PLUMBERS & PIPEFITTERS LOCAL UNION NO. 94 HEALTH & WELFARE PLAN

PLAN DOCUMENT & SUMMARY PLAN DESCRIPTION

Effective May 21, 2022

PLUMBERS & PIPEFITTERS LOCAL UNION NO. 94 HEALTH & WELFARE FUND

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****SPECIAL NOTICE****

It is extremely important that you keep the Fund Office informed of any change in address or desired change in beneficiary. This is your obligation and failure to fulfill this obligation could jeopardize your eligibility or benefits. The importance of a current, correct address on file at the Fund Office cannot be overstated! It is the ONLY way the Trustees can keep in touch with you regarding Plan changes and other development affecting your interests under the Plan.

TO: ALL PARTICIPANTS AND BENEFICIARIES OF THE PLUMBERS & PIPEFITTERS LOCAL UNION NO. 94 HEALTH & WELFARE PLAN

We are pleased to distribute this revised Summary Plan Description detailing the benefits provided by the Plumbers & Pipefitters Local Union No. 94 Health & Welfare Plan. This booklet replaces and supersedes in entirety your previous booklet. Any changes made to the Plan in the future will be mailed to you in order that you may include them in this booklet. In this way, you will have an up-to-date Summary Plan Description for your Health and Welfare Plan.

This booklet summarizes the eligibility rules for participation in the Plan, the benefits provided for those who are eligible, and the procedures that must be followed in filing a claim. In addition, contained in the booklet is important information concerning the administration of the Plan and your rights as a Participant.

A number of changes have occurred in the Plan since the previous distribution of your booklet. We urge you to review this booklet carefully so you are informed of the financial protection provided for those eligible for benefits under the Plan. Your specific attention is directed to the section of the booklet detailing continuation of coverage for you and your eligible dependents under a federal law (COBRA) in certain instances where coverage under the Plan would ordinarily end.

The Board of Trustees has full, complete and binding authority to define, interpret and apply all of the terms and provisions of the Plan, the Trust Agreement and Restated Trust Agreements establishing the Plan and this Summary Plan Description, and all contracts entered into by the Trustees of the Plan with any third parties. This authority to define, interpret and apply includes, but is not limited to, all issues that relate to eligibility, the amount of and entitlement to any forms of benefit, all issues that directly or indirectly relate to covered employment and all issues that directly or indirectly relate to benefit terminations. Although the Board of Trustees intends to continue the Plan and the benefits provided under the Plan, the Board reserves the right, in its sole discretion, to amend or terminate the Plan by written amendment or resolution without prior notice to Participants and Beneficiaries except as may be required by law. Without limiting in any way the authority of the Board of Trustees recited above, the Trustees delegate that same authority to the Plan’s Administrator.

The Trustees by their signature at the end of this document intend that this document shall serve as both the Plan Document and Summary Plan Description for this Fund.

Please note the receipt of this booklet does not automatically mean you are eligible for benefits. Your eligibility will be determined in accordance with the Plan's Rules of Eligibility, which are set forth in this booklet.

If you have questions concerning your eligibility, schedule of benefits or general provisions of the Plan, please write or call the Fund Office.

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Administrative Manager at BeneSys, Inc., 3660 Stutz Drive, Ste. 101, Canfield, OH 44406. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Sincerely yours,

BOARD OF TRUSTEES OF THE
PLUMBERS & PIPEFITTERS LOCAL UNION NO. 94
HEALTH & WELFARE PLAN

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ARTICLE I

A. SCHEDULE OF BENEFITS (FOR NON-MEDICARE ELIGIBLE PARTICIPANTS)

	NETWORK	NON-NETWORK
Calendar Year Deductible – Single/Family [1]	$250/$500	$250/$500
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family [1]	$2,000/$4,000	$2,000/$4,000
PHYSICIAN/OFFICE SERVICES		
Office Visit (Illness/Injury) [2] Includes telemedicine services through Cleveland Clinic (available to out-of-state members at in-network coverage)	$15 co-pay, then 100%	$15 co-pay, then 80%
Urgent Care Office Visit [2]	$15 co-pay, then 100%	$15 co-pay, then 80%
Podiatry Service (See p. 37)	90% after deductible	80% after deductible
Voluntary Second Surgical Opinion (See p. 33)	90% after deductible	80% after deductible
Immunizations (tetanus toxoid, rabies, vaccine, meningococcal polysaccharide vaccine	90% after deductible	80% after deductible
Hepatitis B vaccine Influenza shots (all causes, all ages) [3]	Hepatitis B vaccine: 90% not subject to deductible Influenza shots: 90% not subject to deductible	Hepatitis B vaccine: 80% not subject to deductible Influenza shots: 80% not subject to deductible

[1] Deductible and coinsurance expenses incurred for services by a non-network provider will also apply to the network deductible and coinsurance out-of-pocket limits. Deductible and coinsurance expenses incurred for service by a network provider will also apply to the non-network deductible and coinsurance out-of-pocket limits.

[2] The office visit co-pay applies to the cost of the office visit only.

[3] The administrative costs of the COVID-19 vaccine will be covered at zero co-pay. Further, the COVID-19 vaccine will be both a medical and prescription benefit.

	NETWORK	NON-NETWORK
PREVENTATIVE SERVICES		
Office Visit/Routine Physical Exam (Two exams per calendar year) [2]	$15 co-pay, then 100%	$15 co-pay, then 100%
WELL CHILD CARE BENEFIT (Includes exam and immunizations)		
Birth through Age 21	$15 co-payment then 100%	$15 co-payment then 80%
Routine Mammogram (one per calendar year)	90%, no deductible	80%, no deductible
Routine Pap Test (one per calendar year)	90%, no deductible	80%, no deductible
Prostate Specific Antigen test	90%, no deductible	80%, no deductible
Routine EKG, Chest x-ray, complete blood count, comprehensive metabolic panel, urinalysis (ages nine and over, one each per calendar year)	90%, no deductible	80%, no deductible
Routine colonoscopy/sigmoidoscopy for participants and eligible dependents age 40 and over	90%, no deductible	80%, no deductible
OUTPATIENT SERVICES		
Surgical Services (See p. 32)	90% after deductible	80% after deductible
Diagnostic Services (See p. 33)	90% after deductible	80% after deductible
Chemotherapy (See p. 34)	90% after deductible	80% after deductible
Radiation Therapy (See p. 34)	90% after deductible	80% after deductible
FDA Approved Gene Therapy (See p. 39)	90% after deductible	80% after deductible
Dialysis (See p. 31)	90% after deductible	80% after deductible
Respiratory Therapy (See p. 31)	90% after deductible	80% after deductible
Physical Therapy/Occupational Therapy – Facility and Professional (maximum 64 visits per calendar year except for Autism related therapies) (See p. 38)	90% after deductible	80% after deductible

	NETWORK	NON-NETWORK
Chiropractic Therapy – Professional only (Not to exceed 36 visits) (See p. 38)	90% after deductible	80% after deductible
Speech Therapy – Facility and Professional (maximum 40 visits per calendar year)	90% after deductible	80% after deductible
Emergency Use of an Emergency Room (See p. 34)	90% (no deductible)	90% (no deductible)
Non-Emergency Use of an Emergency Room (See p. 34)	90% after deductible	80% after deductible

INPATIENT FACILITY		
Semi-private room and board (See p. 31)	90% after deductible	80% after deductible
Inpatient Consultation (See p. 33)	90% after deductible	80% after deductible
Skilled Nursing Facility (90 days per calendar year)	90% after deductible	80% after deductible
Cardiac Rehabilitation	90% after deductible	80% after deductible

ADDITIONAL SERVICES		
Allergy Testing and Treatments	90% after deductible	80% after deductible
Ambulance	90% after deductible	80% after deductible
Case Management	100%	100%
Durable Medical Equipment	90% after deductible	80% after deductible
Home Healthcare	90% after deductible	80% after deductible
Hospice (See p. 37)	90% after deductible	80% after deductible
Organ Transplant (See p. 35)	90% after deductible	80% after deductible
Organ Donor Expense (See p. 35)	90% after deductible	80% after deductible
Private Duty Nursing (90 days per calendar year)	90% after deductible	80% after deductible
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Mental Health (See p. 36)	90% after deductible	80% after deductible
Inpatient/Outpatient Substance Abuse Services and Alcoholism (See p. 36)	90% after deductible	80% after deductible
Outpatient Mental Health (See p. 36)	90% after deductible	80% after deductible

NOTE: Services requiring a co-payment are not subject to the single/family deductible.

DENTAL AND VISION SERVICES

The Plan will pay eighty percent (80%) for any combination of Dental/Vision expenses up to a maximum payment of Two Thousand Dollars ($2,000.00) per family per calendar year ($2,500.00 in charges paid at 80%). ***Note***: Claims are payable only through the Fund Office either directly to the Provider or, for expenses paid by the Participant, directly in reimbursement to the Participant. Benefits cannot be assigned.

B. NO SURPRISES ACT – OUT-OF-NETWORK EMERGENCY AND AIR AMBULANCE SERVICES

Effective May 1, 2022, notwithstanding the Schedule of Benefits in the above Section A:

1) In accordance with the Title I of Division BB of the Consolidated Appropriations Act of 2021 (the "No Surprises Act"), the Plan will apply in-network cost-sharing to out-of-network air ambulance services, and emergency services for treatment of emergency medical conditions by out-of-network providers and out-of-network emergency facilities (unless the patient received proper notice and consented to the out-of-network billing rates for certain post-stabilization services, as allowed under the No Surprises Act).

2) Notwithstanding any Plan provision to the contrary, for out-of-network services covered by the No Surprises Act, the in-network coinsurance percentage shall be applied to the lower of the billed charge or the qualifying payment amount. There will be no balance billing for services covered by the No Surprises Act.

3) Any amount paid by a covered individual under the Plan for emergency services (in-network or out-of-network) shall be applied toward any applicable deductible and cost-sharing limit.

4) The Plan shall not impose prior authorization requirements on emergency services, whether in-network or out-of-network, and shall not apply any limitation on coverage of emergency services provided by an out-of-network provider or facility that are more restrictive than the requirements that apply to in-network emergency services.

5) For services covered under the Plan and subject to the No Surprises Act, the Plan will pay the provider or facility, subject to all applicable Plan limitations and exclusions, an agreed upon amount, and if there is no agreed upon amount, an amount determined by an Independent Dispute Resolution (IDR) process.

6) If there is a conflict between the Plan and the No Surprises Act or the Affordable Care Act, then the No Surprises Act or the Affordable Care Act shall govern, as applicable.

7) For purposes of this section and any related No Surprises Act provisions of this Plan (Article I(B)-(E)), the following definitions shall apply:

   a. “Qualifying payment amount” means the Plan’s median contracted rate for the item or service in the same geographic region, as adjusted under 29 C.F.R. § 2590.716-6(c).

   b. “Independent Dispute Resolution” or “IDR” means a process established by the No Surprises Act and its enforcing regulations to resolve a payment dispute between payers and out-of-network providers, initiated only if the parties are unable to agree on an acceptable payment rate.

   c. “Emergency service” means, with respect to an emergency medical condition, the following:

      i. An appropriate medical screening examination (as required under § 1867 of the Social Security Act (42 U.S.C. § 1395dd), or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition.

      ii. A medical service within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under § 1867 of the Social Security Act (42 U.S.C. § 1395dd), or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

      iii. Any additional item or service for which benefits are provided or covered under the Plan and are furnished by an out-of-network provider or out-of-network emergency facility (regardless of the department of the hospital in which such items or services are furnished) after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the service is furnished.

   d. “Emergency medical condition” means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a

prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to:

i. place the individual's health in serious jeopardy, or with respect to a pregnant woman, the health of the woman or her unborn child;

ii. result in serious impairment to the individual's bodily functions;

iii. result in serious dysfunction of any bodily organ or part of the individual.

e. "Air ambulance service" means medical transport service by a rotary wing air ambulance, as defined in 42 C.F.R. § 414.605, or fixed wing air ambulance, as defined in 42 C.F.R. § 414.605, for patients.

f. "Emergency facility" means an emergency department of a hospital or an independent freestanding emergency department.

g. "Independent freestanding emergency department" means a health care facility that is geographically separate and distinct and licensed separately from a hospital under applicable state law; *and* provides any emergency services as described in 29 C.F.R. § 2590.716-4(c)(2)(i).

C. NO SURPRISES ACT – CERTAIN SERVICES AT IN-NETWORK HOSPITAL OR AMBULATORY SURGICAL CENTER

Effective May 1, 2022, notwithstanding the Schedule of Benefits in the above Section A:

1) The following ancillary services provided at an in-network hospital or ambulatory surgical center (as described in Section 1833(i)(1)(A) of the Social Security Act) shall be billed at the Plan's in-network cost-sharing amount even if provided by an out-of-network provider:

a) Emergency Medicine

b) Anesthesia

c) Pathology

d) Laboratory

e) Neonatology

f) Assistant Surgeon

g) Hospitalist

h) Intensivist Services

i) Radiology

2) For services provided by an out-of-network provider at an in-network facility, this Plan shall not impose cost-sharing on coverage for out-of-network services greater than cost-sharing that applies to in-network services unless the provider has complied with notice requirements pursuant to the No Surprises Act in the form and method prescribed by the Department of Health and Human Services, and the patient consents to using the out-of-network provider. However, this notice-consent exception is not available to providers (in other words, in-network cost-sharing shall apply) to the following:

a) The ancillary services described in this Section (C)(1)(a)-(i) above

b) Services provided as a result of unforeseen, urgent medical needs that arise at the time a covered service is furnished

c) An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, including ancillary services routinely available to the emergency department, to evaluate whether an emergency medical condition exists

d) Such further medical examination and treatment as may be required to stabilize the patient (regardless of the department of the hospital in which the further medical examination and treatment is furnished) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department

D. NO SURPRISES ACT – CONTINUITY OF CARE

Effective May 1, 2022, notwithstanding the Schedule of Benefits in the above Section A:

1) This Plan shall provide 90 days of continued in-network coverage for a “continuing care patient” where the treating in-network provider leaves the network for any reason except a for-cause termination of the provider’s in-network contract.

2) A “continuing care patient” means a person who is (1) undergoing a course of treatment for a serious and complex condition from the provider; (2) undergoing a course of inpatient care from the provider; (3) scheduled for nonelective surgery from the provider; (4) pregnant and undergoing a course

of treatment for pregnancy from the provider; or (5) determined to be terminally ill and receiving treatment for such illness from the provider.

3) This Plan shall provide notice to a "continuing care patient" as soon as administratively practical after the applicable provider leaves the Plan's network. Said notice shall inform the "continuing care patient" how to elect this continued coverage.

E. NO SURPRISES ACT – EXTERNAL REVIEW OF ADVERSE BENEFIT DETERMINATION

1) Effective May 1, 2022, an adverse benefit determination involving items and services within the scope of the above Article I(B)–(D) are eligible for External Review as follows:

a) "External Review" is a review of an Adverse Benefit Determination by an Independent Review Organization/External Review Organization (ERO) or by the State Insurance Commissioner, if applicable.

b) You must complete all of the levels of standard appeal described in Article XVIII of this Plan before you can request External Review, other than in a case of Deemed Exhaustion. Subject to verification procedures that the Plan may establish, your Authorized Representative may act on your behalf in filing and pursuing this voluntary appeal.

c) The notice of Adverse Benefit Determination that you receive from the Plan will describe the process to follow if you wish to pursue an External Review, and it will include a copy of the Request for External Review Form.

d) You must submit the Request for External Review Form to the Plan within one hundred twenty-three (123) calendar days of the date you received the Adverse Benefit Determination or Final Internal Adverse Benefit Determination notice. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

e) If you file this voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, this appeal is voluntary and you are not required to undertake it before pursuing legal action.

f) If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

2) Preliminary Review Upon Plan's Receipt of Requests for External Review Form

a) Within five (5) business days following the date of receipt of the Request for External Review, the Plan or its designee must provide a preliminary review determining:

i. you were covered under the Plan at the time the service was requested or provided;

ii. you have exhausted the internal appeals process (unless Deemed Exhaustion applies); and

iii. you have provided all paperwork necessary to complete the External Review.

b) Within one (1) business day after completion of the preliminary review, the Plan or its designee must issue to you a notification in writing. If the request is complete but not eligible for External Review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (the toll-free number is 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete, and the Plan or its designee must allow you to perfect the request for External Review within the one hundred twenty-three (123) calendar days filing period or within the 48-hour period following the receipt of the notification, whichever is later.

