Certification (IBSAC) or an equivalent board in the state in which the

services are provided. The individual therapist must be a licensed social worker, licensed mental health counselor, licensed psychologist, or licensed physician.

The Plan will cover Medically Necessary inpatient treatment for Mental Health and Substance Abuse Conditions in a network facility only (unless due to an emergency).

The Plan pays for inpatient treatment in the same way hospitalization is covered under the Medical benefit.

An Employee may receive Weekly Income benefits while receiving inpatient mental health treatment.

Surgical Care

The Plan pays charges for major medical expenses associated with serious illness, hospitalization and surgery. After you pay the Deductible, the Plan will share the remainder of the cost of expenses such as:

1. Preoperative exams;
2. Organ transplants;
3. Surgical treatment of sleep-related conditions; and
4. Serious illnesses such as heart disease or cancer;
    a. Including the medical and surgical benefits in connection with a mastectomy; and
    b. In compliance with federal law, the Plan provides benefits for certain reconstructive breast surgery the same as other medical and surgical benefits. This covers reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance and prostheses and physical complications of all stages of mastectomy, including lymphedemas.

Hospice Care

The Plan will pay for covered Hospice care charges for up to a maximum of 210 days.

Before a person is eligible to receive Hospice care, the following conditions must be met:

1. The covered person has a life expectancy of six months or less;
2. The charges are incurred at a Hospice Care program certified as such under the Federal Medicare Program or by the Joint Commission on Accreditation of Healthcare Organizations;
3. A written Hospice care plan is drafted by the program and approved by the covered person's treating physician, who agrees to work with the program in implementing the plan;
4. The plan provides for Hospice care to be provided to the covered person at home, rather than in a Hospital, nursing home, or other facility; and
5. The program agrees to accept the Hospice care benefits provided under this Plan as payment in full for services and supplies provided to the covered person.

Covered Hospice care charges are limited to the Reasonable and Customary Charges for the following services:

1. Nursing care provided by or under the supervision of a registered nurse;
2. Physical, occupational, and speech therapy;

3. Medical social services, if under the direction of a physician;
4. Personal care services and household services needed to maintain a safe and sanitary environment, but only if not provided by a person who ordinarily resides in the covered person's household or who is a member or the covered person's family;
5. Drugs, medical supplies, and the use of medical appliances or durable medical equipment;
6. Physician services;
7. Short-term inpatient care in an appropriate inpatient facility ("crisis care") but only on an intermittent, non-routine, and occasional basis, and for no more than five (5) consecutive days; and
8. Counseling for members of the covered person's family with respect to care of the terminally ill individual and the adjustment to his death.

Dental Care

The Plan’s Medical benefit covers the following Dental services when provided by a physician or Dentist:

1. Treatment of natural teeth resulting immediately and exclusively from an injury;
2. Cutting procedures for the treatment of diseases of the teeth, jaw, or gums;
3. Removal of impacted teeth;
4. Treatment of fractures and dislocation of the jaw; and
5. Charges for the extraction of teeth, fillings, dentures, or straightening of teeth or other dental services not specifically described in this paragraph, including other care or treatment related to the mouth, teeth, gums, or jaws (such as treatment of temporomandibular joint syndrome, also known as TMJ) are specifically excluded from coverage under the Comprehensive Medical Benefits Program. This means these expenses will not be paid under this portion of the Plan. Any such services will be covered under this Plan, if at all, only under the Dental Benefits Program.

Additional Expenses the Medical Plan Will Pay

1. Physician, physician assistant, and nurse. Charges for diagnosis and treatment of Sickness and injury. This includes both medical and surgical treatment, but does not include any chiropractic or alternative treatment. Diagnosis and treatment is covered whether performed at a doctor's office, clinic, other outpatient facility, or a Hospital or other facility.
2. Professional anesthesiologist.
3. Diagnostic services. Including x-ray and laboratory services in connection with a Sickness or injury.
4. Inpatient pharmaceuticals. Including charges for drugs, biologicals, supplies and other items (including oxygen and blood or blood products) administered by a properly licensed or certified health care provider at a Hospital or other medical facility.
5. Medical or surgical treatment of a covered Sickness or injury, and for the supplies necessary for such treatment. Covered items include but are not limited to physical therapy, radiation therapy, physical rehabilitation, cardiac rehabilitation, or respiratory therapy or rehabilitation so long as the treatment or therapy is administered by a properly licensed or certified health care provider, is prescribed by a physician, is medically necessary, and is generally recognized as an appropriate and reasonable treatment by physicians specializing in the area of medicine implicated by treatment.

6. Services provided by certified nurse midwives in a hospital setting.
7. Mastectomy related benefits. Will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits under this Plan and are not subject to a separate Deductible. The specific services described in this Section are deemed Medically Necessary. For these benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:
   a. All stages of reconstruction of the breast on which the mastectomy was performed;
   b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
   c. Prostheses; and
   d. Treatment of physical complications of the mastectomy, including lymphedemas.
8. Vasectomy, subject to the same deductibles and coinsurance as any other medical and surgical benefits.

Expenses the Medical Plan will not pay

Notwithstanding any other provision of this Plan, covered charges will not include any of the following expenses:

1. Services or treatment in excess of the Allowed Amount. The Allowed Amount is the negotiated amount of Covered Charges charged by an In-network provider for each service or product. For Out-of-network providers, it is the lesser of the billed amount or the amount as determined by the Claims Administrator and the Fund's Preferred Provider Network, which may be calculated by the Fund's Preferred Provider Network using several methods. You are responsible for any charges in excess of the Allowed Amount;
2. Hospitalization or medical or surgical treatment provided at no charge to the Claimant or paid for by any government agency;
3. Expenses related to an injury or Sickness cause by war or any act of war;
4. Expenses related to an injury or Sickness incurred while engaged in the service of the armed forces of any nation or state;
5. Expenses which you are not required to pay;
6. Routine physical or screening examinations, except as specifically provided under the Preventive Benefit;
7. Expenses for injuries which occurred on the job and are to be covered by Workers Compensation insurance;
8. Expenses resulting from a motor vehicle accident wherein there is insurance in place for medical expenses;
9. Expenses resulting from a court order;
10. Medical or surgical treatment rendered for cosmetic purposes;
11. Services and supplies that are not Medically Necessary;
12. Expenses in which there is third party liability (e.g., Workers Compensation or motor vehicle accident);
13. Expenses that occur due to non-compliance with primary insurance guidelines;
14. Services or supplies that are experimental or do not meet accepted standards of medical practice;
15. Supplies or equipment for personal hygiene, comfort, or convenience, such as telephone, television, cosmetics, wigs, guest trays, magazines, beds or cots for family

members or other guests, travel and lodging, air conditioners, humidifiers, dehumidifiers, allergy air filters, physical fitness or exercise equipment, water beds, hot tubs, or swimming pools;

16. Medical or surgical treatment or examination required by an Employer as a condition of employment;
17. Charges made for confinement in a nursing home, long-term care facility, or any facility primarily providing personal care, assisted living, and/or general custodial services, rather than acute medical care;
18. Any expense that is not incurred (an expense is incurred at the time the service or supply is actually provided) while the Covered Person is covered under this Plan, unless a Plan provision specifically provides otherwise;
19. Speech therapy, unless it is required because of a physical impairment caused by a disease or injury;
20. Services performed by a chiropractor, which is limited to $1,000 per year and paid through the HRA only;
21. Dental treatment, except as otherwise specifically provided under the provisions of this Plan;
22. Actual or attempted impregnation or fertilization, involving a covered person or a surrogate as a donor or recipient;
23. Diagnosis or treatment of infertility or for any treatment of sexual dysfunction that is not caused directly by a Sickness or injury;
24. Surgical procedures related to weight loss such as gastric banding, gastric bypass, and LAP-BAND;
25. Expenses incurred by a Dependent child in connection with her pregnancy, the birth of her child, or complications arising from either;
26. Failure to keep a scheduled visit, charges for completion of a claim form or charges for medical information;
27. Expenses incurred for services performed and supplies furnished by a person other than a physician unless specifically included (i.e., routine eye examination by optometrist);
28. Radial keratotomy (Lasik);
29. Voluntary abortions, except that the Plan will cover complications of abortion for Employees or their spouses;
30. Acupuncture, acupressure, hypnosis, or for massage therapy;
31. Loss or change of sexual function, sex transformation, or any treatment related to sexual dysfunction or inadequacy;
32. Surgical procedure to implant an artificial mechanical device designed to replace a human organ, other than a pacemaker or similar device which merely assists rather than replaces the function of the organ;
33. Home construction or conversion of motor vehicles to accommodate a Disabled person;
34. Occupational therapy, unless it is required to restore a physical function;
35. Education, special education, job training, or work hardening, whether or not given in a facility that also provides medical or psychiatric treatment and regardless of the type of education, the purpose of the education, the recommendation of the attending physician, or the qualification of the individual rendering the educational services;
36. Services of a medical social worker except as specifically provided in the Mental Health benefit of this Plan;

37. Therapeutic devices and appliances (i.e., hypodermic needles, syringes, support garments, bandages, or other non-medical substances), regardless of their intended use, except when required for insulin injection;
38. Injury or Sickness resulting from participation in a public disturbance or riot or resulting from the commission of a felony, except that the Plan will cover injuries or Sickness arising from acts of domestic violence;
39. Injury or Sickness resulting from voluntary acceptance of extraordinary risks (i.e., sky diving, speed contests, or fighting) unless a sanctioned event;
40. Equipment which does not significantly enhance the medical management of patient care;
41. Treatment or service for or in connection with marriage or family counseling or group therapy;
42. Self-help programs;
43. Treatment or services for primal therapy, Rolfing, psychodrama, megavitamin therapy, bioenergetic therapy; vision perception training, or carbon dioxide therapy;
44. Genetic testing and counseling, except for counseling and BRCA testing for women with an increased risk of breast cancer, which is covered as Preventive Care;
45. The cost of Durable Medical Equipment supplies, (e.g., filters, tubes, hoses, masks, or humidifiers for CPAP machines) or maintenance when the Plan already paid the purchase price for that item;
46. A claim that is older than one year from date of service;
47. Treatment of pathological gambling addiction;
48. Expenses which arise from subsequent treatments or complications related to any exclusion under this Plan,
49. Taxes, shipping or service charges, and
50. Over-the-counter items.

Additional Coverage

24-Hour Online Doctor

- You have quick and easy access to a doctor wherever you are, 24 hours a day, seven days a week, 365 days a year. The online service, provided in partnership with Anthem BlueCross BlueShield, is called *LiveHealth Online®*. If you or a family member is under the weather, getting a private, secure and convenient online medical visit through LiveHealth Online is a great option when you are away from home or your doctor is unavailable. LiveHealth Online doctors can answer medical questions, make a diagnosis and even prescribe medication for you, if needed (except in certain states). They can help with minor injuries and common medical ailments like colds, flu symptoms, fevers, allergies, infections, headaches, sore throats, minor rashes and earaches.
- You can save time and get the care you need without having to schedule a doctor's appointment or be exposed to other sick people while sitting in a doctor's waiting room. Moreover, it's faster and cheaper than going to an emergency room or urgent care facility.
- The Plan covers 100% of the cost each time you visit a doctor through LiveHealth Online. The deductible will not apply to LiveHealth Online visits and each online session generally lasts about 10 minutes.
- You can connect directly with LiveHealth Online board-certified doctors face-to-face using a computer with a webcam or through your mobile device. You can access LiveHealth Online from your Android or iOS mobile device by downloading the free app. On your computer, you can go to livehealthonline.com.
- We recommend that you go online or open up the app and enroll in LiveHealth Online at your earliest convenience. That will save you time when you need to talk to a doctor. And, if you don't enroll, your online session will not be covered by the Fund. If you enroll correctly, the site will bill the Plan and you should not be asked for any payment information. Do not enter any credit card information.

Physical Therapy Coverage

The Plan will pay a percentage of each visit to a physical therapist. Refer to the *Schedule of Benefits* for Coinsurance information.

If you exceed 20 visits in a calendar year, your physical therapist must submit a course of treatment in writing to the Fund Office for the additional visits, including a treatment plan, progress notes, and why the extra visits are medically necessary. When the Fund Office does not have your written course of treatment on file, or if you see the therapist for treatment outside of the written course of treatment, the Plan will not cover those treatments.

Durable Medical Equipment Coverage

The Medical Plan covers durable medical equipment. The Plan will pay purchase price and/or maintenance only once per item. Durable Medical Equipment means equipment, devices or supplies that:

1. Are certified, in writing, by the prescribing physician as necessary in the treatment or rehabilitation of a handicapped person;
2. Are clearly related to and necessary for the treatment, rehabilitation or training of persons with a specified handicap;
3. Improve the function of a malformed body part or retard further deterioration of the handicapped person's condition;
4. Would not be necessary in the absence of a physical or mental Disability;
5. Are primarily and customarily used to serve a medical or rehabilitative purpose rather than primarily for transportation, comfort or convenience;
6. Are not beyond the appropriate level of performance and quality required under the circumstances (i.e., non-luxury, non-deluxe); and
7. Are appropriate for and intended for use in the home.
8. Durable Medical Equipment includes, but is not limited to:
   a. Artificial limbs or eyes to replace natural limbs or eyes;
   b. Surgical dressings and bandages;
   c. Splints;
   d. Trusses;
   e. Casts;
   f. Braces;
   g. Crutches; and
   h. Rental, up to purchase price, of Hospital type beds, wheelchairs, ventilators or other durable medical equipment requiring a physician's order.

The Plan covers charges for deluxe items only up to the cost of standard items. In addition, expenses for special fittings, adaptations, or maintenance agreements for Durable Medical Equipment are not covered.

The Plan will pay for charges for the rental or purchase (whichever costs less) of certain medical supplies and durable medical equipment prescribed by a physician, subject to the following:

1. Covered supplies must be Medically Necessary for the treatment of a Sickness or injury.
2. No payment will be made under the Plan for supplies that have the principal purposes of an individual's convenience or general comfort. Benefits are not available under this Program for therapeutic devices or appliances (i.e., hypodermic needles, syringes, support garments, bandages, or other non-medical substances), regardless of their intended use, except when required for insulin injections.
3. Any charge in excess of the lesser of the cost for renting or purchasing the necessary equipment will not be calculated into the determination of the Allowable Charge for medical supplies or durable medical equipment.
4. Benefits are not available under this Plan for medical equipment used, rented, or purchased for use during a patient's confinement in a Hospital, skilled nursing facility, intermediate care facility, nursing home, or any other facility.

None of the limitations provided in this Section will be deemed to limit coverage for supplies and equipment necessary for the treatment of diabetes.

Emergency Room Coverage

You will receive a charge, in addition to your Medical Plan annual Deductible and Coinsurance, when you receive care in an emergency room. When you are admitted to the Hospital within 24-hours of receiving care in the emergency room, the charge will be waived.

Ambulance Service Coverage

The Plan will pay for Ambulance Service to:

1. Transport the covered person to the nearest appropriate facility for care of an emergency medical condition; and
2. Transfer a covered person who has received emergency care or who is an inpatient at an acute care facility to the nearest appropriate facility where appropriate care can be provided.

When an Out-of-Network Ambulance Service is necessary as the result of an emergency, the Plan will pay a percentage of the Reasonable and Customary Charge after you pay the Out-of-Network Deductible. You are responsible for the remaining charges. Refer to the *Schedule of Benefits* for the Coinsurance and Deductible.

Sleep Treatment Coverage

During his or her lifetime, a covered Participant can receive sleep treatment, up to the Plan maximum. This includes sleep studies and office visits. Any surgical treatment of sleep-related conditions will be covered under the major medical section of the Plan, so long as the surgery is Medically Necessary. If you require durable medical equipment as part of your treatment, these are covered under the Durable Medical Equipment benefit (see page 43).

Organ Transplant Coverage

The Plan will cover human organ transplant expenses that are Reasonable and Customary charges incurred for the following:

Expenses incurred by a recipient for:

1. The use of temporary mechanical equipment while the recipient is waiting for a "matched" human organ;
2. Multiple transplants during one operative session;
3. Replacement(s) or subsequent transplant(s); or
4. Follow-up expenses for covered services (including immunosuppressant therapy) provided while the Recipient is hospitalized.

Expenses incurred by a donor for:

1. Testing to identify suitable donor(s);
2. The expense for the acquisition of organ(s) from a donor;
3. The expense for life support of a donor pending the removal of usable organs; or
4. Transplant of organ(s) or a donor on life support.

Expenses incurred by a Recipient for covered expenses associated with the transplants (including immunosuppressive therapy) that are incurred after discharge from the Hospital in which the transplant occurred.

Covered expenses under the transplant benefit are included with other covered expenses to determine if the Deductibles and limitations under the Comprehensive Major Medical Expense Benefit have been met.

All of the exclusions listed in the Exclusions section of this document apply to Transplant benefits. Transplant benefits are also subject to the following exclusions:

1. Organ transplants are excluded unless there is medical documentation that conventional treatment could be unsatisfactory, unavailable, and/or more hazardous than a transplant;
2. Any animal organ or mechanical equipment, device or organ (other than for temporary usage as described above);
3. Any monetary payment to the donor other than for an expense incurred in the performance of or in relation to transplant surgery. Expenses are considered incurred on the date the service or supply is received; and
4. Human organ transplants that are in excess of Reasonable and Customary Charges.

HEARING COVERAGE

The Hearing Coverage will pay the following products and services:

1. Physical examination by either an otologist or otorhinolaryngologist; and
2. Test of hearing ability and condition by an otologist or otorhinolaryngologist or a licensed audiologist.

The Hearing Coverage will *not* pay the following products and services:

1. Services or supplies provided by a licensed audiologist which are not prescribed by an otologist or otorhinolaryngologist;
2. Charges for hygienic cleaning of the hearing aid; or
3. Batteries and their installation.

The cost of the hearing aid is covered under the Hearing Aid Benefit – a maximum per person, per four years. Refer to the *Schedule of Benefits*.

HEARING AID BENEFIT

The Plan covers the cost of a hearing aid, up to the Hearing Aid Benefit maximum, per four-year period, for each covered person. The four-year period is determined from the date you initially purchase a hearing aid. When expenses reach the Hearing benefit maximum, you are responsible for the remaining cost.

Benefit includes fitting and purchase of a hearing aid, if required, which includes expenses for the manufacture of ear molds by an otologist, otorhinolaryngologist or a licensed audiologist (covered in accordance with the Plan's Coinsurance).

Refer to the *Schedule of Benefits* for the Hearing Aid Benefit four-year maximum.

Prescription Drug Benefit

Using your prescription drug card at retail pharmacies at the time of your prescription purchase ensures that you receive the lower negotiated rate for your prescription drugs. If you do not show your prescription drug card at the time of purchase, you will be responsible for the full cost of your prescription.