3) Referral to External Review Organization (ERO)

a) The Plan or its designee will assign an ERO accredited as required under federal law, to conduct the External Review. The assigned ERO will timely notify you in writing of the request's eligibility and acceptance for External Review, and will provide an opportunity for you to submit in writing within ten (10) business days following the date of receipt, additional information that the ERO must consider when conducting the External Review. Within one (1) business day after making the decision, the ERO must notify you, the Plan and its designee.

b) The ERO will review all of the information and documents timely received. In reaching a decision, the assigned ERO will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

i. your medical records;

ii. the attending health care professional's recommendations;

iii. reports from appropriate health care professionals and other documents submitted by you, the Plan, its designee or your treating health care providers;

iv. the relevant terms of the Plan to ensure that the ERO's decision is not contrary to those terms, unless the terms are inconsistent with applicable law;

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

vi. any applicable clinical review criteria developed and used by the industry, unless the criteria are inconsistent with the terms of the Plan or applicable law; and

vii. the opinion of the ERO's clinical reviewer or reviewers after considering the information described in the notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

c) The assigned ERO must provide written notice of the Final External Review Decision within forty-five (45) days after the ERO receives the request for the External Review. The ERO must deliver the notice of Final External Review Decision to you and the Plan.

d) After a Final External Review Decision, the ERO must maintain records of all claims and notices associated with the External Review process for six (6) years. An ERO must make such records available for examination by the claimant, Plan, or state or federal oversight agencies upon request, except where such disclosure would violate state or federal privacy laws.

e) Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

4) Expedited External Review

a) The Plan must allow you to request an Expedited External Review at the time you receive:

i. an Adverse Benefit Determination, if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal described in Article XVII(7)(f) would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

ii. a Final Internal Adverse Benefit Determination, if you have a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, health care item or service for which you received emergency services, but have not been discharged from a facility.

b) Immediately upon receipt of the request for Expedited External Review, the Plan or its designee will determine whether the request meets the reviewability requirements set forth above for standard External Review. The Plan or its designee must immediately send you a notice of its eligibility determination.

5) Referral of Expedited Review to ERO

a) Upon a determination that a request is eligible for External Review following preliminary review, the Plan or its designee will assign an ERO. The ERO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an Expedited External Review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned ERO must provide written confirmation of the decision to you and the Plan.

6) Appeal to the Plan

a) If you choose to appeal to the Plan or its designee following an adverse determination by External Review, you have the right to do so under Article XVIII(9).

ARTICLE II - RULES OF ELIGIBILITY

A. Eligible Classes of Participants. Classes of Participants eligible for benefits provided by the Plumbers & Pipefitters Local Union No. 94 Health &

Welfare Fund shall include:

1) Active Participants working under the terms of the Collective Bargaining Agreement and their Dependents.

2) Full-time employees of Local Union No. 94, including the Business Manager and Business Representatives.

3) Retired Participants who have satisfied the eligibility provisions of the Retiree Program set forth in this Plan.

4) Surviving Spouses and Eligible Dependents of deceased Participants.

B. Eligibility of Active Participants (DOES NOT INCLUDE APPRENTICES) Working Under the Terms of a Collective Bargaining Agreement.

1) **Initial Eligibility.** A Participant will be eligible for benefits under the Plan provided:

a) The Participant is covered under the terms of the Collective Bargaining Agreement entered into between the Union and the Employers; and

b) The Participant is a member of the Plumbers and Pipefitters Local Union No. 94; and

c) The Participant has worked a total of 600 hours within five (5) consecutive preceding calendar months for which contributions to the Fund have been made on his behalf.

2) After a Participant has met the above requirements and becomes eligible, the Participant will be eligible for two (2) months of coverage starting on the first day of the month following the month in which the Participant has accumulated a total of 600 hours of employment within (5) consecutive preceding calendar months and all contributions for such hours are due.

3) **Initial Eligibility of MES and Residential Active Participants Entering the Plan from the State Plan.** An MES employee and Residential employee member active Participant who first comes into this Plan after June 1, 2017 will be eligible for benefits under the Plan provided:

a) The Participant is covered under the terms of the

Collective Bargaining Agreement entered into between the Union and the Employers; and

b) The Participant is a member of the Plumbers and Pipefitters Local Union No. 94; and

c) The Participant has worked a total of 600 hours within three (3) consecutive preceding calendar months for which contributions to the Fund have been made on his behalf.

After this Participant has met the above requirements and becomes eligible, the Participant will be eligible for two (2) months of coverage starting on the first day of the month following the month in which the Participant has obtained the 600 hours as provided in c) above.

However, for this MES Active Participant who has worked less than the 600 hours within this initial eligibility period, and in order to receive immediate coverage, this Participant will have the option to receive negative bank hours at the outset in the amount of the difference necessary to give him the requisite 600 hours during this period.

The amount of reserve work hours accumulated during these two (2) months will be first used to pay off the number of negative bank hours extended to reach the initial 600 hour requirement. Then, the number of hours of employment in those two (2) months in excess of the pay-off amount will be credited to this Participant's Reserve Dollar Bank pursuant to Article II, Section D of the Plan. Hours of employment after these two (2) months will then be applied toward this Participant's Continuation of Eligibility pursuant to Article II, Section C of the Plan.

It is expected that any Participant who elects to receive negative bank hours, as provided above, will "pay back" those hours as soon as possible but, at the latest, within three (3) years from the receipt of a negative bank hour(s). Failure to pay back can result in the Participant being assessed each pay an appropriate pay back amount until full pay back is completed.

C. Continuation of Eligibility. Once having become eligible, the Participant's continued eligibility will be based on the continuation of contributions being made on the Participant's behalf, with the amount of contributions as established by the Trustees to be deducted monthly from the Participant's Reserve Dollar Bank. For each calendar month the Participant is credited with contributions which are less than sufficient to maintain monthly eligibility, the Participant will lose eligibility for one month unless the Participant has accumulated sufficient contributions in the Participant's Reserve Bank to make up the difference between the actual contributions and the required amount for maintenance of eligibility, or the Participant makes the required self-payment.

D. Accumulations of Reserve Dollars. A Participant may accumulate

Credited Reserve Dollars as follows:

1) During the initial eligibility period, all contributions in excess of those required to purchase initial eligibility.

2) All contributions paid to the Fund on the Participant's behalf following the effective date of his coverage which are in excess of the amount set by the Trustees to maintain eligibility will be credited to the Participant's Reserve Bank, up to a maximum reserve dollar accumulation equivalent to thirty-six (36) months of coverage based on the current hourly rate times 150.

E. Self-Contributions. If the Participant's eligibility for benefits terminates under the provisions as stated above, the Participant may arrange with the Trustees to continue eligibility at the Participant's own expense subject to the following conditions:

1) If the Participant has an amount in the Participant's Reserve Dollar Bank which is less than the required amount to continue the Participant's eligibility, the Participant will be permitted to make self-payments representing the difference between the amount of contributions in the Participant's Reserve Bank and the contributions required for maintenance of eligibility. Self-contributions shall be limited to a maximum of 18 consecutive months of full self-payment, except that eligibility can be retained for up to an additional 12 consecutive full self-payment months should the Participant become disabled so as to be prevented from performing his normal duties and that disability continues after the 18-month period.

2) A Participant may preserve his eligibility as set forth above if he satisfies one or more of the following:

a) If laid off or unemployed, but actively seeking work, meaning the Participant maintains his membership in U.A. Local No. 94 and registers with said local his continued availability for work.

b) If on an authorized strike.

c) If by reason of union activities or governmental service or activity related to the construction industry, a Participant may preserve his eligibility during the leave of absence period.

d) If a Participant becomes disabled so as to be prevented from performing his normal duties and

remains so disabled after the 18 consecutive full self-contribution period, then the Participant can retain eligibility for up to an additional 12 consecutive full self-contribution months. However, such eligibility period will terminate upon the occurrence of the first of one of the following events during the additional 12-month full self-contribution period: (i) the 12-month period ends; (ii) the disability ends; or (iii) the Social Security Administration holds during this 12-month period that the Participant's disability has made him eligible for Medicare.

All self-contributions received become the property of the Fund the day received and will not be refunded. Hours received relative to the work month for which the self-contribution was made, whether as a result of a late payment or reciprocity agreement, will be credited in their entirety to the Participant's credited Reserve Dollar Bank.

F. Reinstatement of Eligibility. A Participant who fails to maintain eligibility as set forth above will be reinstated in the Plan on the first day of the month following the month in which the Fund Office receives 150 hours of credited service for the Participant with one or more contributing Employers. The 150 hours of credited service shall be calculated by adding the Participant's credited hours of service in each month following the month in which the Participant lost eligibility.

G. Initial Eligibility and Negative Bank Option for Non-MES, Non-Residential Active Participants and for Active Apprentices Effective June 1, 2017. Effective June 1, 2017, any other Active Participant and Active Apprentice Participant who first enters into this Plan after June 1, 2017, is working under the terms of a collective bargaining agreement entered into between the Union and Employers, and is a member of the Plumbers & Pipefitters Local Union No. 94, and, for the Apprentice, is a registered Apprentice with Plumbers & Pipefitters Local Union No. 94, will have the option to receive up to 300 negative bank hours at the outset in order to be entitled to immediate coverage.

Note that, any Apprentice Active Participant who is directed into the Plan by the International after May 1, 2020 will have the option to receive an advance of up to 150 bank hours to use toward the threshold of 300 hours to satisfy initial eligibility for Plan coverage.

Otherwise, any other non-Apprentice Active Participant who is directed into the Plan by the International after May 1, 2020 will NOT have the option to receive advance negative bank hours toward the threshold of 300 hours to satisfy initial eligibility for Plan coverage.

Any reserve work hours accumulated at any time in accordance with Article II,

Paragraph D of the Plan will be first used to pay off the number of negative bank hours extended to reach the initial 300 hour requirement. The number of hours of employment in excess of the payoff amount will be credited to this Participant's Reserve Dollar Bank pursuant to Article II, Section D of the Plan and can then be applied toward this Participant's Continuation of Eligibility pursuant to Article II, Section C of the Plan.

It is expected that any Participant who elects to receive negative bank hours, as provided above, will "pay back" those hours as soon as possible but, at the latest, within three (3) years from the receipt of a negative bank hour(s). Failure to pay back can result in the Participant being assessed each pay an appropriate pay back amount until full pay back is completed.

H. Eligibility of Full-Time Employees of Local Union No. 94, Including the Business Managers and Business Representatives.

1) A full-time employee of Local Union No. 94, including the Business Manager and Business Representatives, shall become eligible for benefits under the Plan provided that:

a) The Participant is a full-time employee working at least a minimum of thirty (30) hours per week, as reflected in the payroll records of the Local;

b) The Local has signed an Assent to Participate in the Plumbers and Pipefitters Local Union No. 94 Health and Welfare Fund; and

c) Contributions at a monthly rate established by the Board of Trustees are payable at the Fund's depository by the fifteenth (15th) day of the month pursuant to the Assent of Participation.

I. Participants Serving in Armed Forces. In the event a Participant enters the Armed Forces of the United States on a full-time basis, coverage under the Plan shall be extended in accordance with Section below.

J. Eligibility of Retired Participants Under the Retiree Program.

1) Eligibility for the Plan's Retiree Program shall be restricted to the following Retired Participants:

a) Those Participants who are at least fifty-five (55), who are no longer actively employed and who are receiving retirement benefits from a qualified pension plan acceptable to the Trustees;

b) Those Participants under age fifty-five (55) and considered to be totally and permanently disabled and who are eligible to receive retirement benefits provided through the Social Security Administration and are enrolled in Medicare, including Part B, if eligible to do so and/or are receiving pension benefits from a qualified pension plan acceptable to the Trustees.

c) Participants are retired Office and Salary and who have been "grandfathered" in their eligibility.

2) A Retired Participant meeting the Eligibility Rules stated above must have been continuously covered under the Plan for at least twelve (12) months prior to the month said Participant ceases work. Within thirty-one (31) days following the Participant's eligibility to participate, the Participant must satisfactorily complete a Retiree Program application and must remit the necessary contributions as required by the Trustees. Participants working under the terms of the collective bargaining agreement, after having made the necessary arrangements, shall be provided the opportunity of exhausting, at the rates applicable to Active Participants, any amounts remaining in their accumulated Reserve Dollar Banks.

Coverage will be automatically transferred to the Retiree Program effective on the effective date of the Participant's retirement as determined by the Plumbers and Pipefitters National Pension. Further, a Retired Participant who is maintaining coverage while exhausting his Reserve Dollar Bank amounts will be entitled to the Plan's Accident & Sickness benefit only to the extent necessary to finish such entitlement which was commenced prior to the Participant's retirement and only up to a total of twenty-six (26) weekly benefits as calculated from the start of that commencement of use of this benefit prior to retirement.

3) **Payment of Premium.** The amount of payment which those Participants under the Retiree Program shall be required to make shall be determined by the Trustees and may be adjusted from time to time. Any payments required by the Retired Participants must be received by the Trustees prior to the beginning of the period for which coverage is to be effective.

4) **Eligible Dependents of Retired Participants**.

a) **Eligibility for Coverage.** An Eligible Retired Participant shall be entitled to coverage under the Plan for his Eligible Dependents. Such coverage shall become effective on the later of the following dates:

i) On the date the Eligible Retired Participant's coverage became effective; or

ii) On the date the Participant first acquires an Eligible Dependent.

5) **Termination of Coverage.** If the coverage of a Retired Participant lapses due to the Retired Participant's non-payment of premiums or a request by the Participant to terminate coverage, the Participant shall be able to reinstate such coverage within one (1) year of such termination. However, the Participant shall only be eligible for such reinstatement one time. **Furthermore, if a Retired Participant ceases or loses coverage and enrolls in the Medicare Part D prescription plan, the said Participant will not be eligible to re-enroll for prescription coverage through this Plan.**

6) **Special rule for Married Participants.** A Participant who is the Spouse of another Participant, and who retires from active service, (hereinafter, the first retiring Spouse shall be referred to as Participant A), shall be entitled to be carried as a Dependent under the Plan by the spouse that remains as an active participant (the remaining active spouse shall be referred to as Participant B). Participant A shall not be required to draw down Participant A's Reserve Bank while being carried as a Dependent by Participant B. If Participant A becomes Medicare eligible, Participant A shall no longer be carried as a Dependent by Participant B. If Participant B retires from active service while carrying Participant A as a Dependent, Participant B shall be required to begin drawing upon Participant B's Reserve Bank, for coverage under the Plan. During such time, Participant A will continue to be carried by Participant B as a Dependent under the terms of the Plan. When Participant B exhausts Participant B's Reserve Bank, Participant A will be required to draw down Participant A's Reserve Bank and carry Participant B as a Dependent. When Participant A and Participant B have each exhausted their Reserve Banks, and prior to becoming Medicare eligible, Participant A or Participant B will be required to self-pay to the Plan in order to maintain eligibility and may carry the other participant as a Dependent. Reserve Banks shall be drawn down at, and self-payments shall be made at, the full rate required by the Trustees. It is the intention of the Trustees that Participant A and Participant B be treated as Retired Participants at the time when each becomes Medicare eligible. In order to be eligible for the benefits appearing in this paragraph (6), married Participants each must have had contributions made to the Plan for ten consecutive years prior to the retirement of one of the participants. The benefits described in this paragraph (6) shall be available to married Participants notwithstanding any apparently contrary provisions of the Plan.

K. Eligibility of Surviving Spouses and Eligible Dependents of Deceased Participants.

1) The surviving spouse and the eligible Dependents of a deceased Participant shall be eligible for benefits under the following conditions:

a) The surviving spouse and/or eligible Dependents may utilize any Reserve Bank Dollars accumulated by the deceased Participant to continue their benefit coverages under the Plan. A surviving spouse who remarries shall have the right to continue to draw down the Dollar Bank, provided, however, that the surviving spouse's new spouse shall not be eligible for coverage under this Plan as a dependent. The preceding disqualification shall not apply if the new spouse has independently established eligibility for coverage under the Plan as a Participant.

b) The surviving spouse and/or eligible Dependents shall be entitled to the same benefit coverages that were extended to them under the Plan immediately prior to the deceased Participant's death.

However, the "Death Benefit" offered by the Plan, as explained on Page 43, is not a benefit to which the surviving spouse and/or eligible Dependents are entitled.

c) Upon exhaustion of the Reserve Bank Dollars accumulated by the deceased Participant, the surviving spouse and/or eligible Dependents shall be entitled to continue coverage under the Plan by making the self-payment that otherwise is required of Retired Participants under the Plan.

L. Special Enrollment Rights. If a Participant and/or eligible Dependent previously declined enrollment for themselves and/or eligible Dependents, such Participant and/or Eligible Dependent may enroll for coverage under the terms of the Plan should the individual Participant lose other health care coverage, if each of the following conditions are met:

1) The Participant or dependent was covered under a group health plan or had health insurance at the time coverage was previously offered to the Participant or dependent;

2) The Participant stated in writing at such time that coverage under a group health plan or health insurance was the reason for declining enrollment and provided a copy of such written statement to the Fund office;

3) The Participant or Dependent's coverage:

a) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

b) was not under such COBRA provisions and either the coverage was terminated as a result of loss of eligibility for coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions toward such coverage was terminated; and

c) The Participant or Dependent requests such enrollment not later than thirty (30) days after the date of exhaustion of coverage or termination of coverage or employer contributions.

Notwithstanding the foregoing, a Participant and/or Eligible Dependent shall have the right to special enrollment in the Plan after a marriage, birth, adoption or placement for adoption. If any of the preceding events occur, the Participant and/or Eligible Dependent must request special enrollment within ninety (90) days of the event that triggered the special enrollment right.

M. Family and Medical Leave Act. The Family and Medical Leave Act of 1993 (FMLA) guarantees certain employees a minimum of 12 weeks of coverage under this Plan based on premium payment provisions in effect immediately prior to such leave.

1) Notwithstanding any provision in this Plan to the contrary, the following provisions shall apply to an Eligible Participant who requests, and receives, a leave of absence pursuant to the FMLA:

a) If the Eligible Participant is covered by the collective bargaining agreement negotiated by the Union, the Fund shall continue eligibility for the Participant and credit contributions on behalf of the Participant who is using FMLA leave as though the Participant had been continuously employed for a maximum of 12 weeks as allowed by law.

b) If the Eligible Participant is a full-time employee of Local No. 94, the Employer of such Participant shall continue to make contributions on behalf of the Participant using FMLA leave as though the Participant had been continuously employed.

c) For the duration of the Participant's FMLA leave, coverage by the Plan, and benefits provided pursuant to the Plan, shall continue at the level coverage would have continued if the

Participant had remained actively employed.

d) A Participant using FMLA leave shall not be required to utilize his Reserve Bank hours, or pay any greater premiums, than the Participant would have been required to pay if the Participant had been continuously employed.

e) A Participant, upon returning from a FMLA leave, shall be reinstated in the Plan to the same status as provided when the leave began, subject to benefit changes that affect all Participants in the Plan. The Participant shall not be subjected to any restrictions, waiting periods, physical examinations or other pre-existing condition exclusions that would not have been imposed upon the Participant had he not taken the FMLA leave.

f) Effective January 28, 2008, Participants with members in the Armed Services are entitled to FMLA leave under the following circumstances:

1) When leave is needed so that the Participant can care for an injured or ill family member in the Armed Services; and

2) When such leave is required due to "any qualifying exigency" related to a family member's service or call to duty.

The Participant must be a spouse, parent, child or nearest blood relative of the member in the Armed Services. A Participant who is eligible for FMLA leave under this provision will be granted up to twenty-six (26) weeks of leave in a single twelve (12) month period.

N. Participants Serving in the Armed Forces.

1) A Participant who enters the Armed Forces of the United States on a full time basis shall have the option of freezing his Reserve Bank, if any, until discharged from active full-time military duty; or utilizing his Reserve Bank, if any, to continue coverage under the Plan, as provided hereafter.

2) In the event a Participant who enters into full-time military duty of the United States has no Reserve Bank, has an insufficient Reserve Bank to maintain coverage while serving in the military service, or does not elect to utilize said Participant's Reserve Bank to maintain coverage while serving in active full-time military service, continuation of coverage under the Plan

for the Participant and said Participant's Eligible Dependents can be continued for eighteen (18) months upon receipt of a timely application and required contributions established by the Board of Trustees.

3) If a Participant enters the Armed Forces on a short-term basis of thirty-one (31) days or less of continuous military service, coverage under the Plan will be continued for the Participant and Eligible Dependents at the Plan's expense. For military service that exceeds thirty-one (31) days, the Participant shall be responsible for contributions for those months of service subsequent to the initial service of thirty-one (31) days.

4) A Participant shall notify the Fund Office as soon as said Participant knows or understands that said Participant will be entering the military service of said Participant's desire to purchase continuation health care coverage for that period of time when said Participant is in active military service, not to exceed eighteen (18) months. This notice requirement shall be adhered to by the Participant unless giving such notice is precluded by military necessity or is otherwise impossible or unreasonable.

5) Upon a Participant's honorable discharge from military service, the Participant's eligibility status under the Plan will be restored to the status that existed when said Participant entered military service, with the exception of any Reserve Bank Dollars that the Participant may have elected to utilize during military service. In order to restore such eligibility in the Plan, the Participant must notify the Fund Office, in writing, within sixty (60) days of his discharge of his intent to return to covered employment. In addition to such written notice, the Participant shall also supply the Fund Office with copies of said Participant's discharge papers showing the date of said Participant's education or enlistment in military service and the date of said Participant's discharge. Failure on the part of the Participant to file such notice and documentation with the Fund Office may be deemed an indication that the Participant does not wish to restore said Participant's eligibility status under the Plan.

O. Termination of Coverage.

1) Coverage for Active Participants working under the terms of the Collective Bargaining Agreement and/or Assent of Participation and/or for eligible employees of Local No. 94 shall terminate when any of the following occurs:

a) Termination of the Plan as to Active Participants;

b) Modification of the Plan to terminate coverage for the class to which the Participant belongs;

c) Plan modification to terminate a particular type of benefit and/or coverage under the Plan;

d) The Participant fails to maintain the eligibility requirements as set forth above.

e) The date the Participant is no longer employed by any contributing Employers;

f) The date the Participant fails to make any required self-payment or COBRA payments;

g) The date of the Participant's termination of membership in the classes eligible for coverage;

h) The Participant enters the Armed Forces on full-time active duty (See, Participants Serving in Armed Forces, Section N above);

i) The Participant allows a non-covered or ineligible person to use the said Participant's benefit card to obtain or attempt to obtain benefits from this Plan; or

j) The Participant materially misrepresents information provided to the Plan or commits fraud or forgery.

2) If the Participant voluntarily 1) terminates membership in the classes eligible for coverage, 2) voluntarily leaves the trade, and/or 3) voluntarily terminates membership in the Local, then Plan coverage will terminate, and any accumulated bank will be forfeited to the Fund. Further, the Participant must notify the Fund within sixty (60) days of such action in order to preserve rights under COBRA.

3) Retired Participant coverage shall terminate when any of the following occurs:

a. Termination of the Plan;

b. The date the Retiree Program terminates;

c. The date of expiration of the period for which the last contribution is made to the Trustees, as required, to the account of the Retired Participant;

d. The date the Retired Participant ceases to be within the

classes of persons eligible for coverage under the Retiree Program;

e. The date the Retired Participant dies;

f. The date the Plan is discontinued;

g. The date an Eligible Retired Participant allows a non-covered or ineligible person to use said Participant's benefit card to obtain or attempt to obtain benefits fro this Plan; or

h. The date an Eligible Retired Participant materially misrepresents information provided to the Plan or commits fraud or forgery.

i. Additional reasons for termination of coverage are found in Section J (5) above.

4) Surviving Spouse and Dependent coverage shall terminate when any of the following occurs:

a) Termination of the Plan;

b) Termination of the supporting Participant's coverage;

c) The date on which the surviving spouse becomes covered under another plan other than for coverage under Medicare;

d) When a Dependent ceases to be an Eligible Dependent;

e) Termination of Surviving Spouse and/or Dependent benefits under the Plan;

f) The date on which the Surviving Spouse and/or Eligible Dependents fail to make a required self-payment under the Plan;

g) The Surviving Spouse or Surviving Dependent enters the Armed Forces on full-time active duty (See, Participants Serving in Armed Forces in Section N, above);

h) The Surviving Spouse or Surviving Dependent allows a non-covered or ineligible person to use said Surviving Spouse and/or Surviving Dependent's benefit card to obtain or attempt to obtain benefits from this Plan; or

i) The Surviving Spouse or Surviving Dependent

materially misrepresents information provided to the Plan or commits fraud or forgery.

P. Eligibility of Employees of Newly Organized Employers

1. An employee of a newly organized Employer and who is a member of a bargaining unit represented by the Union shall be eligible for benefits under this Plan on the following terms:

a. The employee is accepted into the Plumbers & Pipefitters Local Union 94 Joint Apprenticeship and Training Program; or, is registered by the Union as a journeyman.

b. If the employee is accepted as an apprentice, his eligibility benefits shall be determined by Article III, Section H.

c. If the employee is registered by the Union as a journeyman, the employee shall be entitled to immediate coverage. However, the employee shall initially have a negative Reserve Dollar Bank equivalent to 600 hours. Once the negative Reserve Dollar Bank is paid off by contributions made on the employee's behalf, the provisions of this Plan applicable to active participants shall apply.

ARTICLE III - BENEFITS FOR ELIGIBLE ACTIVE AND OFFICE AND SALARIED PARTICIPANTS AND DEPENDENTS

A. If a covered person incurs expenses as a result of non-occupational illness or injury, the Plumbers and Pipefitters Local Union No. 94 Health and Welfare Fund shall provide the benefits described below, subject to the applicable maximums, deductibles and co-insurance as set forth in the Plan's Schedule of Benefits.

1) **In-Patient Hospital Expense Benefits.**

a) Semi-private hospital room, board, and general nursing services;

b) Hospital charges for other necessary non-professional services, supplies (exclusive of replaced blood and replaced blood plasma and treatments) during the period that room and board charges are payable;

c) If an eligible person has had a break in hospital confinement of 90 or more consecutive days, that eligible person will again be entitled to 365 days of care for a subsequent confinement,

subject to the provisions of this Plan. If an eligible person is a hospital inpatient, within 90 days of his last hospital confinement, such subsequent confinement shall be deemed a continuation of the first confinement and shall be subject to the initial 365 days of care, subject again to the provisions of the Plan.

2) **Outpatient Expense Benefits**. The benefits payable in connection with confinement as an inpatient are also payable under the Plan on an outpatient basis, in accordance with the Plan's Schedule of Benefits. Such outpatient treatment must be: (1) a result of a surgical operation performed as part of outpatient treatment; (2) for emergency treatment (rendered within twenty four (24) hours after and as a result of accidental bodily injury; (3) for preadmission testing prior to a scheduled hospital confinement; or (4) for two scheduled office visits, in a physician's office or an outpatient or ambulatory facility, per year.

3) **Surgical Expense Benefits**. Surgical benefits will be payable based on Traditional Amounts, up to the maximum amounts detailed in the Plan's Schedule of Benefits, subject to the following limitations:

a) Therapeutic abortions for female Participants or spouses of male Participants are considered as an eligible expense under the Plan only in the event medically necessary as a life-sustaining measure on behalf of the mother, or if as a result of a criminal act.

b) No benefits are payable for expenses which are excluded under the general provisions of the Plan, or for expenses for reconstructive surgery unless due to an accident and providing the surgery is performed within one (I) year from the date of the accident, or if it follows previous surgery which was performed to alleviate or eliminate an illness or injury, or if it is a result of a mastectomy as outlined in Section 3(d) below.

c) The Plan does not provide coverage for transgender/transsexual surgery and treatment leading to or in connection with the surgery, subject to the following exception:

i) Where such services are considered to be “medically necessary” as that term is defined by the Plan, such surgery and treatment will be covered.

d) The Plan shall not cover any charges relating to cosmetic surgery except (i) services performed to improve a body function; (ii) services to treat a scar caused by an injury or surgery; (iii) services to correct a birth defect; or (iv) medical and surgical

benefits with respect to a mastectomy for an eligible Participant or Dependent of the Plan who elects breast reconstruction in connection with such mastectomy as listed below:

i) reconstruction of the breast on which the mastectomy has been performed,

ii) surgery and construction of the other breast to produce symmetrical appearance,

iii) coverage for prostheses and physical complications of all stages of the mastectomy including lymphedema; in a manner determined in consultation with the attending physician and the patient.

4) **Secondary Opinions**. The Plan does not require that you receive a second surgical opinion. However, if you or your dependents request one, it may be provided for you. If the first and second opinions are different, you have the option of obtaining a third surgical opinion. Your medical plan pays the cost of the second and third opinion as outlined in accordance with the Plan's Schedule of Benefits.

5) **Anesthesia Benefits**. When surgery is performed and payable in accordance with the Schedule of Benefits, either as an outpatient or while confined, the charge is payable in accordance with the Plan's Schedule of Benefits.

6) **Medical Expense Benefits (In-Hospital)**. Medical Expense Benefits, while confined, shall be based on the sum of the charges made by a physician for medical treatment during the period of hospital confinement, but not more than the maximum benefit stated in the Schedule of Benefits. One consultation charge (per admission) shall be considered an eligible expense. "Medical Treatment" shall mean professional services provided by a physician, but shall not include dental care or treatment, examinations for fitting of eyeglasses, contact lenses or hearing aids, x-ray examinations, drugs, dressing, medicines or other supplies. No benefits shall be payable under this provision for expenses which are excluded under the general provisions of the Plan or for expenses for post-operative treatment during the same period of hospital confinement for the condition necessitating surgery or a related condition.

7) **Diagnostic Laboratory Expense Benefits**. If a covered person incurs expense for a laboratory examination in connection with the diagnosis of illness or accidental bodily injury, the benefit shall be equal to the amounts charged for laboratory examinations, with the approval of a physician and reasonable and necessary to the diagnosis of the sickness

or injury. Benefits shall be provided for routine mammograms/pap smears and prostatic specific antigen (PSA) tests. No benefits shall be payable under this provision for expenses which are excluded under the general provisions of the Plan.

COVID-19 Diagnostic Testing

Effective March 1, 2020, the Plan will waive eligible Participants' and Dependents' cost-sharing, including co-pays, co-insurance, and deductibles for COVID-19 diagnostic testing as long as the testing is ordered by a medical provider.

Effective January 15, 2022 and continuing for as long as the COVID-19 Public Health Emergency remains in effect as directed by the U.S. Department of Health and Human Services, the Plan will cover the cost of Participants' and Dependents' purchase of FDA-approved over-the-counter COVID-19 test kits. This is a Pharmacy benefit provided through the Plan's Pharmacy Benefit Manager. This coverage will be without cost-sharing, prior authorization, or medical management requirements. Coverage under this provision will be limited to 8 test kits per covered Participant/Dependent per month; for example, a covered family of four would be entitled to coverage of the purchase cost of up to 32 test kits per month.

8) **Pre-Admission Testing and Same-Day Surgery**. If a physician orders pre-admission testing in a hospital or same-day surgery performed in an operating room and such services are in lieu of becoming a bed patient, the amount for these services will be paid in accordance with the Plan's Schedule of Benefits.

9) **Emergency Hospital Treatment**. The Plan shall provide benefits for outpatient emergency hospital treatment, in accordance with the Plan's Schedule of Benefits, rendered within twenty-four (24) hours after and as a result of accidental bodily injury. In addition, emergency treatment will be payable when emergency hospital treatment is received for reasons due to a medical emergency, which can be considered necessary for sustaining life, or under circumstances which can be reasonably determined as emergencies. Subject to the provisions of Article I(C), treatment for general medical-related expenses (headaches, colds, etc.) are not considered eligible expenses under this provision of the Plan and are considered for payment under the Plan's Supplemental Medical Benefits provisions and in accordance with the deductible and co-insurance provisions set forth under those provisions.

10) **Radiotherapy Expense Benefits**. If a covered person incurs expense for the necessary therapeutic use of x-ray, radium or other radioactive substances in connection with the treatment of an illness or accidental bodily injury, the Fund will pay benefits, as set forth in the Schedule of Benefits.

11) **Maternity Expense Benefits**. Maternity-related expenses shall be payable under the Plan's Schedule of Benefits for the mother or the newborn, as any other illness for female Participants and legal spouses of male Participants for a minimum of 48 hours (following a normal vaginal delivery) and for a minimum of 96 hours (following a cesarean section). However, the benefits shall not be affected if the Participant or Spouse leaves earlier with approval of her physician.

12) **Organ Transplant Procedures**. The following organ transplant procedures shall be payable as any other illness under the Plan's Schedule of Benefits provided the procedure is not considered to be experimental:

- bone marrow;
- cornea;
- heart;
- heart/lung;
- kidney;
- liver;
- lung;
- pancreas; and
- pancreas/kidney

A transplant must occur during a transplant benefit period. A transplant benefit period starts five days before the day of the first covered transplant and ends 12 months later. A new transplant benefit period starts only if the next covered transplant occurs more than 12 months after the last covered transplant was performed. No transplant benefit periods and/or organ transplant maximums will apply to kidney, pancreas/kidney or cornea transplants.