1. When you purchase a generic alternative, you pay 20% and the Plan pays 80% of the cost;
2. When you purchase a brand name drug because a generic alternative *is not* available, you pay 20% and the Plan pays 80% of the cost; and
3. When you purchase a brand name drug when a generic alternative *is* available, you pay 20% and the Plan pays 80% of the cost for the generic alternative. In addition to 20% of the generic, you will be responsible for paying the difference in cost between the brand name and the generic alternative.
4. Your prescription drug out-of-pocket expenses are limited to an annual maximum. If you reach the annual out-of-pocket maximum, the Plan pays 100% of the cost of your prescription drugs. Refer to the *Schedule of Benefits* for the annual out-of-pocket maximum amount.
5. Smoking cessation prescription drug products will be covered at 100% for a 90-day supply up to twice each year.
6. Prescription prenatal vitamins for pregnant women are covered.
7. Prescription drugs related to human immunodeficiency virus (HIV) are covered.
8. FDA approved contraceptives are covered at 100%.

PRESCRIPTION DRUG CLASSES NOT COVERED

1. Non-sedating antihistamines (such as Clarinex, Zyrtec, Allegra);
2. Proton pump inhibitors (such as Prilosec, Nexium), unless prescribed for the treatment of cancer of the mouth, throat, esophagus or stomach, or prescribed for post-surgical treatment, or when medically necessary and prescribed in the suspended or solutab form through age 7;
3. Non-steroidal anti-inflammatory drugs (such as Celebrex) unless approved under prior authorization;
4. The class of drugs known as PCSK9 drugs for lowering LDL (“bad”) cholesterol; and
5. Statins (except for adults aged 40-75, with cardiovascular disease risk factors).

Dental Benefit

The Dental benefit pays 100% of Preventive dental services. This includes expenses incurred for an examination and cleaning by a dentist, up to two per year. These services are not subject to any Deductible, Coinsurance, or Dental benefit maximum.

The Plan also pays 100% of restorative procedures (i.e., dentures, bridges, and repair of pre-existing devices). For covered persons under age 19, preventive and restorative services do not accumulate toward the Plan's maximum.

Refer to the *Schedule of Benefits* for the Coinsurance and Plan Maximum for the Dental benefit.

INCLUDED IN DENTAL COVERAGE

Covered services are the Reasonable and Customary Charges incurred for the following services:

1. A dental examination and cleaning by a dentist, up to two per year;
2. One bitewing x-ray per year;
3. A full mouth series or panoramic x-ray once every five years;
4. Topical fluoride once per year, up to the 19th birthday for a Dependent;
5. Sealants for Dependents up to the 19th birthday for a Dependent;
6. Restorative procedures;
7. Periodontal;
8. Endodontic;
9. Dentures;
10. Bridges;
11. Repair of pre-existing devices; and
12. Extractions.

EXCLUDED FROM DENTAL COVERAGE

No expenses are payable under this benefit for the following:

1. Fluoride treatment for individuals past the 19th birthday;
2. Occlusal guards;
3. Occlusal adjustments;
4. Occlusal wear;
5. Occlusal x-rays;
6. Pulp test;
7. Apesi tray;
8. Bleaching;
9. Whitening;
10. Hygiene tips;
11. Over-the-counter items such as toothpaste, toothbrushes, mouth rinse, etc.;
12. Enamel microabrasions plaque control; and

13. Facial photographs and diagnostic casts.

Additionally, any expenses over the maximum amount allowed under the benefit will not be considered a covered charge or expense under any other benefit provision of the Plan, including the Medical Plan.

ORTHODONTIA BENEFIT

The Orthodontia benefit is available only to Dependent children, of an Active Employee under age 19.

You and the Plan share the cost up to the Plan maximum. When expenses reach the Plan maximum, you are responsible for the remaining cost. You may use your HRA to reimburse orthodontic expenses up to the maximum amount shown in the *Schedule of Benefits*.

Covered expenses under this benefit include the Reasonable and Customary Charges incurred for treatment for the proper alignment of the teeth. Refer to the *Schedule of Benefits* for the Coinsurance and Plan Maximum for the Orthodontia benefit.

Vision Benefit

The Plan covers expenses incurred for routine vision care, up to the Vision benefit's annual maximum, per covered person. When expenses reach the Plan maximum, you are responsible for the remaining cost. Separate from the Plan's Vision benefit maximum, there is a $1,000 annual maximum (per person/per calendar year) that is reimbursable from the HRA.

Refer to the *Schedule of Benefits* for the Plan Maximum for the Vision benefit.

The Vision benefit will pay the following products and services:

1. Eye examination by either an ophthalmologist or optometrist;
2. Refraction;
3. Prescription glasses; and
4. Contacts.

The Vision benefit will *not* pay the following products and services:

1. Eye examination required by any Employer as a condition of employment;
2. Extra charges for glasses with tinted lenses, unless prescribed by an optometrist or ophthalmologist as Medically Necessary;
3. Non-prescription sunglasses;
4. Special or unusual procedures such as (but not limited to) orthoptics, vision training, subnormal vision aids, aniseikonic lenses, and tonography;
5. Vision examinations rendered and lenses or frames ordered before a person became eligible for vision benefits under this Plan;
6. Lenses or frames ordered while a person is covered under this Plan which are not delivered until 61 days or more after coverage terminates under this Plan;
7. Lasik surgery,
8. Warranties, taxes, shipping and/or service fees, and
9. Over-the-counter supplies, such as cases, cleaners, and accessories.

Claims and Appeals

FILING A CLAIM

File your claim with the Plan Administrator at:

2501 Bell Avenue
Des Moines, IA 50321.

No communication with or inquiry to the claims administrator or the Fund Office will be construed as an attempt to file a claim for benefits unless it contains at least:

- Name of covered person;
- Medical condition or symptom; and
- Treatment, service, or product for which approval is requested.

The Plan Administrator shall not have any obligation to solicit further information from a covered person unless the communication or inquiry received can reasonably be construed as an attempt to submit a claim for benefits.

If you are filing a claim, you must include:

- The provider's billing statement and receipt, if applicable;
- Name and Member Identification Number of the Employee or Retiree;
- Name and date of birth of the patient and relationship to the Employee or Retiree;
- Date or dates the health care service or treatment was provided;
- Name, billing address, and taxpayer identification number of the provider;
- Type of treatment or service provided;
- Number of units (for anesthesia and certain other claims);
- Diagnosis for which the treatment or service was provided;
- If accident, the details of the accident;
- Information about other insurance coverage available to the patient;
- Billed charge; and
- Signature of both the patient or his designated representative and the health care provider.

No communication with any person, including the Plan Administrator, a member of the Board of Trustees, or any other person who may otherwise have authority to act on behalf of the Plan, will constitute an authoritative declaration of Plan benefits available. Neither this document nor any other communication may be relied upon as a guarantee of benefits. A final determination on coverage and payment cannot be made until a formal claim is filed and properly acted upon in accordance with these rules. Only a written notification from the Plan Administrator (in the form of an Explanation of Benefits or other written notice) will constitute notice of a benefit determination.

When a claim is submitted, it will be determined if you are eligible for benefits and the amount of benefits due will be calculated. All claims will be processed promptly after complete claim information is received.

Health Care Claims

The Plan will make a determination within 30 days of receiving the claim. If the Plan needs more time, due to matters beyond its control, the Plan will provide you written notification within 45 days. If the Plan needs you to provide additional information, the 45-day period will be suspended and the Plan will contact you. You will have 45 days from receipt of the notice to provide the requested information. Within 45 days of receiving the additional information from you, the Fund will determine payment.

Benefits payable for medical charges may be paid directly to the Hospital, laboratory, physician or other person rendering the services to the covered person. The Plan will deny claims older than one year from the date of service.

Disability Claims

The Plan will make a determination within 45 days of receiving the claim. If the Plan needs more time, due to matters beyond its control, the Plan will provide you written notification within 45 days. The Plan may extend the initial deadline up to an additional 60 days. However, if the Plan does not make a determination within 75 days, it will notify you. If the Plan needs you to provide additional information, the 45-day period will be suspended and the Plan will contact you. You will have 45 days from receipt of the notice to provide the requested information. Within 45 days of receiving the additional information from you, the Fund will determine payment.

Subject to receipt of proof of a Disability, weekly income benefits will be paid at the expiration of each one-week period. Any balance remaining unpaid upon the termination of the period of Disability will be paid immediately upon the termination of the period of Disability.

Death and Accidental Death Benefit Claims

The Plan will make a determination within 90 days of receiving the claim. If the Plan needs you to provide additional information, the 90-day period will be suspended and the Plan will contact you. You will have 45 days from receipt of the notice to provide the requested information. Within 45 days of receiving the additional information from you, the Fund will determine payment.

The Death Benefit will be paid to the designated Beneficiary(s) on file in the Fund Office upon receipt of proof of death. All claims for the Death Benefit must be accompanied by proof of death, such as a copy of the death certificate.

The Plan provides 90 days in which to file proof of claim. However, no claim will be denied due to failure to file proof of your claim within the time specified if it can be shown that it was not reasonably possible to furnish such proof on time and that it was furnished as soon as possible, except in no event may proof of claim be filed later than 12 months from the time the covered service is provided.

Written Claim Determinations

If the Plan approves and pays 100% of the total billed amount of a claim, the Participant will still receive a notice of benefit determination by the Plan. It is the general policy of this Plan to send an Explanation of Benefits (EOB) for each claim submitted. Only a formal notice of benefit determination, or EOB, shall constitute an official Plan decision as to whether benefits are available, subject to appeal as set forth below. No other communication, whether written or oral, shall constitute a promise to pay or a guarantee of benefits under this Plan.

If a claim is denied, in whole or in part, or if the Plan pays less than the total amount charged, the Plan Administrator will always send the Employee a notice explaining the benefit determination (an Explanation of Benefits, or EOB). The notice will be sent in writing and will set forth:

- Reason for the adverse benefit determination;
- Reference to the specific plan provisions on which the claim determination is based;
- Description of any additional material or information necessary to perfect the claim, and an explanation of why that material or information is necessary; and
- Description of the plan's review (appeals) procedures and the time limits applicable to those procedures, including a statement of the Claimant's right to bring a lawsuit under section 502(a) of the Employee Retirement Income Security Act, as amended (ERISA) following an adverse benefit determination on review.