(a) Organ Transplant Pre-Certification is required in order for an organ transplant to be a Covered Service and the proposed course of treatment must be pre-certified and approved. No benefits will be provided for organ transplant services which have not been pre-certified.

(b) A treating physician must provide the Plan Administrator with:

- the proposed course of treatment for the transplant:
- the name and location of the proposed transplant center: and
- copies of all medical records, including diagnostic reports showing the suitability and medical necessity of the transplant services.

A determination will be made in accordance with uniform medical criteria specifically tailored to each organ. A Participant may also be required to undergo an examination by a physician chosen by the Plan .

(c) Obtaining Donor Organs - The following services will be Covered Services when they are necessary in order to acquire a legally obtained human organ:

- evaluation of the organ;
- removal of the organ from the donor; and
- transportation of the organ to the transplant center.

Expenses necessary for obtaining an organ from a living donor or cadaver are covered. Donor benefits are provided and processed under the transplant recipient's coverage only and are subject to any applicable limitations and exclusions, including the limits in the Schedule of Benefits.

(d) Benefits After Termination of Coverage - Benefits will be provided for Covered Services related to the organ transplant which you receive during a transplant benefit period which began while you were a Covered Person.

(e) The Plan will not provide organ transplant benefits for services, supplies or charges:

- which are not furnished through a course of treatment which has been approved by the Plan:

- which are not provided during a transplant benefit period;

- for other than a legally obtained human organ; or

- for travel time and the travel-related expenses of a Provider.

13) **Nervous and Mental Disorders**. The benefits provided under the Plan relating to the treatment of Nervous and Mental disorders, on either an inpatient and/or outpatient basis, shall be payable as any other medical benefit.

14) **Chemical, Alcohol and Drug Abuse**. The benefits provided under the Plan relating to the treatment of chemical, alcohol and drug abuse, on either an inpatient and/or outpatient basis, shall be payable as any other Medical benefit.

15) **Podiatric Expenses**. Podiatric expenses are payable in accordance with the provisions of the Plan. However, no benefits shall be provided for podiatric care due to: treatment of weak, strained or flat feet or instability or imbalance of the foot; treatment of corns, calluses or the free edge of toenails except when necessitated due to peripheral vascular disease or other illnesses of similar medical severity.

16) **Hospice Services**. Hospice services consist of health care services provided to a terminally ill Covered Person. Hospice services must be provided through a freestanding Hospice Facility or a hospice program sponsored by a Hospital or Home Health Care Agency. Hospice services may be received by the Covered Person in a private residence. Benefits for hospice services are available when the prognosis of life expectancy is six months or less. The following Covered Services are considered hospice services:

- professional services of a registered or licensed practical nurse;
- treatment by physical means, occupational therapy and speech therapy;
- medical and surgical supplies;
- prescription drugs: limited to a two-week supply per prescription order or refill (These prescription drugs must be required in order to relieve the symptoms of a condition, or to provide supportive care).
- oxygen and its administration;
- medical social services, such as the counseling of patients
- home health aide visits when you are also receiving covered nursing or therapy services;
- acute inpatient hospice services;
- respite care;
- dietary guidance;
- counseling and training needed for a proper dietary program;
- durable medical equipment; and
- bereavement counseling for family members.

A treatment plan must be developed and submitted to the Claims Payor by the Covered Person's Physician and the Provider of the hospice services. The treatment plan must be approved by the Claims Payor. Non-covered hospice services include but are not limited to:

- volunteer services;
- spiritual counseling;
- homemaker services;

- food or home delivered meals;
- chemotherapy or radiation therapy if other than to relieve the symptoms of a condition;
- custodial care, rest care or care which is only for someone's convenience

17) **Physical Therapy** – Services of a licensed physical therapist, when certified by an attending physician. The individual may be required to have an independent medical examination by a provider selected by the Trustees. Treatment will be limited to a maximum number of 64 visits per calendar year, except for that required for treatment of Autism.

18) **Treatment for Neuromusculoskeletal Conditions – Chiropractic Therapy Expenses.**

a) Except as otherwise provided or limited in this Plan, covered expenses shall include charges incurred only for active therapeutic rehabilitative treatment for an acute or chronic condition which treatment is directed toward the correction of the condition within an anticipated reasonable and predictable period of time.

b) Diagnostic tests and/or therapeutic treatments must be considered to be scientifically valid and clinically accepted in accordance with established medical review mechanisms and standards.

c) Treatments using manipulation or adjustment which are performed by hand only shall be considered as an covered expense under the Plan.

d) X-ray expenses shall be considered for covered expenses under the Plan provided they are medically necessary. Full spine x-rays shall not be considered for covered expenses under the Plan.

e) Manipulation, mobilization, adjustment, massage and/or physical therapy charges which are incurred by a Dependent Child who is under the age of ten (10) shall not be considered covered expenses by the Plan, unless a certificate of necessity is furnished by a Board-certified pediatrician and/or Board-certified pediatric orthopedist.

f) Up to thirty-six (36) chiropractic treatments shall be considered covered expenses under the Plan. However, if a provider proposes to exceed the initial twenty-four (24) treatments, then the provider shall be required to submit to the Plan, prior to the completion of the initial twenty-four (24) treatments, documentation which, in the opinion of the Plan, will justify up to twelve (12) additional treatments. The Plan is entitled to utilize an independent medical examination by a provider selected by the

Plan to assist the Plan in determining whether any further additional treatments should be approved.

g) No coverage shall be provided for the following:

i) Maintenance, preventative or reconstructive treatment;

ii) Experimental drugs and medicines which are not commercially available and approved for general use by the United States Food & Drug Administration as effective for the treatment or diagnosis of the injury or illness;

iii) Services and procedures which are not considered effective for the treatment or diagnosis of the injury or illness at the time they are performed or provided.

19) **FDA-Approved Gene Therapy.** The Plan provides coverage for current and subsequent FDA-approved gene therapies. Such therapies will be covered exclusively as medical benefits and not pharmacy or prescription benefits. Therapies must be medically necessary and are subject to precertification and preauthorization under the Plan to assure that their use meets FDA-approved indications.

ARTICLE IV - PRESCRIPTION DRUGS

1) Covered expenses include prescription drugs, self-administered drugs and medicines requiring a physician's written prescription, insulin and syringes without a physician's written prescription (provided the Fund is advised in advance of prescribed dosage). Prescription drugs include pre-natal vitamins during pregnancy. Also, effective August 28, 2014, coverage is provided for prescription contraceptives to the same extent as coverage is provided for prescription drugs, devices, and services that are used to prevent the occurrence of medical conditions other than pregnancy.

Further, effective October 15, 2015, covered expenses will not include PCSK9 Inhibitor drugs. These drugs are new to the market and, thus, have not previously been covered.

2) The percent co-pay for brand name drugs without a generic equivalent is 20% for both retail and mail order prescriptions.

3) The percent co-pay for generic drugs is 10% for both retail and mail order prescriptions.

4) If you choose to use a brand name drug when a generic equivalent is available, the percent co-pay will be 30%.

5) For maintenance medications that have been filled at a non-CVS/Caremark retailer, any fill after the first three (3) refills shall only be available through CVS/Caremark mail order or at a CVS/Caremark retailer.

ARTICLE V - BASIC PLAN FOR RETIREES AND DEPENDENTS

1) RETIRED PARTICIPANTS AND ELIGIBLE DEPENDENTS WHO ARE NOT MEDICARE ELIGIBLE: The Schedule of Benefits of the Active Program will apply and will be provided to retired participants and eligible dependents who are not Medicare eligible. Provided, however, vaccines for Shingles and Whooping Cough that are provided to eligible Medicare participants under Article I, Schedule of Benefits, shall not be subject to the co-pay requirements in Article I, Schedule of Benefits.

Effective August 1, 2020, the Plan shall provide coverage for the Shingrex and Zostavax shingles vaccines for Medicare retiree Participants. The Plan will pay 100% of the cost of the vaccine for these retired Participants.

2) RETIRED PARTICIPANTS AND ELIGIBLE DEPENDENTS WHO ARE MEDICARE ELIGIBLE, THE FOLLOWING BENEFITS SHALL APPLY:

Prescription Drug Benefit as provided in Prescription Drug Program Policy

Other Benefits - Medicare Supplemental Coverage as provided below.

3) MEDICARE SUPPLEMENTAL COVERAGE

Medicare Supplemental Coverage shall be provided to Eligible Retired Participants and their Dependents by the Fund. The Board of Trustees has elected to provide these benefits on an insured basis. This election may be changed or cancelled at any time by the Board of Trustees. The following benefits are provided to all Eligible Retired Participants and their Dependents who are eligible for, and enrolled in, Medicare Parts A and B:

Medicare Part A Expenses (inpatient hospital charges)	Medicare Deductible Amounts
Medicare Part B Expenses	Applicable Deductible Amounts
Other Benefits	As provided by the individual policy issued to the Retired Participant under the Retiree Program

IF YOU, AS A RETIRED PARTICIPANT, CEASE OR LOSE COVERAGE UNDER THE PLAN AND ENROLL IN MEDICARE PART D PRESCRIPTION COVERAGE, YOU WILL NOT BE ELIGIBLE TO RE-ENROLL IN THE PLAN TO OBTAIN PRESCRIPTION COVERAGE.

IF A PARTICIPANT IS ELIGIBLE FOR BUT NOT ENROLLED IN MEDICARE PARTS A AND B, THE RETIREE INSURANCE PROGRAM WILL MAKE ITS PAYMENTS BASED UPON THE BENEFITS WHICH WOULD HAVE BEEN PAYABLE ON THE PARTICIPANT'S BEHALF UNDER THE MEDICARE PROGRAM.

ARTICLE VI - PLAN EXCLUSIONS AND LIMITATIONS

1) Plan Exclusions. Eligible or covered expenses do not include any charges which are excluded under the general provisions of the Plan, including the following:

a) Hospitalization, medical or surgical treatment provided by the U.S. Government or any instrumentality therefor, except as required by law.

b) Any services for which any benefits are available under federal, state or other laws (except where payment under the Plan is mandated).

c) Except as otherwise provided in this Plan, any loss incurred while engaged in any branch of the military, naval or air service.

d) Any loss caused by war or an act of war.

e) Any loss incurred while attempting or during the commission of a felony.

f) Services rendered for cosmetic purposes, except for an accidental injury occurring while coverage is in effect.

g) Reconstructive surgery except as otherwise provided.

h) Abortions which are not medically necessary as a life-sustaining measure or as a result of a criminal act.

i) Hearing aids, or the examination for their fining.

j) Routine foot care and removal of corns, calluses, toenails or subcutaneous tissue.

k) Travel, even though prescribed by a physician.

l) Services for training or educational purposes.

m) Pregnancy-related charges for a Dependent Child.

n) Charges in excess of Traditional Amounts.

o) Custodial or medically unnecessary care relating to routine daily activities (bathing, feeding, etc.)

p) Massotherapy charges.

q) Personal services and supplies (including telephone rentals, convenience items).

r) Orthotics, except as provided herein.

s) Non-prescription items (except for insulin and related supplies and where specifically included herein).

t) Charges relating to temporomandibular joint dysfunction (TMJ).

u) Speech therapy, except for purposes of rehabilitative treatment, as prescribed by your physician.

v) Charges relating to weight loss and treatment of obesity.

w) Treatment at sleep disorder centers.

x) Marriage counseling.

y) Charges relating to infertility, impotency.

z) Charges relating to in-vitro fertilization.

aa) Charges for which the covered person is not required to payor for which he may not be legally billed.

bb) Charges incurred during confinement in a hospital owned or operated by a state, province or political subdivision unless there is an unconditional requirement to pay these charges.

cc) Charges incurred to the extent that benefits are payable therefor by any plan which this Plan replaces.

dd) Any charges incurred for any service or treatment which is not recommended by a physician

ee) Services performed by a member of a Participant's immediate family.

ff) Accidental bodily injuries arising out of or in the course of the employment of a Participant or eligible person or sickness and/or disease covered by a Workers' Compensation law or similar legislation.

gg) Services, treatments, or supplies furnished by or for the United States Government or any agency thereof.

hh) Charges for which the covered person is not required to pay.

ii) Charges incurred to the extent that benefits are payable therefore by any plan which this Plan replaces.

jj) Any charges incurred for any service or treatment which is not recommended by a physician.

kk) Rest, custodial care.

ll) Services for treatment rendered in facilities outside of the United States for which Medicare will not pay. (Retired Participants only.)

mm) Any expense that Medicare does not cover, unless a specific extension of such benefits is provided under the Plan. (Retirees only).

If a Participant is eligible for but not enrolled in Medicare Parts A and B, the Retiree Insurance Program will make its payments based upon the benefits which would have been payable on the Participant's behalf under the Medicare Program.

No duplication of payments will be made by the Plan.

ARTICLE VII - DEATH AND DISMEMBERMENT BENEFITS

1) **Death Benefits - (Active Hourly and Retired Participants).** In the event of an active hourly and retired Eligible Participant's death while covered under this Plan, the Plan will provide a payment of twelve thousand dollars ($12,000) to the person who has been designated as the Active Hourly or Retired Participant’s Beneficiary. This benefit is not available to a surviving spouse and/or dependents.

2) **Dismemberment Benefits.** The Fund shall provide a benefit to Eligible Participants for losses resulting from injuries sustained in an accident, provided:

a) The losses occur within ninety (90) days following the date of the accident, and are a direct result of such injuries; and

b) The injuries are evidenced by a contusion or visible wound.

3) **Benefits Payable for loss of:**

Life	Principal sum	($12,000)
Both Hands or Both Feet	Principal sum	($12,000)
Sight of Both Eyes	Principal sum	($12,000)
One Hand	One half of Principal sum	($6,000)
One Foot	One half of Principal sum	($6,000)
Sight of One Eye	One half of Principal sum	($6,000)

Loss of a hand or foot means actual severance through or above the wrist or ankle joint. Loss of an eye means the entire and irrevocable loss of sight of the eye.

4) **Maximum Benefit.** The maximum benefit which shall be payable for all losses resulting from injuries sustained in anyone accident shall be the largest benefit which is specified in the above Schedule.

5) **Limitations on Dismemberment Benefits.** No benefits shall be payable for any loss resulting from:

a) Disease or infection, except an infection resulting from an accidental cut or wound;

b) Declared or undeclared war, or an act of war;

6) **Designation of Beneficiary.** The Eligible Participant's Beneficiary shall be the person who has been designated by the Participant on a form satisfactory to the Fund. The Participant may change his Beneficiary at any time by filing a written notice satisfactory to the Fund. The new designation shall take effect on the date the Eligible Participant signs the notice of change. When a new Beneficiary is designated, the interest of any previously designated Beneficiary shall cease.

7) If, at the death of the Eligible Participant, no named Beneficiary is surviving, the amount of the benefit will be paid, in a single sum, to the Eligible Participant's Spouse, if living; otherwise, in equal shares to the then living children of the Eligible Participant, if any; or if none, in equal shares to the father and mother of the Eligible Participant or to the survivor of them; if none, then to the estate of the Eligible Participant. All other benefits provided by the Fund shall be payable to the Eligible Participant or Eligible Retired Participant as the eligible person.

ARTICLE VIII - WEEKLY ACCIDENT AND SICKNESS BENEFITS
(Excludes Retired Participants Except As Provided in Article II, Section K(2) of The Plan)

1) Subject to the Limitations and Exclusions as stated herein, the Plan shall pay the Eligible Participant the following benefits:

a) For the first day of a disabling accident, heart attack, or a condition which

requires hospital confinement from the outset. Otherwise, the benefit will commence on the eighth (8^{th}) day of disabling illness in the amount of $580/week (rate effective September 23, 2021) based on a 7 days per week basis.

2) **Maximum Benefits.** A maximum benefit of twenty-six (26) weeks in any calendar year shall be applied for each period of disability. However, should the Participant's treating provider submit sufficient documentation to the Plan that the Participant's same-cause disabling condition still exists after the 26 weeks and will likely continue to exist thereafter, then the Participant can remain eligible for this disability benefit for the duration of that condition but only for up to 13 more weeks.

3) **Period of Disability.** Successive periods of disability due to unrelated causes which are separated by the eligible Participant's return to full-time employment for at least one (1) day shall be considered separate periods of disability for purposes of determining maximum benefits.

4) Successive periods of disability related to the same cause shall be considered as one period of disability unless the subsequent disability is separated from the prior disability by at least eighty (80) or more hours of active employment.