If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, the notice will either set forth the specific rule, guideline, protocol, or other similar criterion in full, or it will contain a statement that an internal rule, guideline, protocol, or other similar criterion was relied upon in making a determination, and that a copy of the specific rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and, if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limitation, the notice will contain either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or the notice will contain a statement that such an explanation will be provided free of charge upon request.

Notices of benefit determination will be sent within 30 days of receipt of the claim by the Plan Administrator. The Plan Administrator may extend this period up to 15 days, if the Fund Office both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Employee, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision. If such an extension is necessary due to the Employee's failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Employee will be given at least 45 days from receipt of the notice within which to provide the specified information.

A claim will be considered filed with the Fund Office when it is received by the Fund Office, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that the period of time is extended due to the Employee's failure to submit the information necessary to decide the claim, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

FILING AN APPEAL

Within 180 days of receipt of a written notification of Adverse Benefit Determination, the individual whose coverage was wholly or partially denied or their authorized representative may appeal an adverse benefit determination to the Board of Trustees.

The appeal must be made in writing to the Plan Administrator.

Your written appeal must explain the reasons you disagree with the decisions on your claim. You may also submit additional materials with your appeal, including comments, statements, or documents.

The individual appealing the determination is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to their claim.

If you file your appeal on time and follow the required procedures, a new, full, and independent review of your claim will be made. The Board of Trustees will review an appeal and make a determination at its next regularly scheduled Board meeting, unless the request for review is filed within 30 days of that meeting. In such case, the Trustee's review and determination will be made at the second meeting following receipt of the request for review. In such case, the Board of Trustees will provide notice of the extension to the proper individual, describing the special circumstances and the date as of which the determination will be made.

An appeal will be considered filed with the Board of Trustees when it is received by the Plan Administrator, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that the period of time is extended due to the failure to submit the information necessary to decide the claim, the period for making the benefit determination will be tolled from the date on which the notification of extension was sent until the date on which the Employee responds to the request for additional information.

An Employee appealing an Adverse Benefit Determination may request to appear in person at the Trustee meeting at which the Trustees will review the claim. The request must be made in writing to the Plan Administrator. If the Board of Trustees determines it is beneficial for the Employee to attend the meeting, the Plan Administrator will notify the Employee of the date, time and location to appear.

The Board of Trustees will review each claim de novo, which means that the Trustees will consider the claim and make its determination without giving deference to the initial Adverse Benefit Determination by the Plan Administrator. If the appeal is based in whole or in part on a medical judgment, including determination with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Board of Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. All medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial Adverse Benefit Determination will be identified, without regard to whether the advice was relied upon by the Plan Administrator in making the benefit determination so that the health care professional consulted by the Board will be neither the individual consulted in connection with the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.

The Board of Trustees will notify the Employee, in writing, of its determination, within five days after the determination is made. In the case of an Adverse Benefit Determination, the notification will set forth the specific reason for the adverse determination, referencing the specific Plan provisions on which the determination was based. In addition, the notification will state that you are entitled to receive, upon request to the Fund Office and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. Whether a document, record or other information is relevant to a claim for benefits is discussed above.

If the Board of Trustees states in its notification that it relied upon an internal rule, guideline, protocol, or other similar criterion in making its Adverse Benefit Determination, the notification will include such rule, guideline, protocol, or other criterion or will state that the Employee may request a copy of such rule, guideline, protocol, or other criterion from the Plan Administrator, which will be provided to the Employee free of charge. If the Board of Trustees based its Adverse Benefit Determination on a medical necessity or experimental treatment or similar exclusion or limit, the notification will include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or a statement that such explanation will be provided free of charge upon request to the Fund Office.

OTHER RESOURCES TO HELP YOU

For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). Additionally, a consumer assistance program may be able to assist you at Iowa Consumer Advocate Bureau, 330 Maple St., Des Moines, IA 50319-0065, (877) 955-1212 or http://www.insuranceca.iowa.gov, or e-mail to insuranceca@iid.iowa.gov.

External Review of Claims

This external review process is intended to comply with the Affordable Care Act (ACA) external review requirements. For purposes of this section, references to “you” or “your” include you, your covered Dependent(s), and you and your covered Dependents’ authorized representatives; and references to “Plan” include the Plan and its designees.

You may seek further, external review by an Independent Review Organization ("IRO"), if your appeal of a health care claim or post-service claim, including a claim under the HRA plan, is denied and it fits within the following parameters:

1. The denial involves medical judgment, including but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational. The IRO will determine whether a denial involves a medical judgment; and/or
2. The denial is due to a rescission of coverage (retroactive elimination of coverage), regardless of whether the Rescission has any effect on any particular benefit at that time.

Generally, you may only request external review after you have exhausted the internal claims and appeals process described above. This means that, in the normal course, you may only seek external review after a final determination has been made on appeal.

External Review of Standard Claims

Your request for external review of a standard claim must be made, in writing, within four months of the date that you receive notice of an initial claim benefit determination or adverse appeal claim benefit determination. For convenience, these determinations are referred to below as an "adverse determination," unless it is necessary to address them separately.

Preliminary Review of Standard Claims

1. Within five business days of the Plan's receipt of your request for an external review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:
    a. You are/were covered under the Plan on the date the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan on the date the health care item or service was provided;
    b. The adverse determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan; your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination; or to a failure to pay causing a retroactive cancellation of coverage.
    c. You have exhausted the Plan's internal claims and appeals process; and
    d. You have provided all of the information and forms required to process an external review.

2. Within one business day of completing its preliminary review, the Plan will notify you in writing as to whether your request for external review meets the above requirements for external review. This notification will inform you:
   a. If your request is complete and eligible for external review; or
   b. If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).
   c. If you submit an incomplete request, the notice will describe the information or materials needed to complete the request, and allow you to perfect (complete) the request for external review within the four-month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

Review of Standard Claims by an Independent Review Organization (IRO)

1. If the request is complete and eligible for an external review, the Plan will assign the request to an IRO. (Note that the IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IROs with which it contracts.) Once the claim is assigned to an IRO, the following procedure will apply:
   a. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, you are to submit such information within ten business days).
   b. Within five business days after the external review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its Adverse Determination.
   c. If you submit additional information related to your claim to the IRO, the assigned IRO must, within one business day, forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review.
2. However, if upon reconsideration, the Plan reverses its Adverse Determination, the Plan will provide written notice of its decision to you and the IRO within one business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.
   a. The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

b. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating (attending) health care providers, other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).
c. The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives the request for the external review.

3. If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.
4. If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).
5. The assigned IRO's decision notice will contain:
   a. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, health care provider, claim amount (if applicable), diagnosis code and its corresponding meaning, and treatment code and its corresponding meaning, and reason for the previous denial);
   b. The date that the IRO received the request to conduct the external review and the date of the IRO decision;
   c. References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;
   d. A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;
   e. A statement that the IRO's determination is binding on the Plan (unless other remedies may be available to you or the Plan under applicable State or Federal law);
   f. A statement that judicial review may be available to you; and
   g. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

Privacy and Security Policy

The Plan is required to protect the confidentiality and security of your private health information (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services.

You may find a complete description of your rights under HIPAA in the Plan's Privacy Notice that describes the Plan's privacy policies and procedures and outlines your rights under the privacy rules and regulations.

Your rights under HIPAA include the right to:

- Receive confidential communications of your health information, as applicable;
- Copy your health information;
- Receive an accounting of certain disclosures of your health information;
- Amend your health information under certain circumstances; and
- File a complaint with the Plan or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

If you need a copy of the Privacy Notice, please contact the Plan's Privacy Official at the Plan Office.

The Plan's Protection of Your Protected Health Information (PHI)

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 that was distributed to you upon eligibility. The privacy notice is available from the Plan Administrator.

1. The Plan will use and/or disclose Protected Health Information (PHI) only to the extent and according to the provisions of the HIPAA Privacy Rule. The Plan does not perform any treatment activities, but may disclose information to health care providers treating an Employee, Dependent or Retiree in order to facilitate the providers' treatment of the Employee. The Plan has a need to use and/or disclose PHI in the course of health care operations and payment activities.
2. The Board of Trustees, as Plan Sponsor, is permitted to use and/or disclose PHI for the purpose of making benefit claim determinations on review. The Board will receive and use only the minimum information necessary to decide the appeal, and will avoid making any disclosure of the information unless necessary to the claim determination, such as for the purpose of obtaining medical, legal, or actuarial advice regarding the claim determination that is being reviewed. When disclosing any such information, the Board will obtain adequate assurance from the party to whom the information is being disclosed that the party will protect the privacy of the information. Any Business Associate agreement entered into between the third party and the Plan will protect the Board of Trustees to the same extent it protects the Plan.

3. The Board of Trustees, as Plan Sponsor, will use and/or disclose PHI when specifically compelled by law, including, but not limited to, court orders and court-ordered warrants, subpoenas or summons issued by a court, grand jury, a government or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits; and pursuant to requests of the Secretary of Health and Human Services (HHS) or his or her designee(s). Unless specifically directed by the governing legal document or authority, the Plan Administrator and other employees of the Plan Administrator will ordinarily respond to legal process compelling the disclosure of PHI, without the necessity of any action on the part of the Plan Sponsor.
4. The Plan will use and disclose PHI as permitted by authorization of the Employee or appointed representative. With an authorization, the Plan will disclose PHI for the purposes related to administration of these plans.
5. The Board of Trustees will release PHI to an authorized representative or another representative only upon receipt of a completed written authorization form that can be obtained from the Plan Administrator.
6. The Board of Trustees is further permitted to use and disclose de-identified or summary health information for the following purposes, and is permitted to use and/or disclose individually identifiable health information in connection with the following activities only when the Board is unable to carry out its responsibility to administer the Plan without the particular individually identifiable health information being requested.
7. The Plan may make certain medical information available through online access. In lieu of paper statements, participants, beneficiaries, and/or retirees of the Plan may elect to retrieve electronic Explanation of Benefits statements (EOBs) detailing the medical treatments and services paid by the Plan on their behalf through online server access. Any such electronic disclosure must meet the requirements of 29 C.F.R. Part 2520.104b-1 and must be reasonably calculated to ensure actual receipt of the material by Plan participants, beneficiaries, and/or retirees.
    a. Once maintained or submitted electronically, such PHI shall become Electronic Protected Health Information (e-PHI). The Plan shall continue to adhere to all applicable HIPAA Privacy Rule regulations while online access to EOBs is available. In addition, the Plan shall implement reasonable and appropriate measures to ensure the safety of e-PHI, including the use of administrative, technical, and physical safeguards designed to comply with the HIPAA Security Rule at 45 C.F.R. Part 164 *et seq*. In compliance with the HITECH Act, the Plan shall notify affected individuals in the event of a security breach affecting e-PHI within a reasonable time, but in no event shall time extend beyond sixty (60) days following discovery of the breach.
    b. All Business Associates and subcontractors thereof shall be subject to the same restrictions and conditions that apply to the Plan, or its employees, contractors, and third-party administrators, with regard to the maintenance and/or transmission of PHI and e-PHI.

8. Administering the Plan or amending its provisions, including but not limited to:
    a. management activities relating to implementation of and compliance with the requirements of the privacy rule;
    b. customer service, including the provision of data analyses for covered persons, participating Unions, and Contributing Employers, provided that PHI is not provided to the covered persons, Unions, or Employers;
    c. resolution of internal grievances;
    d. the sale, transfer, merger, or consolidation of the Plan with another employee welfare benefit plan, and due diligence related to such activity;
    e. creating de-identified health information or a limited data set;
    f. developing protocols, policies and procedures for the administration of the Plan;
    g. conducting quality assessment and improvement activities;
    h. reviewing the competence of qualifications of health care providers and institutions contracting with the Plan;
    i. actuarial and related activities relating to the creation, renewal or replacement of 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);
    j. conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
    k. business planning and development, such as conducting cost management and planning related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of methods of payment or coverage policies; and
    l. to carry out Payment activities of the Plan that cannot be delegated to the Plan Administrator staff.
9. The Board of Trustees further agrees:
    a. not to use or further disclose PHI other than as permitted or required in the documents governing the Plan or as required by law;
    b. to ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Board of Trustees with respect to the information;
    c. not to use or further disclose the information for employment-related actions and decisions;
    d. not to use or disclose the information in connection with any other benefit or employee benefit plan established pursuant to the collective bargaining agreements that establish this Plan;
    e. to report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
    f. to make available PHI as required by statute or regulation to the extent that the Board of Trustees, rather than the Plan Administrator, has control of any PHI;
    g. to make available PHI for amendment and to incorporate any amendments to PHI as required by statute or regulation, to the extent that the Board of Trustees, rather than the Plan Administrator, has control of any PHI;

h. to make available the information required to provide an accounting of disclosures as required by statute or regulation, to the extent that the Board of Trustees, rather than the Plan Administrator, has control of any PHI;
i. to make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of HHS for purposes of determining compliance with the Privacy Rule by the Plan;
j. if feasible, to return or destroy all PHI received from the Plan that the Board of Trustees still maintains in any form and to retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
k. to ensure that the adequate separation between the Plan and the Board of Trustees as required by statute or regulation is established.

All employees of the Plan Administrator (also known as employees of the Plan), including the Plan Administrator, claims processor(s), and customer service representative(s), do and will have access to PHI in the course of the services they perform for the Plan. These individuals are employed by the Plan itself, and are not employees of the Board of Trustees, that is the Plan Sponsor. No employees of the Board of Trustees, or of any member of the Board of Trustees, will have any access to PHI held by the Plan except as noted previously. All Fund employees will protect the privacy of individually identifiable health information received, created, or maintained in the course of their employment, and will use and/or disclose such information only according to the terms of this Summary Plan Description.

Fund employees, including the Fund Administrator, will have access to covered persons' protected health information only to perform the Plan administration functions that the Fund Administrator provides for the Fund.

Any Fund employee who fails to comply with the preceding paragraph will be subject to the disciplinary procedures and sanctions, up to and including termination of employment or affiliation with the Plan, in appropriate circumstances, as established by the Plan or by the Board of Trustees relating to unauthorized use or disclosure of PHI, for any use or disclosure of Plan Participants' PHI in violation of or noncompliance with the terms and provisions of this Plan.

The Plan will develop and distribute to all participants a Notice of Privacy Practices that will comply with all statutes and regulations, said notice will be approved by the Board of Trustees and will describe the policies and procedures that the Plan will follow with respect to protecting the privacy of PHI.

It is expected that the Board of Trustees will not have a need for access to PHI except in connection with review of an Adverse Benefit Determination or in unusual circumstances. The Board has delegated the daily responsibility for administering the Plan to the Plan Administrator and his or her staff. The Plan Administrator and Plan Administrator staff will carry out their administrative duties on behalf of the Plan, such as claims processing and regular Plan administration, without disclosing PHI to the Board of Trustees unless such a disclosure is necessary, and then will disclose only the minimum information necessary to carry out the purpose of the disclosure to the Board of Trustees, and only according to the terms of the Privacy Rule and this Summary Plan Description.

The following definitions are specific to this Privacy section:

1. Business Associate means a person or entity that provides services to a Plan involving or using PHI, such as consultants, lawyers, network providers and others.
2. Health Plan means an individual or group health plan that provides or pays the cost of medical care. It also includes health insurance issuers, HMOs, Medicare and Medicaid.
3. HIPAA means the Health Insurance Portability and Accountability Act of 1996.
4. HIPAA Privacy Rule or "Privacy Rule" means the Code of Federal Regulations promulgated by the Department of Health and Human Services according to HIPAA.
5. Protected Health Information or "PHI" means individually identifiable health information that:
    a. is created or received by a health care provider, health plan, employer or health care clearing house;
    b. relates to an individual's past, present or future physical or mental health or condition, receipt of health care, or payment for health care; and
    c. identifies the individual or can be reasonably used to identify the individual that is transmitted or maintained in any form or medium.

Sole Authority on Plan Benefits

Under the documents creating the Benefit Fund (and the terms of the Plan), the Trustees have sole discretionary authority to make final determinations regarding eligibility for benefits, the types and forms of benefits, any applications for benefits, the interpretation of the Plan and any administrative rules adopted by the Trustees. Benefits under this Plan will be paid only if and when the Board of Trustees or persons to whom such decision making authority has been delegated by the Trustees, in their sole discretion, decide the participant or covered Dependent is entitled to benefits under the terms of the Plan.

The decision of the Trustees is final and binding and will receive judicial deference to the extent that it does not constitute an abuse of discretion. If a decision of the Trustees is challenged in court, the decision will be upheld unless the court finds that it is arbitrary and capricious. Individual Trustees, Employers, or Union representatives do not have the authority to interpret the Plan on behalf of the Board of Trustees or to act as agents of the Board with respect to interpretation of the Plan. You may only rely on information regarding the Plan that is communicated to you in writing and signed on behalf of the full Board of Trustees either by the Trustees or, if authorized by the Trustees, signed by the Board's designated representative.

You must follow the Plan's claims and appeals procedures before you bring any legal action under the Employee Retirement Income Security Act of 1974 (ERISA) to obtain Plan benefits. You or any other Claimant may not begin any such legal action, including proceedings before administrative agencies, until you have followed and fully exhausted the Plan's claims and review procedures described in this booklet. You may have, at your own expense, legal representation at any stage of the review process. If a provision of the Trust Agreement or the Plan, or any amendment to the Trust Agreement or the Plan, is determined 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 Plan.

General Coordination and Non-duplication of Benefits

The Benefit Plan is designed to help you pay for your health care expenses, including medical, prescription drug, and hearing care. It is not intended that you receive greater benefits than your actual health care expenses. The amount of benefits payable under this Plan will be coordinated with any coverage you or an Eligible Dependent has under other health care plans. Other plans include benefits or services provided by:

- Group, blanket or franchise insurance coverage;
- Service plan contract, group practice, individual practice, and other prepayment coverage;
- Any labor-management Trusteed plans, Union welfare plans, Employer organization plans, or Employee benefit organization plans; and
- Any coverage under governmental programs, including any coverage required or provided by any statute.

This Fund will always pay either its regular benefits in full, or a reduced amount that, when added to the benefits payable on your behalf by other plans, will equal the total regular benefits in full. However, no more than the maximum benefits payable under this Plan will be paid.

Order of Payment

If you or your Eligible Dependent is covered under more than one plan, the primary plan pays first, regardless of the amount payable under any other plan. The other plan, the secondary plan, will adjust its benefit payment so that the total benefits payable does not exceed 100% of covered expenses incurred.

The following rules determine which plan is the primary plan:

- A plan that does not have a coordination of benefits rule is always primary;
- A plan that covers an individual as an Employee is primary; and
- A plan that covers an individual as a laid-off Employee or Retiree or Dependent of such person is primary.

In addition, if an eligible person receives benefits or services pursuant to group or individual automobile policy, then this Plan will be secondary.