5) **Exceptions and Limitations.**

a) Payment under this Plan provision shall be made over and above all other payments provided under the Plan and shall not be coordinated with any other Plan.

b) No payment shall be provided by the Plan for those disabilities which result from the Employee's occupation or employment and which are considered eligible for payment under any Workers' Compensation or similar law.

c) The Participant must be under the care of a legally qualified Physician, in order to be eligible for weekly benefits provided by the Plan, with acceptable certification of the disabling illness/accident provided to the Fund Office by the Physician.

ARTICLE IX - DENTAL AND VISION BENEFITS
(Includes Retiree Participants)

1) The Dental and Vision Benefits provided by the Plan will be a maximum combined benefit of $2,000.00 for coverage to Eligible Participants and their Eligible Dependents for dental and vision expenses. The Plan will pay eighty percent (80%) of dental and vision expenses up to a maximum payment of $2.000.00 per family per calendar year for combined vision and dental benefits. Provided, however, that, effective January 1, 2012, pediatric dental and vision essential benefits shall not be subject to the $2,000.00 per family per calendar year limitation.

2) Claims are payable through the Fund Office either directly to the Provider or, for

expenses already paid by the Participant, directly in reimbursement to the Participant upon Participant's submission of proof of payment to the Fund Office. Benefits cannot be assigned. Dental Benefits are not subject to the Plan's Coordination of Benefits provision.

ARTICLE X - CONTINUATION OF COVERAGE (COBRA)

Federal law requires most employers sponsoring group health plans to offer Employees and their families the opportunity to elect a temporary extension of health coverage, called "continuation coverage" or "COBRA coverage", in certain instances where coverage under the group health plan would otherwise end. You do not have to show that you are insurable to elect continuation coverage. However, you will have to pay the entire premium for your continuation coverage.

This summary is intended only to summarize your rights and obligations under the law. The Plan offers no greater COBRA rights than what the COBRA statute requires, and this Notice should be construed accordingly.

Both you (the Employee) and your spouse should read this summary carefully and keep it with your records.

Qualifying Events

If you are an Active Participant covered by the Plan, you have a right to elect continuation coverage if you lose coverage under the Plan because of any one of the following two "qualifying events":

1. Termination of your employment for reasons other than your gross misconduct, and
2. Reduction in the hours of your employment.

If you are the Spouse of an Active Participant or Retired Participant covered by the Plan, you have the right (if you have not waived such right) to elect continuation coverage if you lose coverage under the Plan because of any of the following four "qualifying events":

1. The death of your Spouse.

2. A termination of your Spouse's employment for reasons other than gross misconduct or reduction in your Spouse's hours of employment with the Employer.

3. Divorce or legal separation from your spouse. Also, if an Employee drops his or her Spouse from coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Administrative Manager within 60 days of divorce and can establish that the coverage was dropped earlier in anticipation of divorce, then COBRA coverage may be available for the period after the divorce or legal separation.

4. Your Spouse becomes entitled to Medicare benefits.

In the case of a dependent child of an Active Participant covered by the Plan, he or she has the right to elect continuation coverage if group health coverage under the Plan is lost because of any of the following five "qualifying events":

1. The death of the Active Participant's parent.

2. The termination of the Active Participant parent's employment for reasons other than gross misconduct or reduction in the Employee parent's hours of employment with the Employer.

3. Parents' divorce or legal separation.

4. The Active Participant's parent becomes entitled to Medicare benefits.

5. The dependent ceases to be a "dependent child" under the Plan.

Notices and Election

The Plan provides that your Spouse's coverage terminates and, thus, is lost as of the last day of the month in which a divorce or legal separation occurs. A dependent child's coverage terminates the last day of the month in which he or she ceases to be an eligible dependent under the Plan (for example, after attainment of a certain age). Under the COBRA statute, the Participant or a family member has the responsibility to notify the Administrative Manager upon a divorce, legal separation, or a child losing dependent status. You or a family member must provide this notice no later than 60 days after the last day of the month of the divorce, legal separation, or a child losing dependent status. If you or a family member fails to provide this notice to the Administrative Manager within this 60 day notice period, any family member who loses coverage will NOT be offered the option to elect continuation coverage. Further, if you or a family member fails to timely notify the Administrative Manager and any claims are paid mistakenly for expenses incurred after the last day of the month of the divorce, legal separation, or a child losing dependent status, then you and your qualifying family members will be required to reimburse the Plan for any claims so paid.

If the Administrative Manager is provided timely notice of a divorce, legal separation, or a child's losing dependent status that has caused a loss of coverage, the Administrative Manager will notify the affected family member of the right to elect continuation coverage.

You and/or your qualifying family member will be notified of the right to elect continuation coverage automatically, without any action required by you or a family member, upon the following events that result in a loss in coverage: the termination of your employment other than for gross misconduct, reduction in hours, death, or you becoming entitled to Medicare.

You (the Active Participant or Retired Participant) or your qualifying family member must elect continuation coverage within 60 days after Plan coverage ends, or, if later, 60 days

after the Administrative Manager sends you or your family member notice of the right to elect continuation coverage. If you or your qualifying family member does not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage. Your (or your qualifying family member's) election is effective on the day the election is sent to the Administrative Manager. Please Note: No claims will be paid until the COBRA payment is received.

An Active Participant or the Spouse of the covered Active Participant may elect continuation coverage for all qualifying family members. The covered Active Participant and his or her Spouse and dependent children each have an independent right to elect continuation coverage. Thus, a Spouse or dependent child may elect continuation coverage even if the Active Participant does not or is not deemed to elect it.

You or your qualifying family member can elect continuation coverage if you or the family member, at the time you or the family member elect continuation coverage, are covered under another employer-sponsored group health plan or are entitled to Medicare.

Type of Coverage; Premium Payments

Ordinarily, you or your qualifying family member will be offered COBRA coverage that is the same coverage that you, he, or she had on the day before the qualifying event. Therefore, a person (Active Participant or Retired Participant, spouse or dependent child) who is not covered under the Plan on the day before the qualifying event is generally not entitled to COBRA coverage except, for example, where there is no coverage because it was eliminated in anticipation of a qualifying event like divorce.

If the coverage for similarly situated employees or their family members is modified, COBRA coverage will be modified the same way.

The premium payments for the "initial premium months" must be paid for you and any qualifying family member by the 45th day after electing continuation coverage. The initial premium months are the months that end on or before the 45th day after the date of the COBRA election. All other premiums are due on the 1st of the month for which the premium is paid, subject to a 30-day grace period. A premium payment is made on the date it is post-marked or actually received whichever is earlier.

Maximum Coverage Periods

36 Months. If your spouse or dependent child loses group health coverage because of the Active Participant's death, divorce, legal separation, or the Active Participant becoming entitled to Medicare, or because the dependent loses status as a dependent under the Plan, the maximum coverage period for spouse and dependent child is 36 months from the date of the qualifying event.

18 Months. If you (Active Participant, spouse or dependent child) lose group health coverage because of the Active Participant's termination of employment other than for gross misconduct or reduction in hours, the maximum continuation coverage period for the Active Participant, spouse and dependent child is 18 months from the date of termination or reduction in hours. There are three exceptions:

* If an Active Participant or Retired Participant or family member is disabled at any time during the first 60 days of continuation coverage, running from the date of termination of employment or reduction in hours, the continuation coverage period for all qualified beneficiaries under the qualifying event is 29 months from the date of termination or reduction in hours. The Social Security Administration must formally determine under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the disability exists and when it began. For the 29-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided to the Employer or the Administrative Manager both within the 18-month coverage period and within 60 days after the date of the determination.

***** If a second qualifying event that gives rise to a 36 month maximum coverage period, i.e., the Employee dies or becomes divorced, occurs within an 18-month or 29-month coverage period, the maximum coverage period becomes 36 months from the date of the initial termination or reduction in hours.

* If the qualifying event occurs within 18 months after an individual becomes entitled to Medicare, the maximum coverage period for the spouse and dependent child ends 36 months from the date the individual became entitled to Medicare.

Children Born To or Placed for Adoption with the Active Participant after the Qualifying Event

If, during the period of continuation coverage, a child is born to, adopted by, or placed for adoption with the Active Participant and the Active Participant has elected continuation coverage for himself or herself, the child is considered a qualified beneficiary. The Active Participant or other guardian has the right to elect continuation coverage for the child provided the child satisfies the otherwise applicable plan eligibility requirements (for example, age). The Active Participant or a family member must notify the Administrative Manager within 30 days of the birth, adoption, or placement to enroll the child on COBRA, and COBRA coverage will last as long as it lasts for other family members of the Active Participant. The 30-day period is the Plan's normal enrollment window for newborn children, adopted children, or children placed for adoption. If the Active Participant or family member fails to so notify the Administrative Manager in a timely fashion, the Active Participant will NOT be offered the option to elect COBRA coverage for the child.

Extension of the length of continuation coverage

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Office of the Administrative Manager of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An eleven (11) month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Office of the Administrative Manager of that fact within 30 days of SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have cause the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Office of the Administrative Manager within 60 days after a second qualifying event occurs.

Termination of COBRA Before the End of Maximum Coverage Period

Continuation coverage of the Active Participant, Retired Participant, spouse and/or dependent child will automatically terminate before the end of the maximum coverage period when any one of the following six events occurs:

1. The Plan no longer provides group health coverage.

2. The premium for the qualified beneficiary's COBRA coverage is not timely paid.

3. After electing COBRA, you (Active Participant, Retired Participants, Spouse or dependent child) become covered under another group health plan as an Employee or otherwise that has no exclusion or limitation with respect to any preexisting condition that you have. If the other plan has applicable exclusions or limitations, your COBRA coverage will terminate after the exclusion or limitation no longer applies, i.e., after a 12-month preexisting condition waiting period expires. This rule applies only to the qualified beneficiary who becomes covered by another group health plan. Note that under Federal law (the Health Insurance Portability and Accountability Act of 1996, an exclusion or limitation of the other group health

plan might not apply at all to the qualified beneficiary, depending on the length of his or her creditable health plan coverage prior to enrolling in the other group health plan.

4. After electing COBRA, you (Active Participants, Retired Participants, Spouse or dependent child) become entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.

5. If you (Active Participants, Retired Participants, Spouse or dependent child) became entitled to a 29-month maximum coverage period due to disability of a qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than 30 days after the determination).

6. Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered Employees or their spouses or dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of Federal law.

Retired Participants

1. Pre-65. If you retire prior to age 65 and have exhausted your Reserve Bank, you shall be offered COBRA coverage to the extent you have not already received retiree coverage from the Fund. Any period of retiree coverage from the Fund shall be counted against the applicable continuation coverage.

2. 65 and older. If you retire at age 65 or older, you shall have the option to receive retiree medical coverage through the Plan or COBRA. However, if you chose retiree medical coverage at retirement then you will cease to be a qualified beneficiary once the COBRA election period has expired and you will not be eligible for any COBRA coverage.

Election of continuation coverage

To elect continuation coverage, you must complete an Election Form and furnish it according to the direction on the form. Obtain the Election Form from the Administrative Manager's Office. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied

to you by other group health plans if you have more than a 63-day gap in health coverage, and the election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the rights to request special enrollment in another group health plan for which you are otherwise eligible such as a plan sponsored by your spouse's employer within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Cost for continuation coverage

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent or, in the case of an extension on continuation coverage due to a disability, 150 percent of the cost to the group health plan including both employer and employee contributions for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for continuation coverage for each option is described in this Notice.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event that is an involuntary termination of employment during the period beginning with September 1, 2008 and ending with December 31, 2009. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the Plan. This premium reduction is available for up to nine months. If your COBRA continuation coverage lasts for more than nine months, you will have to pay the full amount to continue your COBRA continuation coverage.

Particularly, the law gives "Assistance Eligible Individuals" the right to pay reduced COBRA premiums for periods of coverage beginning on or after February 17, 2009 and can last up to 9 months.

To be considered an "Assistance Eligible Individual" and get reduced premiums you:

- MUST be eligible for continuation coverage at any time during the period from September 1, 2008 through December 31, 2009 and elect the coverage;

- MUST have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through December 31, 2009;

- MUST NOT be eligible for Medicare; AND

- MUST NOT be eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse's employer.[4]

Individuals who experienced a qualifying event as the result of an involuntary termination of employment at any time from September 1, 2008 through February 16, 2009 and were offered, but did not elect, continuation coverage OR who elected continuation coverage and subsequently discontinued it may have the right to an additional 60-day election period.

IMPORTANT

- If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you MUST notify the plan in writing. If you do not, you may be subject to a tax penalty.

- Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.

- The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than $125,000 (or $250,000 for married couples filing a joint federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at www.irs.gov.

For general information regarding your plan's COBRA coverage you can contact the Office of The Administrative Manager, Plumbers & Pipefitters Local 94 Health & Welfare Fund, 3660 Stutz Drive, Ste. 101, Canfield, OH 44406, Phone 330-779-8874.

For specific information related to your plan's administration of the ARRA Premium Reduction or to notify the plan of your ineligibility to continue paying reduced premiums, contact the Office of The Administrative Manager, Plumbers & Pipefitters Local 94 Health & Welfare Fund, 3660 Stutz Drive, Ste. 101, Canfield, OH 44406, Phone 330-779-8874.

If you are denied treatment as an "Assistance Eligible Individual," you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction, go to: www.dol.Qov/COBRA or call 1-866-444-EBSA (3272)

[4] Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

There may be other coverage options for you and your family under the Patient Protection and Affordable Care Act. When the key parts of this new health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

When and how must payment for COBRA continuation coverage be made?

First payment for COBRA 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 no later than 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 not later than 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Plan.

You are responsible for making sure that the amount of your payment is correct. You may contact the Office of the Administrative Manager to confirm the correct amount of your first payment.

Your first payment for COBRA continuation coverage should be sent to:

Office of The Administrative Manager
Plumbers & Pipefitters Local 94 Health & Welfare Fund
3660 Stutz Drive, Ste. 101
Canfield, OH 44406

Periodic payments for COBRA continuation coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. The amount due for each coverage period for each qualified beneficiary is shown in this Notice. Under the Plan, these periodic payments for continuation coverage are due on the first day of each month. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods.

Periodic payments for COBRA continuation coverage should be sent to:

Office of The Administrative Manager
Plumbers & Pipefitters Local 94 Health & Welfare Fund
3660 Stutz Drive, Ste. 101
Canfield, OH 44406

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic 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 pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of its grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated going back to the due date when the periodic payment is made. 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 periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA continuation coverage under the Plan.

Can you elect other health coverage besides continuation coverage?

Yes. Under the Plan, if you have exhausted your COBRA continuation of coverage, you have the right to elect additional coverage for a period of one (1) year at the same cost as the COBRA continuation coverage rates set by the Board of Trustees. Such coverage is limited to a maximum benefit of $60,000.00 and is conditioned upon the Participant actively pursuing alternative coverage. You must contact the Office of the Administrative Manager if you wish to elect such additional coverage.

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your Summary Plan Description or from the Office of the Administrative Manager.

Further, the “General Notice of COBRA Continuation Coverage Rights”, the “Election Notice”, and the “Election Form” are all available from the Administrative Manager.

Please be reminded that if your marital status changes, or an Eligible Dependent or Eligible Retiree Dependent ceases to be a dependent eligible for coverage under the Plan, or you or your spouse’s address change, you must immediately notify the Administrative Manager.

If you have any questions concerning the information in this Notice, your rights to coverage, or if you want a copy of your Summary Plan Description, you should contact the Office of The Administrative Manager, Plumbers & Pipefitters Local 94 Health & Welfare Fund, 3660 Stutz Drive, Ste. 101, Canfield, OH 44406, Phone 330-779-8974.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), the Patient Protection and Affordable Care Act (PPACA) and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA web site at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.)

ARTICLE XI - COORDINATION OF BENEFITS

1) If an Eligible Person has coverage with any other insurance carrier or medical benefit plan and all or a portion of the cost thereof shall directly or indirectly have been payable by an Employer or paid by or through payroll deductions or payable by or through a group or association, and if such other coverage provides to such Eligible Person any of the services and supplies or reimbursement for any part of the cost thereof for which benefits are payable to or on behalf of such Eligible Person hereunder, then this Plan will coordinate its Schedule of Benefits with the other Plan. However, such coordination of benefits shall not apply to Dental or Vision Benefits of this Plan.

2) **Definition.** The term "another plan" or “other plan" includes any plan providing benefits or services for or by reason of hospital or medical treatment which benefits or services are provided by:

a) Group, blanket or franchise insurance coverage.

b) Any coverage under labor management trusted plans, union welfare plans, employer organization plans, employee benefits organization plans or any other arrangement of benefits for individuals of a group.

c) Any other plan which has a coordination provision within that

plan.

d) Any other plan which provides coverage arising out of any claim or cause of action which might accrue because of an alleged negligent conduct of a third party.

e) Any governmental plan or program created by federal or state statute or regulations for the purpose of providing some or all of the benefits as set forth in this Plan, including but not limited to Medicare, whether enrolled in or applied for.

f) The term "plan" shall be considered separately for each plan and also between that part of any plan which applies to the Anti-Duplication provision and that part which does not.

g) "Allowable Expenses" shall mean any necessary, reasonable and customary item of expense for hospital or medical treatment which is covered under at least one of the Plans covering the person for whom a claim is made. If both spouses are Participants, one hundred percent (100%) of all covered expenses shall be paid.

3) **Provision for Allowable Expenses.** Benefits payable for allowable expenses incurred during a claims determination period shall be paid subject to the following limitations:

a) If an Eligible Participant is covered as an Eligible Participant under another plan, the Fund will pay initially one-half of the allowable expense, and after the other plan has paid a share equal to the Fund's initial contribution, the Fund shall pay remaining allowable expenses, if any.

b) If a Dependent of an Eligible Participant is covered for benefits under another plan as a Dependent of an individual who is not an Eligible Participant of this Plan, the plan covering the parent whose birthday occurs earlier in the calendar year will pay first as the primary payor on behalf of the child, subject to the Plan's Schedule of Benefits (providing the parents are not separated or divorced). In the event the other parent's plan is not required to follow this provision (the Birthday Rule), this Fund will pay its pro rata share, up to one-half (1I2) of the allowable expenses as determined by benefits provided under this Fund and the remaining allowable expenses, if any, after the other plan has paid all it can pay and its share becomes less than the share paid by this Fund.

c) If the Dependent fails to comply with the requirements of the other plan or fails to utilize the requirements of the other plan or fails to utilize a Health Maintenance Organization (HMO) which has been selected by the individual who is a Participant under the other plan which would have

been the primary provider, this Fund will pay its pro rata share, up to one-half (1/2) of the allowable benefits provided under this Fund.

d) If a Dependent of an Eligible Participant is covered for benefits as a participant under another plan, this Fund will not pay any benefits towards the Dependent's claim until that Dependent's benefits under the other plan are exhausted: if there are additional bills payable towards that claim, this Fund shall pay any remaining allowable expenses, if any. If the Dependent, as a participant in the other plan, fails to comply with the requirements of the other plan or fails to utilize a Health Maintenance Organization (HMO) which has been selected by the Participant under the other plan which would have been the primary provider, this Fund will not pay any portion of the allowable expenses incurred by the individual.

e) In the event of any payment for services by this Fund, the Fund shall to the extent of such payment be subrogated to all the rights of recovery of the Eligible Participant and/or Eligible Dependent arising out of any claim or cause of action which may accrue because of the alleged negligent conduct of a third party. The Eligible Participant and/or Eligible Dependent shall reimburse the Fund for any benefits paid out of any monies recovered from any third party as the result of judgment, settlement or otherwise. The Eligible Participant and/or Eligible Dependent shall furnish such information and assistance, and execute and deliver all necessary instruments as the Fund may require to facilitate the enforcement of its rights.

4) **Coordination with Governmental Programs and Programs Required by Statute.** Benefits payable for allowable expenses included during a claims determination period shall be paid subject to the following limitations:

a) **Medicare.** This Plan will pay its benefits before Medicare for the following individuals:

1. An actively employed Eligible Participant who is of Medicare-qualifying age and/or an actively employed Eligible Participant's Spouse who is of Medicare qualifying-age:

2. A disabled Eligible Participant who is of Medicare-qualifying age and who has a relationship with a participating Employer indicative of an employee status, or the Active Participant's disabled Spouse or Dependent who is of Medicare-qualifying age and who is eligible for benefits under Medicare.

3. This Plan will be considered the primary payor of

benefits for an Eligible Participant and/or Dependent under Medicare-qualifying age who is disabled due to end-stage renal disease for the first thirty (30) months following the date of Medicare entitlement.

b) For all other Eligible Participants. Retirees or Dependents eligible for Medicare, whether or not enrolled in or applied for, benefits are to be paid first by Medicare, after which this Plan will make its coordinated benefit payment. The amount of benefits payable under this Plan will be coordinated so that the aggregate amount of benefits paid will not exceed the Medicare determined regular and customary expenses. In no event will the amount of benefits paid under this Plan exceed the amount which would have been paid if no other Plan was involved.

c) **Other Governmental Programs.** For all Eligible Participants, Retirees or Dependents eligible for benefits under a governmental program or eligible for benefits as a result of any state or federal statute or regulation (other than Medicare), this Fund will pay its pro rata share up to one-half (1/2) of the allowable expenses as determined by benefits provided under the Fund. If after the other plan has paid its allowable share, its share is less than the share paid by this Fund and it would leave a balance for the individual, then this Fund will pay the remaining allowable expenses, if any.

5. Coordination of Benefits – Eligible Dependent Children of Divorced or Separated Parents. In the case of children whose parents are divorced or separated and who are eligible for coverage under this Plan, the primary payor shall be the plan which covers the child as a Dependent of the Parent who:

a) by Qualified Medical Child Support Order, is responsible for the child's health care expense;

b) has custody of the child and if the parent has remarried, the spouse (stepparent) of such parent;

c) does not have custody of the child; or

d) If none of the above apply, the program in effect the longest is the primary program. An individual who is an Eligible Participant of the Plan cannot also be an Eligible Dependent under the Plan.

6. Coordination of Benefits - Participants or Dependent Children of Both Spouses who are both Participants in the Plan. In the case of children

whose parents are both Eligible Participants under the Plan, the Plan will pay one hundred percent (100%) of the Eligible Participant's and Dependent child's health care expenses.

7. Liability of the Fund. In the event benefits are reduced as provided above, each benefit otherwise payable shall be reduced proportionately, and only the reduced amount shall be charged against any applicable benefit limit under the Fund. If benefits have been paid under any other plan which should have been reduced in accordance with an anti-duplication provision, the Fund may pay at its option, to such other plan to the extent required to offset the reduction required by the existence of the Fund, and such payment shall reduce the liability of the Fund, to the extent of such payment. If payment has been made by the Fund in excess of that permitted by this provision, the Fund shall have the right to recover such excess from any party acquiring same.

ARTICLE XII - SUBROGATION

1) The Plan will use its right of Subrogation if the Participant and/or Dependents are paid benefits under this Plan for expenses due to injuries or illness for which a third party may be obligated to pay you for any reason.

2) This subrogation provision applies when the Participant and/or Dependents are sick and/or injured as a result of the act and/or omission of a third person and/or party. Subrogation means the Plan's right to recover any payments made to the Participant and/or Dependent by a third party. Third party includes but is not limited to another person, organization, corporation, insurance carrier, governmental agency, uninsured and/or underinsured insurance coverage and/or your insurance company. The Plan's subrogation right shall extend to first-party and/or third-party contracts and claims.

3) The Plan reserves the right of subrogation. This means that, to the extent the Plan provides and pays benefits for Covered Services, the Plan assumes the Participant and/or Dependent's legal rights to recover the value of those benefits or expenses from any person, entity, organization or insurer, including the Participant and/or Dependent's own insurer and any under insured or uninsured coverage, that may be legally obligated to pay the Participant and/or Dependent the value of those benefits or expenses. The amount of the Plan's subrogation rights shall equal the total amount paid by the Plan for the benefits or expenses for Covered Services. The Plan's right of subrogation shall have priority over your or anyone else's rights until the Plan recovers the total amount the Plan paid for Covered Services. The Plan's right of subrogation for the total amount the Plan paid for Covered Services is absolute and applies whether or not the Participant and/or Dependent receive, or are entitled to receive, a full or partial recovery or whether or not the Participant and/or Dependent are "made whole" by reason of any recovery from any other person or entity. **This provision is intended to and does reject and supersede the "make whole" rule, which rule might otherwise require that you be "made whole" before the Plan may be entitled to assert its right of subrogation.**

4) The Plan also reserves the right of reimbursement. This means that, to the extent the Plan provides or pays benefits or expenses for Covered Services, the Participant and/or Dependent must repay the any amounts recovered by suit, claim, settlement or otherwise, from any third party or his insurer and any under insured or uninsured coverage, as well as from any other person, entity, organization or insurer, including the Participant and/or Dependent's own insurer, from which the Participant and/or Dependent receive payments (even if such payments are not designated as payments of medical expenses). The amount of the Plan's reimbursement rights shall equal the total amount paid by the Plan for the benefits or expense for Covered Services. The Plan's right of reimbursement shall have priority over the Participant and/or Dependent's or anyone else's rights until the Plan recovers the total amount the Plan paid for the Covered Services. The Plan's right of reimbursement for the total amount the Plan paid for Covered Services is absolute and applies whether or not the Participant and/or Dependent receive, or are entitled to receive, a full or partial recovery or whether or not the Participant and/or Dependent are "made whole" by reasons of any recovery from any other person or entity. **This provision is intended to and does reject and supersede the "make whole" rule, which rule might otherwise require that you be "made whole" before the Plan may be entitled to assets its right of reimbursement.**

5) The Participant and/or Dependent shall have the following responsibilities to the Plan:

a) The Participant and/or Dependent must promptly advise the Plan whenever a claim is made against a third party with respect to any loss for which the Plan benefits have been or will be paid.

b) The Participant and/or Dependent must provide the Plan's Administrative Manager or its designee any information requested by the Plan or its designee within five (5) business days.

c) The Participant and/or Dependent must execute any assignments, liens, Subrogation Agreements, and/or other documents and provide information as the Plan requests.

d) The Participant and/or Dependent must complete forms providing information as to how the injuries occurred and the identity of any potentially responsible third parties; the disclosure of any applicable insurance coverage; and acknowledging this Plan's subrogation provision by the Participant and/or Dependent's attorney.

e) The Participant and/or Dependent must also sign any other documents and do whatever else is reasonably necessary to secure the Plan's right of subrogation, including but not limited to, executing written acknowledgement of a lien in favor of this Plan that may be delivered to the third party, or that may be filed with a court having jurisdiction in the

matter; allowing intervention by the Plan; and/or allowing the joinder of the Plan in any claim and/or action against the responsible third party.

f) The Participant and/or Dependent must not settle or compromise any claims unless the Plan, or the Plan's Administrative Manager or its designee, is notified as soon as possible before such settlement or compromise is finalized and the Plan or its designee agrees to the settlement or compromise. **You and/or your Dependents benefits may be suspended until the documents and/or information are received**.

6) In consideration of this Plan's covering your expenses and medical claims, which may be the responsibility of the third party, the Participant and/or Dependent agree to acknowledge and abide by the subrogation lien and reimburse this Plan directly to the extent of any benefits paid. The Participant and/or Dependent must not do anything to impair or negate this right of subrogation. This prohibition, includes but is not limited to the following: the Participant and/or Dependent may not release and/or discharge any claim and/or responsible party, effect any settlement, nor dismiss any legal action against another source who may be responsible for paying damages or providing compensation, nor will The Participant and/or Dependent effect satisfaction of any judgment resulting from any legal action without first notifying Plan Counsel and tendering to the Plan's attorneys the full amount of reimbursement due to the Plan.

7) If the Participant and/or Dependent do not attempt a recovery of the benefits paid by the Plan or for which the Plan may be obligated, the Plan shall, at its sole discretion, be entitled to institute a legal action and/or claim against the third party in the name of the Plan or Trustees in order that the Plan may recover all amounts paid to you and/or your dependents.

8) In the event that the Participant and/or Dependent obtain a recovery by judgment and/or settlement and/or otherwise against the third party, the Plan's subrogation interest, to the full extent of benefits or claims paid and/or due as a result of the occurrence causing the injury or illness, shall be deducted from the Participant and/or Dependent your dependents total recovery. The remainder of the balance of any recovery shall then be paid to you and/or your Dependent and your attorneys, if applicable. Once a settlement and/or judgment are reached, additional claims may not be submitted with respect to the same injury covered by said settlement.

9) To the extent of the aforesaid payments made or to be made by the Plan to you and/or your Dependent, any money that may be recovered by you and/or your dependent as a result of such payments by the Plan, or otherwise, from any third-party with respect to the matter giving rise to the above referenced loss, whether by judgment, settlement and/or otherwise, together with such costs as are allowed by law, shall be repaid to the Plan by you and/or your Dependent. The Plan, however, shall not be obligated to share, set-off and/or reimburse any portion of you and/or your Dependent's attorney fees and/or costs and expenses associated with any lawsuit, judgment, settlement, and/or otherwise which preceded such recovery by you and/or your Dependent.

10) If your acts and/or omissions compromise this right of subrogation and recoupment under this Policy, this Plan will seek reimbursement of all appropriate benefits paid directly to the Participant and/or Dependent and/or will offset benefits otherwise payable to the Participant and/or Dependent under this Plan.

11) The completion and/or execution of any documents requested by the Plan' Administrative Manager, or designee, shall be a condition to the Participant and/or Dependent receiving covered for any present or future claim. Further, the Plan shall have the right to suspend all benefit coverage due to a claimant or a dependent, if the claimant or dependent fails to complete and/or execute such documentation.

ARTICLE XIII – MEDICAL REIMBURSEMENT ACCOUNTS

Effective May 1, 2007, a Medical Reimbursement Account ("MRA") benefit was established for all active participants. Employer contributions to the MRA must be made in accordance with applicable collective bargaining and assent of participation agreements. The MRA is an individual sub-account of the Plan for each Participant for whom such contributions are made. These contributions and accounts shall not create or constitute a vested benefit for any Participant, dependent or beneficiary.

When a Participant, or his/her Eligible Dependent, has eligible unreimbursed medical expenses and an existing balance in his/her individual MRA, the Participant may use a "debit pre-paid card" to automatically pay for prescriptions and eligible over-the-counter (OTC) expenses, co-payments, deductibles, self-pays, vision services, dental and orthodontia services, and co-insurance. The Card, which the Plan Administrator shall provide to you, can only be used if the Participant has a balance in the MRA and only for so long as the MRA exists. The Participant may also instead submit, on a form provided by the Fund office, proof of such expenses and apply for reimbursement from his/her individual MRA. Reimbursement checks shall be issued to Participants on a monthly basis.

Medical expenses will be reimbursed only to the extent that reimbursement for such medical expenses is not available to the Participant under any health insurance policy or plan provided through any employer of the Participant. Reimbursement, to the extent the Participant has funds in his/her individual MRA, can be made for deductibles, co-payments and expenses in excess of benefit maximums applied to covered medical expenses under the Plumbers and Pipefitters Local 94 Health and Welfare Fund (hereinafter "Health and Welfare Fund") or other qualified plan for which the Participant or Dependent spouse receive medical benefits; and for self-payments to maintain eligibility under the Health and Welfare Fund or other qualified plan or arrangement or premium or other payments required to maintain coverage under the Plan of Participant's Spouse.

Reimbursement, to the extent the Participant has funds in his/her individual MRA, can also be made for expenses which include the following:

ELIGIBLE EXPENSES

BABY/CHILD TO AGE 13
- Lactation Consultant*
- Lead-Based Paint Removal
- Special Formula*
- Tuition: Special School/Teacher for Disability or Learning Disability*
- Well Baby/Well Child Care

DENTAL
- Dental X-Rays
- Dentures and Bridges
- Exams and Teeth Cleaning
- Extractions and Fillings
- Oral Surgery
- Orthodontia
- Periodontal Services

EYES
- Eye Exams
- Eyeglasses and Contact Lenses
- Laser Eye Surgeries
- Prescription Sunglasses
- Radial Keratotomy

HEARING
- Hearing Aids and Batteries
- Hearing Exams

LAB EXAMS/TEST
- Blood Tests and Metabolism Tests
- Body Scans
- Cardiograms
- Laboratory Fees
- X-Rays

MEDICAL EQUIPMENT/SUPPLIES
- Air Purification Equipment*
- Arches and Orthotic Inserts
- Contraceptive Devices
- Crutches, Walkers, Wheel Chairs
- Exercise Equipment*
- Hospital Beds*
- Mattresses*
- Medic Alert Bracelet or Necklace
- Nebulizers
- Orthopedic Shoes*
- Oxygen*
- Post-Mastectomy Clothing
- Prosthetics
- Syringes
- Wigs*

MEDICAL PROCEDURES/SERVICES
- Acupuncture
- Alcohol and Drug/Substance Abuse (Inpatient treatment and outpatient care)
- Ambulance
- Fertility Enhancement and Treatment
- Hair Loss Treatment*
- Hospital Services
- Immunization
- In Vitro Fertilization
- Physical Examination (not employment-related)
- Reconstructive Surgery (due to a congenital defect, accident, or medical treatment)
- Service Animals
- Sterilization/Sterilization Reversal
- Transplants (including organ donor)

MEDICATIONS
- Insulin
- Prescription Drugs

OBSTETRICS
- Breast Pumps and Lactation Supplies
- Doulas*
- Lamaze Class
- OB/GYN Exams
- OB/GYN Prepaid Maternity Fees (reimbursable after date of birth)
- Pre- and Postnatal Treatments

PRACTITIONERS
- Allergist
- Chiropractor
- Christian Science Practitioner
- Dermatologist
- Homeopath
- Naturopath*
- Optometrist
- Osteopath
- Physician
- Psychiatrist or Psychologist

THERAPY
- Alcohol and Drug Addiction
- Counseling (not marital or career)
- Exercise Programs*
- Hypnosis
- Massage*
- Occupational
- Physical
- Smoking Cessation Programs*

- Transportation*
- Speech
- Weight Loss Programs*

Note: This list is not meant to be all-inclusive, as other expenses not specifically mentioned may also qualify. Also, expenses marked with an asterisk (*) are "potentially eligible expenses" that require a Note of Medical Necessity from your health care provider to qualify for reimbursement. For additional information, contact your Plan Administrator.