If an Eligible Dependent child is covered under more than one plan and the parents are not divorced or separated, the plan that covers the parent whose date of birth occurs earlier in the calendar year (excluding the year of birth) is primary. If the birthday of both parents occurs on the same date, the plan that has covered the parent for the longer period of time is primary.

If an Eligible Dependent child is covered under more than one plan and the parents are divorced or separated, the following rules determine which plan is primary:

- If there is a court decree that establishes the financial responsibility for the health care expenses of the child, benefits will be determined in accordance with the terms of the court decree, provided that the child meets the definition of an Eligible Dependent; or
- If there is no court decree and the parent with custody has:
  - Not remarried, the plan of the parent with custody will be the primary plan and the plan of the parent without custody will be the secondary plan, provided that the child meets the definition of an Eligible Dependent; or
  - Remarried, the plan of the parent with custody will be the primary plan, the stepparent's plan will be the secondary plan, and the plan of the parent without custody will pay third, if the child meets the definition of an Eligible Dependent.

In all instances if no other provision applies, the plan that has covered the individual for the longest period of time is primary, with the following exceptions:

- The benefits of a plan covering the person as a laid-off Employee or Retiree or Dependent of such person is primary.
- If an eligible person receives benefits or services pursuant to a group or individual automobile policy without regard to fault or any other arrangement of insured or self-insured group coverage, this Plan will be secondary to such coverage.

Coordination of Benefits with Medicare

Medicare is a multi-part program:

- Hospital Insurance Benefits for the Aged and Disabled (commonly referred to as Part A of Medicare) covers Hospital benefits, although it also provides other benefits.
- Supplementary Medical Insurance Benefits for the Aged and Disabled (commonly referred to as Part B of Medicare) primarily covers physician's services, although it, too, covers a number of other items and services.
- Medicare Advantage (Part C of Medicare) covers Medicare managed care offerings.
- Medicare Prescription Drug Coverage (Part D of Medicare) covers prescription drug benefits.

Typically, you become eligible for Medicare upon reaching age 65. Under certain circumstances, you may become eligible for Medicare before age 65 if you are a Disabled worker, Dependent widow or have chronic End-Stage Renal Disease (ESRD). You should be aware that even if you do not choose to retire and do not begin receiving Social Security monthly payments at age 65, you are eligible to apply for both Parts A and B of Medicare. Since Part A of Medicare is ordinarily free, you should apply for it as soon as you are eligible. You will be required to pay monthly premiums for Part B of Medicare.

Benefits under this Plan are coordinated with Medicare for covered individuals who are enrolled in Parts A and/or B of the Medicare program due to age or qualifying Disability. This Plan will remain primary if you are actively employed. Once you retire or are Disabled and eligible for Medicare, benefits from this Plan are reduced by the amount of benefits that are eligible for payment under Medicare. Charges for services and/or supplies approved by Medicare but that are not covered charges under this Plan will not be paid by this Plan. In no event will benefits paid by this Plan exceed the applicable amounts listed on the *Schedule of Benefits* for the Program under which you are covered, nor will the combined amounts payable under Medicare and this Plan exceed the covered charges incurred.

For purposes of this Plan, the Prescription Drug benefit terminates immediately for anyone who enrolls in Medicare Part D. However, if the individual subsequently drops Medicare Part D coverage, he or she will be able to re-enroll one time only in the Prescription Drug benefit. The monthly self-payment for any Medicare-eligible individual will not be reduced if the individual enrolls in Medicare Part D coverage. In the event the prescription drug coverage under this Plan becomes less favorable than the prescription drug benefits provided under Medicare Part D, you will receive notification from the Fund Office.

Right to Receive and Release Necessary Information

To determine the applicability of and implement the terms of this Plan (or any provision of similar purpose of any other plan), the Fund may, in accordance with applicable law, without the consent or notice to any person, release to or obtain information from any other welfare fund or group plan, other organization or person any information with respect to any Claimant that the Fund deems necessary. Any Participant claiming benefits under this Plan must furnish all information necessary to implement this provision.

Right of Payment

The Trustees have the right to pay benefits to any other organization or person, as needed, to carry out the provisions of the Plan.

The Trustees may pay for or provide services or equipment that they deem to be Medically Necessary, but not otherwise covered by the Plan, if in their sole discretion, they conclude that paying for or providing such services or equipment would be financially beneficial to the Plan. This action is not deemed to be an amendment to the Plan nor does it establish a precedent, nor will it obligate such actions in the case of any subsequent claim. The Trustees may, but are not required to, delegate to their administrative manager the authority to authorize such payments on a uniform application.

Assignment of Benefits

The benefits described here are exclusively for Plan participants and, if applicable, their eligible enrolled dependents.

The coverage and any benefits under the Plan, including the right to receive payments under the Plan, are not assignable by any participant or dependent or anyone else without the written consent of the Plan, except as required by a Qualified Medical Child Support Order (QMCSO) or a properly completed National Medical Child Support Notice (NMCSN), as described on page 11.

The right to appeal or bring suit cannot be assigned to anyone else, except for claims associated with emergency medical treatment as defined in the Plan.

Payment to a provider does not give the provider any rights, legal or otherwise, under the Plan.

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, by reason of mental or physical disability, in the opinion of the Trustees, is unable to administer such payments properly. In that event, the Trustees may make payments for the benefit of the incompetent person to the guardian of the person or to the individual who has assumed the care and principal support of the incompetent person if there is no guardian for 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.

Right of Recovery

Whenever payments have been made by this Plan in error or on the basis of fraudulent information, the Plan has the right to recover such payments from any person, insurance company or other plan or organization to whom or on whose behalf the payments were made.

Subrogation and Reimbursement

The Plan's right of subrogation arises when benefits are paid on behalf of an eligible individual as a result of an injury or Illness for which another party may be responsible.

In the event the Fund pays or is obligated to pay benefits on behalf of a participant or eligible Dependent for illness or injury to the participant or Dependent and the participant or Dependent have the right to recover the amounts of such benefits from any other person, corporation, insurance carrier, or governmental agency, including uninsured or underinsured insurance coverage, or any other first-party or third-party contract or claim, the Trustees of the Fund and the Fund will be subrogated to all of the participant's or Dependent's right of recovery against such person, corporation, insurance carrier, governmental agency or uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim and will have a right of reimbursement from the participant or Dependent to the full extent of payments made by the Fund and for the costs of collection of these amounts, including attorney's fees.

The full amount of benefits paid will include any Preferred Provider Organization charge or other payment to a medical discount provider paid with respect to the involved benefits, which will be considered part of the amount of benefits paid. The Trustees and the Fund will have an equitable lien by agreement in the amount set forth in this paragraph and this equitable lien by agreement will be enforceable as part of an action to enforce Plan terms under ERISA Section 502(a)(3), including injunctive action to ensure that these amounts are preserved and not disbursed. The Trustees' and the Fund's equitable lien by agreement imposes a constructive Trust upon the assets received as a result of a recovery by the participant or Dependent, as opposed to the general assets of the participant or Dependent, and enforcement of the equitable lien by agreement does not require that any of these particular assets received be "traced" to a specific account or other destination after they are received by the participant or Dependent. The Trustees' and the Fund's equitable lien by agreement is from the first dollar received and its enforcement does not require that the participant or Dependents be "made whole" or that the entire debt be paid to the participant or Dependents prior to the lien's payment. The Trustees' and the Fund's equitable lien by agreement is also not reduced by the legal fees incurred by the participant or Dependent in recovering the amounts or by any state law doctrine, such as the "common fund" doctrine, which would purport to impose such a reduction.

The participant or his or her Dependents or the participant acting on behalf of a minor Dependent will execute and deliver such documents and papers, including but not limited to an assignment of the claim against the other party or parties, assignment to the minor child or any parental claim to recover medical expenses of the minor child, and/or a Subrogation or Reimbursement Agreement to the Fund, as the Trustees may require. The participant or Dependent will do whatever else is necessary to secure the rights of the Trustees and the Fund including allowing the intervention by the Trustees or the Fund or the joiner of the Trustees or the Fund in any claim or action against the responsible party or parties or any uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim.

If the participant or Dependent does not attempt a recovery of the benefits paid by the Fund or for which the Fund may be obligated, the Trustees or the Fund will, if it is in the Fund's best interest and at the Trustees' sole discretion, be entitled to institute legal action or claim

against the responsible party or parties, against any uninsured or underinsured insurance coverage, or against any other first-party or third-party contract or claim in the name of the Fund or Trustees in order that the Fund may recover all benefit amounts paid to the participant or Dependent or paid on their behalf, together with the costs of collection, including attorney's fees.

In the event of any recovery by judgment or settlement against the responsible party or parties or by payment by any uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim, payment of the lien from the proceeds of the recovery will take place in the following fashion. Initially, the reasonable costs of collection of the equitable lien by agreement, including the Fund's attorney's fees, will be distributed to the Fund. Next, the amount of benefits paid from the Fund to and on behalf of the participant or Dependent, to the full extent of benefits paid or due as a result of the Plan's right of subrogation is from the first dollar received by the participant or Dependent and takes effect before the whole debt is paid.

Overpayment and Duty of Cooperation

Whenever payment(s) have been made in excess of the allowable amount under the Plan, the Plan has the right to recover such excess payments from any person(s), service plan, or any other organization to or for which the excess payments were made, or reduce previous or future payments under the Plan.

If an overpayment of benefits has been made to or on behalf of the Employee, Retiree or Dependent, the Plan, at its option, may require immediate repayment in full, set-off the overpayment from current and future benefit payments, or institute legal action to collect the overpayment.

The eligible individual must provide the Plan with any information the Plan deems necessary to determine eligibility, process claims, or implement Plan terms. Failure to provide any information requested by the Plan or its agents may result in the rejection of a claim for benefits.

If an overpayment results from misrepresentations made by or on the behalf of the recipient of the benefits, the Plan may also obtain reimbursement of interest, professional fees incurred, and other damages related to that overpayment.

Misrepresentation or Falsification of Claims

A claim for benefits will be rejected and the Plan will be entitled to recover money that an eligible individual or a service provider has received if a false statement or omission of a material fact was purposely made by any person to receive benefits. The Plan may also obtain reimbursement of interest on this money as well as professional fees incurred and other damages.

If any individual knowingly misrepresents or falsifies any information or matter in connection with a claim filed for Plan benefits, the Trustees may, in their sole discretion, deny all or part of the benefits that might otherwise be due in connection with that claim.

Wrongfully Paid Benefits

Whenever the Trustees pay benefits that exceed the amount of benefits that should be paid under the terms of this Plan, the Trustees will have the right to recover the wrongfully paid benefits from any person(s), service plan, or any other organization to or for which the excess payments were made.

If an overpayment of benefits has been made to or on behalf of an eligible Employee, Retiree or Dependent, the Plan, at its option, may require immediate repayment in full, set-off the overpayment from current and future benefit payments or institute legal action to collect the overpayment.

If an overpayment results from misrepresentations made by or on the behalf of the recipient of the benefits, the Plan may also obtain reimbursement of interest, professional fees incurred, and other damages related to that overpayment.

The Plan Sponsor protects the security of electronic Protected Health Information (PHI) by:

- Implementing administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensuring that an adequate separation between the Plan and Plan Sponsor is maintained, specific to electronic PHI, by supporting reasonable and appropriate security measures;
- Ensuring that any agent, including a subcontractor, to whom it provides electronic PHI, agrees to implement reasonable and appropriate security measures to protect electronic PHI; and
- Reporting to the Plan any security incident of which it becomes aware concerning electronic PHI.

Breach Notification Rights for Unsecured Protected Health Information under HIPAA

The Health Information Technology for Economic and Clinical Health (HITECH) Act requires the Fund Office to provide notification to you following the discovery of a breach of your unsecured PHI. In addition, the Fund Office is also required to notify the Department of Health and Human Services (HHS) if there is a breach. Further, if the breach involved more than 500 individuals, the Act requires the Fund Office to provide notification to the media.

If your unsecured PHI is breached, the Fund Office will notify you without unreasonable delay and in no case no later than 60 calendar days after discovery of the breach. Notice will be provided by first-class mail where possible, so it is important to keep the Plan up to date with your current mailing address.

Under HIPAA, you have a statutory right to file a complaint with the Fund Office or the HHS Secretary if you believe that your privacy rights have been violated. The HITECH Act specifically provides that you also have a right to file a complaint should you feel that the Fund Office has improperly followed the breach notification process.

Important Information about the Plan

Name of Plan

Plumbers and Steamfitters Local Union No. 33 Health and Welfare Trust

Type of Administration of the Plan

This Plan is a collectively bargained, multi-employer health and welfare plan maintained for the purpose of providing Disability and medical benefits in the event of injury or Sickness. All Plan benefits are self-funded by the Health and Welfare Fund.

The Trustees are the formal Plan Administrator; however, they have delegated important administrative responsibilities to third parties. Important third parties are:

General Administration of the Plan

Jama Barbour, Administrator
Plumbers and Steamfitters Local Union No. 33
Health and Welfare Trust
2501 Bell Avenue
Des Moines, IA 50321
515-243-3246

Board of Trustees

Union Trustees

Eric Smith
Director of the JATC for the
Plumbers & Steamfitters Local Union No. 33
2501 Bell Avenue
Des Moines IA, 50321

Grant Hjortshoj
Winger Mechanical
918 Hayune Street
Ottumwa, IA 52501

Brad Meyer
Air-Con Mechanical Corporation
3121 SE 14th Street
Des Moines, IA 50320

Andy Roberts
Plumbers & Steamfitters Local Union No. 33
2501 Bell Avenue
Des Moines IA, 50321

Management Trustees

Curt Baker
The Waldinger Corporation
2601 Bell Avenue
Des Moines, IA 50321

Nate Hagberg
Wolin Mechanical
1720 Fuller Road
West Des Moines, IA 50265

Tom Keck
Winger Mechanical
918 Hayne Street
Ottumwa, IA 52501

Doug Kumm
The Baker Group
4224 Hubbell Avenue
Des Moines, IA 50317

Agent for Service of Legal Process

Any legal process relating to the Plan must be delivered to Fund Counsel. Legal process may also be served upon any of the individual Trustees at the Fund Office.

Felhaber Larson
220 South 6th Street, Suite 2200
Minneapolis, MN 55402
612-339-6321

Identification Numbers

The Plan's IRS Number is 501; the Board of Trustees number is 42-0930021.

Source of Financing of Plan

This Plan is funded through contributions by the Employers on behalf of their Employees under the terms of a Collective Bargaining or Participation Agreement, and by investment income earned on a portion of the Fund's assets. Under certain circumstances, an Employee may be allowed to self-contribute to the Plan.

Collective Bargaining Agreements

This Plan is maintained pursuant to Collective Bargaining Agreements. Copies of any of the Collective Bargaining Agreements may be obtained upon written request to the Plan Administrator and are available for examination at the Fund Office.

Funding Medium

Benefits are provided directly from the Trust Fund assets, which are accumulated under the provisions of Trust Agreement and Summary Plan Description.

Plan Year

The records of the Plan are kept separately for each Plan Year. The Plan Year begins on January 1 and ends on December 31.

Titles are for Reference Only

The titles are for reference only. In the event of a conflict between a title and the content of a Section, the content of the Section will control.

Construction

Except to the extent preempted by Federal law, the provisions of the Plan will be interpreted in accordance with the laws of the state of Iowa.

Contributions to the Plan

The Plan is financed solely by contributions from Employers and, under certain circumstances, participant self-payment contributions.

All benefits, with the exception of medical benefits for Medicare-Age Eligible Retirees and their spouses, are provided on a self-funded basis from a Trust Fund consisting of the assets of the Fund and the investment income earned. Medical benefits for Medicare-eligible Retirees and Medicare eligible Dependents are provided through a separate insurance policy.

Amendments to the Plan

The Trustees, by majority action, may amend or alter the Plan and have full authority at all times to make benefit determinations and to construe and interpret the provisions of the Plan. If the Plan is amended, you will be notified in writing.

Termination

Although the Trustees expect to continue the Plan, they reserve the right to change or modify the Plan from time to time. The Trustees may discontinue all or any part of the Plan at any time if all contributing Employers are no longer obligated through Collective Bargaining Agreements to make required contributions. In the event of Plan termination, claims incurred before the date of termination will be paid out of the Trust that holds the Plan assets and will be applied to all existing benefit obligations in effect on the date of termination of the Plan. No benefits will be payable after the Plan has terminated.

Any balance of the Welfare Fund that cannot be applied as above, will be applied to other uses that will best serve the intentions of the Plan, in the opinion of the Board of Trustees. Upon the distribution of the entire Welfare Fund, the Welfare Fund will then terminate.

The benefits provided by the Plan are payable only to the extent the Welfare Fund has assets available for such payments. Your benefits under the Plan are not vested, and the Plan may be amended or terminated by the Trustees as noted previously.

Your ERISA Rights

Receive Information about Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and Union halls, all documents governing the Plan, including insurance contracts, 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).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description (SPD). The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, which the Plan Administrator is required by law to provide to each participant.

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 SPD and any documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules. Please note that you or any other Claimant may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and review procedures.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Summary Plan Description 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 that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who must pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, 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, U.S. Department of Labor, (address 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 NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Definitions

Throughout this booklet, many words are used that have a specific meaning when applied to your Plan coverage. When you come across these terms while reading this booklet, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. All definitions have been arranged in alphabetical order and are capitalized when used in the booklet.

Ambulance Service: Transportation of an injured or ill person either in an emergency to the nearest appropriate facility for treatment or under circumstances when transportation is Medically Necessary and such transportation by other means would likely endanger the Participant's health, life, or ability to function, or would likely cause extreme pain. Covered Ambulance Services include only licensed Ambulance Services provided by state-certified emergency medical providers (such as Emergency Medical Technicians, Paramedics, Mobile Intensive Care Technicians, etc.). The term includes both emergency Ambulance Services and other state-licensed or -certified medical transportation services.

Association: The Mechanical Contractors Association of Des Moines, Iowa and Vicinity, The Central Iowa Chapter of the Siouxland Plumbing, Heating and Cooling Contractors Association; The Fort Dodge Area Contractors and the Central Iowa Chapter of the MCAI; and The Master Plumbers and Contractors of Mason City, Iowa.

Beneficiary: Any person who the Employee designates to receive the Employee’s death benefits under this Plan.

Claimant: The individual who received the medical care that is the subject of a claim for benefits submitted to the Plan. The term Claimant used in this document also refers to a personal representative or designated representative authorized by the primary Claimant to act on his behalf with respect to a particular claim.

Coinsurance: That portion of covered expenses that a covered individual is responsible for paying. In most cases, the covered individual is responsible for paying a percentage of the total covered expenses that are in excess of the Deductible.

Collective Bargaining Agreement: The agreement and contract by and between members of Central Iowa Chapter of Mechanical Contractors Association of Iowa, Inc. of Des Moines, Iowa and vicinity, Siouxland Plumbing, Heating and Cooling Contractors Association, and the Master Plumbers and Contractors of Mason City, Iowa and The Plumbers and Steamfitters Local Union No. 33 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada, in effect as of the effective date of this Restated Plan Summary Plan Description or any successor agreement thereto; as well as any other Collective Bargaining Agreement between the Union and any other Employer that sets forth benefits to be provided under this Plan or establishes any rights or obligations with respect to participants, beneficiaries, or contributing Employers.