ELIGIBLE OVER-THE-COUNTER ITEMS (Product categories are listed in bold face; common examples are listed in regular face)		
• **Baby Electrolytes and Dehydration** Pedialyte, Enfalyte	• **Eye Care** Contact lens care	• **Incontinence Products** Attends, Depend, GoodNites for juvenile incontinence, Prevail
• **Contraceptives** Unmedicated condoms	• **Family Planning** Pregnancy and ovulation kits	• **Nasal Care** Saline Nasal Spray
• **Denture Adhesives, Repair, and Cleansers** PoliGrip, Benzodent, Plate Weld, Efferdent	• **First Aid Dressings and Supplies** Band Aid, 3M Nexcare, non-sport tapes	• **Prenatal Vitamins** Stuart Prenatal, Nature's Bounty Prenatal Vitamins
• **Diabetes Testing and Aids** Ascencia, One Touch, Diabetic Tussin, Insulin syringes; glucose products	• **Foot Care Treatment** Unmedicated corn and callus treatments (e.g., callus cushions), devices, therapeutic insoles	• Reading Glasses and Maintenance Accessories
• **Diagnostic Products** Thermometers, blood pressure monitors, cholesterol testing	• **Glucosamine &/or Chondroitin** Osteo-Bi-Flex, Cosamin D, Flex-a-min Nutritional Supplements	• Home Health Care (limited segments) Ostomy, walking aids, decubitis/pressure relief, enteral/parenteral feeding supplies, patient lifting aids, orthopedic braces/supports, splints & casts, hydrocollators, nebulizers, electrotherapy products, catheters, unmedicated wound care, wheel chairs
• **Ear Care** Unmedicated ear drops, syringes, ear wax removal	• **Hearing Aid/Medical Batteries**	• **Elastics/Athletic Treatments** ACE, Futuro, elastic bandages, braces, hot/cold therapy, orthopedic supports, rib belts

For additional information, please contact your Plan Administrator.

The following items <u>shall</u> <u>not</u> be subject to reimbursement:

1) Expenses for which the Participant or Dependent claimed or will claim a medical expense deduction on the Participant's tax returns;

2) Expenses incurred before the Participant became initially eligible for medical benefits under the Health and Welfare Plan, unless permitted by Code Section 213;

3) Except as otherwise provided herein, expenses incurred after termination of employment and eligibility, unless permitted by Code Section 213;

4) Expenses for general health (even if following doctor's advice) such as:

   a. Health club dues, unless prescribed by a doctor for a specific health condition;
   b. Household help (even if recommended by a doctor);
   c. Social activities, such as dancing or swimming lessons; and
   d. Trip for general health improvement.

5) Surgery or other medical procedures for purely cosmetic reasons;

6) Organic food, unless required for specific medical ailment or condition;

7) Life insurance or income protection policies or policies providing payment for loss life, limb, sight, etc.

8) Nursing services for a healthy baby;

9) Medical insurance included in a car insurance policy covering all persons injured in or by the Employee's car;

10) Maternity clothes;

11) Diaper service;

12) Bottled or distilled water;

13) Toothpaste, toiletries, cosmetics;

14) Medical services in a U.S. Government Hospital;

15) Medical services provided at no cost through any public program;

16) Baby-sitting expenses;

17) Expenses for CB radio;

18) Expenses for chauffeur;

19) Expenses for Church of Scientology "auditing" or processing;

20) Expenses for cruises;

21) Expenses for dancing lessons;

22) Deprogramming fees (for prior member of religious cult);

23) Expenses for domestic partner's health expenses unless a dependent for IRS purposes;

24) Ear piercing;

25) Expenses associated with fallout shelter;

26) Funeral expenses;

27) Expenses for hair transplants;

28) House remodeling, except as otherwise provided for herein;

29) Housekeeping and child care expenses;

30) Insurance premiums, except as provided for otherwise herein;

31) Lawn care expenses;

32) Legal expenses, except for expenses associated with having a person legally committed to a hospital;

33) Marijuana and other illegal narcotics;

34) Maternity clothing;

35) Illegal medical operations;

36) Dust-elimination system, accept as otherwise provided for herein;

37) Except as otherwise provided for herein, remedial reading courses where services are primarily educational rather than medical;

38) Resort hotel;

39) Any self-treatment;

40) Tattoo removal;

41) Swimming lessons;

42) Television and television equipment, except for closed-caption decoder for deaf person to display audio portion of program (i.e. subtitles);

43) Vacation expenses;

44) Vacuum cleaning; and

45) Medical expenses for which reimbursement is available under another plan or program.

46) Contact Lens or Eyeglass Insurance

47) Cosmetic Surgery/Procedures

48) Electrolysis

49) Marriage or Career Counseling

50) Swimming Lessons

51) Personal Trainers

52) Sunscreen (spf less than 30)

Further, the IRS does <u>not</u> allow Over-the-Counter (OTC) medicines or drugs to be purchased unless accompanied by a prescription and the prescription is filled by a pharmacist. If you have an OTC prescription, you can use your benefits card for these purchases.

INELIGIBLE OVER-THE-COUNTER MEDICINES AND DRUGS (unless prescribed)		
• Acid controllers	• Cough, cold & flu	• Medicated respiratory treatments & vapor products
• Acne mediations	• Denture pain relief	• Motion sickness
• Allergy & Sinus	• Digestive aids	• Oral remedies or treatments
• Antibiotic products	• Ear care	• Pain relief (includes aspirin)
• Antifungal (Foot)	• Eye care	• Skin treatments
• Antiparasitic treatments	• Feminine antifungal & anti-itch	• Sleep aids & sedatives
• Antiseptics & wound cleansers	• Fiber laxatives (bulk forming)	• Smoking deterrents
• Anti-diarrheals	• First aid burn remedies	• Stomach remedies
• Anti-gas	• Foot care treatment	• Unmedicated vapor products
• Anti-itch & insect bite	• Hemorrhoidal preps	
• Baby rash ointments & creams	• Homeopathic remedies	

- Baby teething pain
- Cold sore remedies
- Contraceptives
- Incontinence protection & treatment products
- Laxatives (non-fiber)
- Medicated nasal sprays, drops, & inhalers

Please note that eligible over-the-counter (OTC) products that are medicines or drugs (e.g., acne treatments, allergy and cold medicines, antacids, etc.) will only be eligible for reimbursement with a physician's prescription that includes his or her address and license number. The only exception is insulin, which will not require a prescription.

Claims for Medical Expense Reimbursements shall be filed no later than one (1) year following the end of the Calendar Year in which the services were rendered.

Any monies deposited in a Participant's individual MRA will remain in such account so long as the Participant is actively employed (or available for such employment) pursuant to a collective bargaining agreement requiring any contributions to the Plumbers & Pipefitters Health and Welfare Fund and for a period of time not to exceed twelve (12) months after the Participant has terminated employment (other than due to retirement or disability retirement) with an employer who is required to make contributions to the Plumbers & Pipefitters Health and Welfare Fund. After termination of such employment and twelve (12) months have expired since such termination, any monies in an individual MRA shall first be used to pay off any negative bank hours owed, and thereafter, any amounts remaining shall revert to the general assets of the Health and Welfare Fund and shall no longer be a benefit available to the individual Participant or his/her Eligible Dependents.

In the event of a Participant's death, his or her individual MRA balance shall be placed in an individual MRA for his or her Spouse, or if unmarried or widowed, for his or her Dependent(s) as allowed by applicable provisions of the Internal Revenue Code or regulations promulgated thereunder. This individual MRA may only be used for reimbursement purposes and shall not be paid directly to the surviving Spouse or the above Dependent other than for reimbursement for eligible expenses.

The Health and Welfare Fund may assess an administrative fee against the Participant's MRA for the administrative costs of processing such reimbursement claims.

Effective January 1, 2017, all contributions to a Participant's Dollars Bank, in excess of the amount that is necessary to maintain three (3) years of coverage under the Plan for the Participant, shall first be used to pay off any negative bank hours owed, and, thereafter, any such excess amounts remaining shall be directed to the Participant's Medical Reimbursement Account. Such excess contributions shall terminate if the amount in the Participant's Dollars Bank account is less than the amount required to maintain coverage for the Participant for a three (3) year period of time.

Effective May 1, 2014, and as directed by the Affordable Care Act (ACA), the Participant will be given the opportunity once each year to opt-out of and waive future reimbursement from the MRA. Further, the Participant will have that same opportunity

upon termination of employment, and upon ceasing to work or being unavailable for work in covered employment. Any opt-out of and waiver of future reimbursement from the MRA is permanent. When a Participant opts-out of the MRA, all funds in the MRA account will revert to the general assets of the Plan and the Participant will be deemed to have permanently forfeited and waived benefits including those for eligible dependent(s).

ARTICLE XIV - GENERAL PROVISIONS AND LIMITATIONS

1) **Guarantee of Benefits.** All benefits under the Plan shall be payable through Employees or Agents of the Trustees acting under their authority. Benefits as authorized under the Plan shall be paid as long as the Fund can operate on a sound financial basis. No benefits shall be payable except those which can be provided under the Plan, and no person shall have any claim for benefits against the Union, the Association, any Employer or the Trustees. The Trustees, the Employers, and the Union shall not be held liable for any benefits or contracts except as provided in the agreement between the Employers and the Union. The Board of Trustees reserves the right to change or eliminate the benefits of all Plan Participants (including the benefits of Retired Participants) in accordance with the amendment procedures in the Plan Document and Agreement of Trust.

2) **Physical Examination and Autopsy.** No medical examination shall be required of any Eligible Participant or Eligible Dependent to secure coverage initially. However, the Trustees shall have the right through its medical examiner to examine an Eligible Participant or Eligible Dependent whose injury or sickness is the basis of a claim as often as may be reasonably required during the pendency of a claim hereunder, and the right to order an autopsy in case of death, where it is not forbidden by law.

3) **Illegal Occupation or Commission of Felony.** The Fund shall not be liable for any loss directly or indirectly related to the commission of. or the attempt to commit, a felony by the person whose injury or sickness is the basis of the claim or directly or indirectly related to such person's being engaged in an illegal occupation or undertaking.

4) **Assignment.** Benefits under the Plan may be assigned by the Participant only to a participating physician or provider (except as noted in Dental and Vision Benefit sections).

5) **Facility of Payment.** Whenever payments which should have been made under this Plan have been made by another plan, the Fund shall have the right, exercisable alone and in its sole discretion, to pay an organization making the payments any amounts it determines are warranted to satisfy the intent of this provision. The amounts so paid will be deemed to be benefits payable under this Plan, and the Fund will be fully discharged from liability under this Plan to the extent of such payment.

6) **Right to Recovery.** Whenever payments have been made by the Fund with respect to allowable expenses in an amount at any time in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision. the Fund shall have the right to recover the excess payments from among one or more of the following, as determined by the Fund: any persons to or from whom the payments were made, any insurance companies and any other organizations.

7) **Right to Receive and Release Necessary Information Consistent with the Fund's Obligations Under HIPAA.** For the purposes of determining the applicability of and implementing the terms of this provision of the plan, or any provision of similar purpose of any other plan, the Fund may, with the consent of the Eligible Participant or eligible Dependent, release to or obtain from any insurance company or other organization or person any information with respect to any person which the Fund deems to be necessary for these purposes. Any person claiming benefits under this Plan shall furnish to the Fund any information necessary to implement this provision.

8) **Word Usage.** Whenever words are used in this document in the singular or masculine form, they shall, where appropriate, be construed so as to include the plural, feminine or neuter form.

9) **Amendments.** The Plan may be amended at any time to any extent by the Board of Trustees of the Plumbers and Pipefitters Local Union No. 94 Health and Welfare Fund. Such amendments shall be effective when approved by a majority of the Trustees, provided such amendments are in writing and consistent with the objectives and purposes of the Trust. Whenever an amendment is adopted in accordance with this section, all necessary parties shall be notified in a reasonable manner within a reasonable time.

10) **Authority of Trustees**. The Board of Trustees has full, complete and binding authority to define, interpret and apply all of the terms and provisions of the Plan, the Trust Agreement and Restated Trust Agreements establishing the Plan and this Summary Plan Description, and all contracts entered into by the Trustees of the Plan with any third parties. This authority to define, interpret and apply includes, but is not limited to, all issues that relate to eligibility, the amount of and entitlement to any forms of benefit, all issues that directly or indirectly relate to covered employment and all issues that directly or indirectly relate to benefit terminations. Without limiting in any way the authority of the Board of Trustees recited above, the Trustees delegate that same authority to the Plan's Administrative Manager.

ARTICLE XV - QUALIFIED MEDICAL CHILD SUPPORT ORDERS

1) ERISA requires the Plan's Administrative Manager to honor court orders or administrative

court directives (i.e., medical child support decrees) to provide medical plan coverage to children and/or other "alternate recipients" and to begin such coverage while you are working.

However, these orders must meet the Qualified Medical Child Support Orders (QMCSO) rules, which require that certain federal standards be satisfied. The Plan's Administrative Manager will deny medical plan coverage under any judgment, decree or order as a "Qualified Medical Child Support Order" unless it satisfies all of the requirements set forth below. Assuming such Order meets these federal requirements, the Plan's Administrative Manager will follow the terms of the Order if this Plan is the proper party to the legal proceeding from which the Order has been issued.

2) The Plan's Administrative Manager will follow court orders or administrative court orders that meet all of the following requirements:

a) The Order relates to the provision of medical child support order.

b) The Order creates or recognizes the existence of an alternate recipient's right to medical coverage under the participant's medical benefits.

c) The Order specifies the name, birth date, last known mailing address, and last four digits of the social security number of the participant and each alternate recipient covered by the Order.

d) The Order specifies the type and period of medical coverage and requires that such coverage be paid by the participant in accordance with the medical plan and federal law.

e) The Order specifically names the Plumbers & Pipefitters Local No. 94 Health and Welfare Fund as the Plan to which the Order applies.

f) The Order does not require this plan to provide any type of medical coverage, benefit(s), or form of coverage or option(s) not otherwise provided under this plan.

3) Upon request to the Administrative Manager, you will be provided with a copy of the Plan's Procedures for Processing Medical Child Support Orders.

ARTICLE XVI - USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1) The Plumbers and Pipefitters Local Union No. 94 Health and Welfare Fund is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

a) The Fund's uses and disclosures of Protected Health Information (PHI),
b) Your rights to privacy with respect to your PHI,
c) The Fund's duties with respect to your PHI,
d) Your right to file a complaint with the Fund and with the Secretary of the U.S. Department of Health and Human Services, and
e) The person or office you should contact for further information about the Fund's privacy practices.

2) Protected Health Information (PHI) Defined The term "Protected Health Information" (PHI) includes all information related to your past or present health condition that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Fund in oral, written, electronic or any other form.

3) When the Fund May Disclose Your PHI The Fund has amended its Plan Documents to protect your PHI as required by federal law. Under the law, the Fund may disclose your PHI without your consent or authorization in the following cases:

(a) **At your request**. If you request it, the Fund is required to give you access to certain PHI in order to allow you to inspect it and/or copy it.

(b) **As required by an Agency of the government.** The Secretary of the Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Fund's compliance with the privacy regulations.