Contributing Employer (Employer): Any entity employing persons to perform work that is covered by the Collective Bargaining Agreement between the Union and the Association within the geographic area covered by such Collective Bargaining Agreement, or a third party to an agreement with the Fund, and approved by the Board of Trustees, which provides, in writing, for the payment of contributions to the Fund for work performed by the Employer's Employees, provided such Employer agrees in writing to be bound by the terms of the Trust Agreement.

Copayment: Copayments are the charges you are responsible for paying for certain covered health services. A Copayment is in addition to any Deductible or Coinsurance you are responsible for paying.

Deductible: A fixed dollar amount of covered expenses incurred in any calendar year that a covered individual is responsible for paying before the Plan begins to pay benefits. The Deductible is usually in addition to any Copayment amount and any Coinsurance percentage of coverage that the covered individual is responsible for paying.

Dependent/Covered Dependent: A person who is the covered Spouse or covered child of an Employee or Retiree.

Disability: An Employee who cannot work at his or her occupation, or any other work for wage or profit, because of an injury or Sickness.

Dollar Bank: A participating Employer contributes to the Plan based on the hours an Employee works. The contributions accumulate in a Dollar Bank account. Premiums are deducted from the Dollar Bank to pay for coverage for Employees and their Dependents. The Plan maintains a separate Dollar Bank for each Employee. A Dollar Bank may accumulate a maximum of six months of contributions; the amount in excess is credited to the Employee's Health Reimbursement Account.

Dollar Bank Charge: The amount per month the Board of Trustees determines necessary to fund coverage for an Employee and covered Dependents.

Eligible Child: Any Dependent child of an Eligible Employee or Retiree who meets the criteria for coverage under this Plan as more fully set out in the *Dependent Eligibility* section of this SPD.

Eligible Dependent: A Spouse or child of an Employee who meets the criteria for Plan coverage.

Eligible Employee: Any Employee employed by an Employer, who has met the requirements to obtain coverage under this Plan.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part; or

With respect to a pregnant woman who is having contractions:

- that there is inadequate time to effect a safe transfer to another hospital before delivery; or
- that transfer may pose a threat to the health or safety of the woman or the unborn child.

If you or your dependent are admitted into an out-of-network facility due to an Emergency Medical Condition, the Fund will pay benefits for the time spent at the out-of-network facility as long as it is medically inappropriate to transfer the individual to an in-network facility. The Fund will only pay for what is Reasonable and Customary. If the out-of-network provider bills more than what is Reasonable and Customary, the participant may be balance billed and held responsible for paying 100% of the difference between what is billed by the provider and what is deemed Reasonable and Customary. Once the participant has been stabilized to a point where he/she may be moved to an in-network facility, the Fund will cover transportation costs to the nearest in-network facility capable of providing further treatment.

If you or your dependent will be admitted to a hospital or any other facility for any reason, be sure to ask and confirm that the facility is an **"In-Network participating provider" in the Anthem network of providers.** Understand that confirmation that a provider "**accepts Anthem insurance**" **does not mean the provider is an Anthem participating provider.** Therefore, in-patient services provided at a facility that states it "accepts" Anthem insurance but does not verify that it is an "In-Network participating provider" will not be covered by the Plan.

Examples of **non-participating** providers that provide in-patient services include *Cancer Treatment Centers of America, Passages Treatment Centers* and many other drug rehabilitation centers as well as Specialized Medical treatment centers. Whenever you or your dependent are going to receive treatment for which an over-night stay is anticipated, it is always a good practice to call the Fund Office at the number listed below to verify coverage.

For help locating an Anthem or Blue Cross provider anywhere in the US, visit www.anthem.com or call the Customer Support number on the back of your card.

Employee: Any person employed by an Employer and on whose behalf contributions are made to the Plan pursuant to the Collective Bargaining Agreement or to any other written agreement with the Fund accepted by the Trustees requiring employer contributions on behalf of the person, in accord with the terms of the Trust Agreement. The term Employee also refers to any regularly paid Employee of the Union on whose behalf the Union makes contributions to the Plan, any regularly paid Employee of the Fund, of the Plumbers and Steamfitters Local No. 33 Pension Fund or the Plumbers and Steamfitters Local No. 33 Apprenticeship Fund. Employee also refers to a non-bargained office Employee employed by a Contributing Employer and covered under a participation agreement.

Expense: A covered service or supply that has been ordered or prescribed by a physician. An expense is considered incurred on the date the service or supply is received. Expense does not include any charge:

- For a service or supply which is not Medically Necessary;
- Which is in excess of the Reasonable and Customary Charges for a service or supply; or
- For a service or supply that the patient may not be legally required to pay.

Fund: The Plumbers and Steamfitters Local No. 33 Health and Welfare Fund.

Fund Office: Any office or other physical location out of which the Fund is administered.

Hospice: Palliative care provided to a person with a terminal illness and his family, to provide for the basic life functions and necessities of life during this time, including pain relief, in anticipation of death, services to assist the family with the loss, and to provide grief counseling.

Hospital:

- An institution constituted, licensed, and operated in accordance with the laws pertaining to Hospitals, which maintains on its premises all facilities necessary to provide for the diagnosis and medical and surgical treatment of injury or Sickness and which provides such treatment for compensation, by or under the supervision of physicians on an inpatient basis with continuous 24-hour nursing service by registered nurses; or
- An institution which qualifies as a Hospital, a psychiatric Hospital, a tuberculosis Hospital, or a provider of services under Medicare, and which is accredited as a Hospital by the Joint Commission on the Accreditation of Healthcare Organizations.
- The term Hospital does not include an institution that is, other than incidentally, a place for rest, a place for the aged, or a nursing home.

Medical Care: Diagnosis, cure, mitigation, treatment, or prevention of a disease; any activities performed for the purpose of affecting any structure or function of the body; transportation primarily for or essential to such care or services; or the payment for any of these.

Medically Necessary: Medical Care that is required to treat an injury or Sickness, and the absence of which could cause adverse consequences for the person in need of such Medical Care.

Medicare: The program of Medical Care benefits provided under Title XVIII of the Social Security Act of 1965, as amended.

Mental Health Care Provider: A person licensed by the state in which the person practices to provide mental health counseling or therapy, and who has an appropriate educational degree or certificate in psychology, counseling, mental health care, or related field.

Non-Occupational: With respect to an injury, an injury that does not arise out of or in the course of any employment for wage or profit, and with respect to Sickness, a Sickness in connection with which the person is entitled to no benefits under any Workers' Compensation law or similar program established by law.

Participant: Any Eligible Employee, Retiree or covered Dependent who has met all of the prerequisites for coverage under this Plan and who is enrolled for coverage in this Plan.

Plan: The Plumbers and Steamfitters Local No. 33 Health and Welfare Plan, as set forth in the Summary Plan Description, and as from time to time amended (that is, the plan of benefits offered under the terms of the Restated Agreement and Declaration of Trust of the Plumbers and Steamfitters Local No. 33 Health & Welfare Fund).

Plan Administrator: The Board of Trustees of the Plumbers and Steamfitters Local No. 33 Health and Welfare Fund. The Board of Trustees retains ultimate authority as the Plan Administrator for this Plan, but may delegate the responsibility for carrying out regular plan

administration functions and activities, along with the authority to carry out such functions and activities, to a third-party administrator or other person or entity.

Plan Sponsor: The Board of Trustees of the Plumbers and Steamfitters Local No. 33 Health & Welfare Fund.

Qualifying Event: The instances in which a covered Employee and/or covered Dependent(s) are eligible for COBRA Continuation Coverage: death of the covered Employee; the termination of the covered Employee (other than by reason of gross misconduct); the covered Employee experiences a reduction of hours; the covered Employee and covered Spouse divorce or legally separate; the covered Employee becomes entitled to Medicare benefits under Title XVIII of the Social Security Act; or a covered child ceases to be a Dependent child.

Reasonable and Customary Charges: Charges in the amount normally charged by the provider for similar services or supplies that do not exceed the amount ordinarily charged by most providers for comparable services or supplies in the locality where the services or supplies are received. In determining whether charges are reasonable, usual, and customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which require additional time, skill, or experience. The Plan Administrator may adopt standard protocols or other criteria to be used in determining whether a particular covered charge is reasonable, usual, and customary.

Retiree: Any person receiving benefits under the Plumbers and Steamfitters Local No. 33 Pension Plan who is eligible to receive benefits under this Plan, as fully set forth in the Plan Participation section of this SPD.

Retiree Self-Pay: The amount determined by the Board of Trustees as necessary to fund coverage for a Retiree and any Dependents covered through that Retiree for one month.

Sickness: Any abnormal physical or mental condition, including physical Sickness, mental illness, or functional nervous disorder, that affects the person's ability to function normally. A recurrent Sickness will be considered to be one Sickness. Concurrent Sicknesses will be considered one Sickness unless the concurrent Sicknesses are totally unrelated. The term Sickness, as used in this SPD document, will also include pregnancy, childbirth, or resulting complications, except in the case of an Eligible child.

Summary Plan Description (SPD): This document, which serves as a summary of all benefits available to Eligible Participants and their Dependents. This SPD complies with all legal requirements and will be provided to participants as required by ERISA.

Surviving Spouse: The Spouse on the date of the Employee's or Retiree's date of death, who has not predeceased the Employee or Retiree.

Trust: The Agreement and Declaration of Trust made as of January 1, 1976, by and between the Union and the Association, as amended and as may be amended or restated from time to time in the future.

Union: The Plumbers and Steamfitters Local No. 33 of the United Association of Journeymen and Apprentices of the Plumbing, Pipefitting, and Sprinkler Fitting Industry of the United States and Canada.