(c) **For treatment. payment or health care operations.** The Fund and its business associates will use PHI without your consent, authorization or opportunity to agree or object in order to carry out.

4) Definitions of Treatment, Payment or Health Care Operations

a) Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

b) Payment includes but is not limited to making coverage determinations and payment. These actions include billing, claims management, subrogation, Fund reimbursement, reviews for medical necessity and appropriateness of care, utilization review and preauthorization.

c) Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical- review, legal services and auditing functions including fraud and abuse compliance programs, business funding and development, business management and general administrative activities.

5) When the Disclosure of Your PHI Requires Your Written Authorization

The Fund will not use or disclose your PHI for any purpose not outlined in this Notice unless you give the Fund your written authorization to do so. The Fund does not make disclosures of information to any other companies that may want to sell their products or services to you. If you give the Fund your written authorization, you may revoke that authorization at any time unless the Fund is taking action in reliance on your authorization. To receive an authorization form, please contact the Privacy Officer at the telephone number indicated in this Notice. If a family members calls with knowledge of your claim, we may confirm certain information about it, unless you have informed us in writing of a need for confidential communication.

6) Use or Disclosure of Your PHI That Requires You be Given an Opportunity to Agree or Disagree Before the Use or Release

a) Disclosure of your PHI to family members, other relatives and your close personal friends is allowed under federal law if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

7) Use or Disclosure of Your PHI for Which Consent, Authorization or Opportunity is not required.

a) The Fund is allowed under federal law to use and disclose your PHI, without your consent, authorization or request under the following circumstances:

1) When required by law.

2) If the disclosure is an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease of condition, if authorized by law.

3) If the disclosure is to public authorities and relates to abuse, neglect or domestic violence if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.

4) If the disclosure is a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

5) If the disclosure relates to legal proceedings, your PHI may be disclosed in response to a subpoena or discovery request, that is accompanied by a court order.

6) If the disclosure relates to law enforcement health purposes, for example, to report certain types of wounds.

7) If the disclosure is related to law enforcement emergency purposes. Law enforcement emergency purposes include:

    i. identifying or locating a suspect, fugitive, material witness or missing person, and

    ii. disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances.

8) If the disclosure is related to determining cause of death or organ donation. We may also disclose PHI for cadaveric organ, eye or tissue donation purposes.

9) If the disclosure is required to be given to funeral directors to carry out their duties with respect to a decedent.

10) If the disclosure is made when, consistent with applicable law and standards of ethical conduct, the Fund in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

11) If the disclosure if necessary to comply with workers' compensation or other similar programs established by law.

12) Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke your authorization.

8) Other Uses or Disclosures

The Fund may contact you to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

The Fund may disclose protected health information to the Plan Sponsor for reviewing your appeal of a benefit claim or for other reasons regarding the administration of this Fund. The "Plan Sponsor" is the Board of Trustees.

9) You May Request Restrictions on PHI Uses and Disclosures

a) You may request the Fund to:

1. Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or

2. Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

b) The Fund is not required to agree to your request if the Fund Administrator or Privacy Official determines it to be unreasonable.

c) The Fund will accommodate an individual's reasonable request to receive communications of PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the individual.

d) You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

10) You Have the Right to Amend Your PHI

a) You have the right to request that the Fund amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set subject to certain exceptions.

b) The Fund has 60 days after receiving your request to act on it. The Fund is allowed a single 30-day extension if the Fund is unable to comply with the 60-day deadline. If the Fund denied your request in whole or part, the Fund must provide you with a written denial that explains the basis for the decision. You or your personal representative may

then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI.

11) You May Inspect and Copy PHI

a) You have a right to inspect and obtain a copy of your PHI for as long as the Fund maintains the PHI. The Fund will provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Fund is unable to comply with the deadline.

b) You or your personal representative will be required to complete a form to request access to the PHI in your designated record set.

c) If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to Fund and the Secretary of the U.S. Department of Health and Human Services.

12) You Have the Right to Receive an Accounting of the Fund's PHI Disclosures

a) At your request, the Fund will also provide you with an accounting of disclosures by the Fund of your PHI. This accounting period starts as of April 14, 2003 and allows you to request an accounting for up to six years of disclosures after that date. The maximum period of time you can request is six years. Please contact the Fund Office for a complete listing of the contents of an accounting. You should request a copy of the Fund's Accounting for Disclosure Policy.

b) The Fund has 60 days to provide the accounting. The Fund is allowed an additional 30 days if the Fund gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

c) If you request more than one accounting within a 12 month period, the Fund will charge a reasonable, cost-based fee for each subsequent accounting.

13) You Have the Right to Receive a Paper Copy Of This Notice Upon Request

a) To obtain a copy of this Notice, contact the Privacy Official at the address provided at the beginning of this Section 3.

b) If you disagree with the record of your PHI, you may amend it.

c) If the Fund denies your request to amend your PHI, you still have the right to have your written statement disagreeing with that denial included in your PHI.

14) Your Personal Representative

a) You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed and approved Appointment of Personal Representative form. You may obtain this form by calling the Fund Office.

b) The Fund retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

c) The Fund will recognize certain individuals as personal representatives without you having to complete an Appointment of Personal Representative form. For example, the Fund will automatically consider spouse's covered under the Fund as the Personal Representative for each other. Additionally, the Fund will consider a covered parent, guardian, or other person acting in loco parentis as the Personal Representative of any dependent covered by the Fund unless applicable law requires otherwise. A parent may act on an individual's behalf, including requesting access to their PHI. Covered Dependents, including your spouse may, however, request that the Fund restrict information that goes to family members as described above at the beginning of Section 3 of this Notice. Additionally, the Fund will automatically consider any person designated under a Power of Attorney which is on file with the Fund as a Personal Representative.

d) You or your spouse may elect not to have one another as your Personal Representative. You or your spouse must fill out an Opt-out of Personal Representation Form and submit the Form to the Privacy Official. Your covered dependent children also have the right to submit an Opt-out Form if they do not wish to have one or both of their parents as their deemed Personal Representative. All requests are reviewed by the Privacy Official who may deny the requests, especially those based upon State law restrictions.

e) You should also review the Fund's Policy and Procedure for the Recognition of Personal Representatives for a more complete description of the circumstances where the Fund will automatically consider an individual to be a personal representative.

15) <u>Maintaining Your Privacy</u>

a) The Fund is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices.

b) This notice is effective beginning on April 14, 2003 and the Fund is required to comply with the terms of this notice. However, the Fund reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Fund

prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to you and to all past and present participants and beneficiaries for whom the Fund still maintains PHI. This revised notice will be mailed to the covered participant and dependents.

c) Any revised version of this notice will be distributed within 60 days of the effective date of any material change to:

- The uses or disclosures of PHI,
- Your individual rights,
- The duties of the Fund, or
- Other privacy practices stated in this notice.

16) Disclosing Only the Minimum Necessary Protected Health Information

a) When using or disclosing PHI or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

b) However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services pursuant to its enforcement activities under HIPAA,
- Uses or disclosures required by law, and
- Uses or disclosures required for the Fund's compliance with legal regulations.

c) This notice does not apply to information that has been de-identified. De-identified information is information that:

- Does not identify you, and
- With respect to which there is no reasonable basis to believe that the information can be used to identify you.

d) In addition, the Fund may use or disclose "summary health information" to the Fund Sponsor for obtaining premium bids or modifying, amending or terminating the group health plan. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health Fund.

17) Additional Rights

a) Certain uses and disclosures of PHI require an individual authorization, including uses and disclosures for marketing purposes, disclosures that constitute a "sale" of PHI, and most uses and disclosures of psychotherapy notes.

b) No uses or disclosures may be made without an individual authorization for a purpose that is not explicitly described in this Plan.

c) Individuals have the right to be notified of a security breach that compromises the privacy of their PHI.

d) Individuals who receive fundraising communications have the right to opt out of receiving any further such communications.

18) Your Right to File a Complaint with the Fund or the DHHS

a) If you believe that your privacy rights have been violated, you may file a complaint with the Fund Privacy Official at the following address:

Plumbers & Pipefitters Local Union 94 Health & Welfare Fund
Privacy Officer
3660 Stutz Drive, Ste. 101
Canfield, OH 44406

You may also file a complaint with:

Secretary of the U.S. Department of Health and Human Services ("DHHS")
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

b) The Fund will not retaliate against you for filing a complaint.

19) If You Need More Information

a) If you have any questions regarding this notice or the: subjects addressed in it, you may contact the Privacy Official at the address provided in Section 3.

20) Federal Law

a) PHI use and disclosure by the Fund is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This notice summarizes the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this notice and the regulations.

ARTICLE XVII - CLAIMS FILING AND BENEFIT DETERMINATION

1) A Participant, beneficiary or their authorized representative may file a claim for benefits under the Plan with the Plumbers and Pipefitters Local No. 94 Health and Welfare Fund ("the Fund"). Your claim shall be in writing, stating the basis of the claim, and authorizing the Fund or its representatives to conduct all necessary investigations into the claim. A claim is not filed until it is received by the Fund. Such claims shall be sent to the office of the Administrative Manager at:

Medical Claims
Medical Mutual
P.O. Box 6018
Cleveland, Ohio 44101

Prescription Claims – Normally you will take your prescription card to an appropriate pharmacy to obtain your prescriptions or obtain your prescription via mail order. However, if you need reimbursed for any prescription you paid for, you may file a claim for reimbursement by sending the receipt, along with a request for reimbursement, to:

CVS/Caremark
695 George Washington Highway
Lincoln, Rhode Island 02865

Death and Dismemberment, and Weekly Accident and Sickness Benefit Claims

Plumbers & Pipefitters Local Union No. 94
Health & Welfare
3660 Stutz Drive, Ste. 101
Canfield, OH 44406

2) If the Fund, upon receipt of a claim for benefits, needs additional information or the claim does not follow the Fund's procedures, the Fund will notify you within twenty-four (24) hours (for an urgent care benefit claim) and thirty (30) days (for non-urgent post-service benefits claims) of receipt of the claim that such information is necessary. In the case of an urgent care claim, notification of additional information may be oral, unless the Claimant requests written notification. The Fund shall allow you a minimum period of forty-eight (48) hours (for urgent care benefit claims) or forty-five (45) days (for non-urgent benefit claims) to furnish such additional information.

3) For those claims where additional information is requested by the Administrative Manager, any partial or total denial of the claim shall be made by the Fund, by delivery or mail of a Notice of Adverse Benefit Determination to you, within forty-eight (48) hours (for an urgent care benefit claim) or thirty (30) days

(for a non-urgent post-service benefit claim) from the date the Fund receives the information requested from you. If additional information is requested, the time period for making a benefit decision is tolled from the date on which the notice is sent to you until the date you respond to the request. In the case of non-urgent care benefit claim, the period for a benefit determination to be made may be extended for a period of fifteen (15) days (for post-service claims) if it is due to circumstances beyond the Fund's control. However, you will be given notice of such extension prior to the original deadline for a determination.

4) An "Urgent Care" claim is defined as any claim for medical care or treatment which cannot be decided under normal time frames because: 1) it can seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or 2) in the opinion of a physician with knowledge of claimant's medical position would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

5) For those claims where additional information is not necessary, the Fund shall make any determination regarding the validity of the claim and, upon any partial or total denial of your claim for benefits, the Fund shall deliver or mail a Notice of Adverse Benefit Determination to you within seventy-two (72) hours (for an urgent care benefit claim) or thirty (30) days (for a non-urgent care post-service benefit claim) of the filing of your claim.

6) If you request that the Fund extend a previously approved course of treatment, by either increasing the number of treatments or the period of time for treatments, any determination on such request will be provided to you within twenty-four (24) hours after receipt of the claim, when the request is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments. If such a request is not made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments, the request must be treated as a claim involving urgent care and decided in accordance with the urgent care claim time –frames. However, if your request does not involve urgent care, the request shall be treated as a new benefit claim and decided within the non-urgent care time-frames. If the Fund decides to reduce or terminate a previously approved course of treatment, such a decision shall be treated as a Notice of Claim Denial. In such case, the Administrate Manage shall provide you with reasonable advance notice of the reduction or termination to allow you to appeal and obtain a determination before the benefit is reduced or terminated.

7) The Notice of Claim Denial shall be in writing and shall contain the following information:

a) the specific reasons for the denial;

b) specific reference to pertinent Plan Document and/or Summary Plan Description on which the adverse benefit determination was based;

c) a description of any additional materials and/or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;

d) a description of the Plan's claim(s) review procedures and the time limits applicable to such procedures;

e) a notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy of such guidelines or protocols;

f) In the case of an adverse benefit determination by a group health plan involving a claim for urgent care, a description of the expedited review process applicable to such claims.

8) SUMMARY OF DEADLINES FOR NOTIFYING CLAIMANTS OF BENEFIT DECISIONS

Claims Procedures	**Group Health (Urgent)**	**Group Health (Post-Service)**
Initial Benefit Determination	72 hours	30 days
Plan Notifies Claimant if Additional Information is Necessary	24 hours	30 days
Minimum Time for Claimant to Finish Information	48 hours	45 days
After Information Requested by Plan Benefit is Received		
Determination is Required (after Claimant submits any additional information)	48 hours	30 days

ARTICLE XVIII - APPEALS PROCEDURE

1) Your or your authorized representative may appeal the Notice of Denial by written notice, received by the Trustees or their agent(s) within one hundred eighty (180) days of the mailing of the Fund's Notice of Claim Denial. The written notice needs to state the subscriber's and patient's full name, identification number, claim number if applicable, the reason for the appeal, date of service, provider/facility name and supporting information or records including photographs or x-rays you would like considered in the appeal. The appeal shall be addressed as follows:

Medical Claims
Board of Trustees
Plumbers & Pipefitters Local No. 94
Health & Welfare Fund
c/o Medical Mutual
Member Appeals Unit
MZ: 01-4B-4809
PO Box 94580
Cleveland, OH 44101-4580
Fax: 216-687-7990

Prescriptions – If you go to an appropriate pharmacy and attempt to obtain a prescription, or submit a mail order prescription, and you are denied, in part or in whole, for such prescription request, please contact the Fund office for your right to appeal such a denial.

Death and Dismemberment, and Weekly Accident and Sickness Benefit Claims

Plumbers & Pipefitters Local Union No. 94
Health & Welfare Fund
c/o Benefits Committee
3660 Stutz Drive, Ste. 101
Canfield, OH 44406

2) An appeal request for an urgent care claim may be made by you orally or in writing. Furthermore, necessary information can be transmitted between the Fund and you or your provider by telephone or facsimile.

3) Prior to a determination on the appeal, you or your authorized representative may have an opportunity to review necessary and pertinent documents upon which the denial in whole or in part is based and may submit written issues and comments pertinent to the appeal. Furthermore, you or your representative may submit additional information prior to any determination on your appeal.

4) If an appeal requires medical judgment, the Trustees or their agent(s) shall consult "appropriate health professional(s)" including but not limited to, medical or vocational experts. The identity of such expert(s) will be disclosed to claimant upon written request.

5) During the appeals process you will afforded access to and copies, free of charge, of the following "relevant information":

a) any information relied upon during the Fund's benefit determination process;

b) any information submitted, considered or generated while making such a benefit determination; and

c) statements of any policy or guidance concerning denied treatment or benefit(s) even if not relied upon in the benefit determination process.

6) During the appeals process, the Plan shall not give deference to the initial denial and any review on appeal may not be conducted by the individual who made the initial denial nor his/her subordinate;

7) The Trustees or their agent(s) shall consider your appeal of an urgent care benefit claim within seventy-two (72) hours and for non-urgent care post-service benefit claim(s), within thirty (30) days. Within five (5) days after consideration of the appeal, the Board of Trustees or its agent(s) shall advise you of its decision in writing. A Notice of Determination on Appeal (i.e. "Appeal Decision") must be provided in written or electronic form. If the determination is adverse, the Notice must provide you with the following information:

a) the specific reason(s) for the adverse determination on appeal;

b) reference to the specific plan provisions on which the determination is based;

c) statement that the claimant is entitled to receive, upon request and free of charge, access to and copies of all documents, records and other information relevant to the benefit claim;

d) a description of any voluntary appeal procedures offered under the Plan, the claimant's right to obtain information about such procedures and a statement regarding the claimant's right to bring a civil action under ERISA §502(a) following an adverse benefit determination on appeal;

e) if applicable, the fact that an internal rule, guideline or protocol that was relied upon to make the adverse determination and your right, upon request, to receive a copy of such rule, guideline or protocol; and

f) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment of the determination of a statement that such explanation will be provided free of charge to you upon request.

8) SUMMARY OF NOTIFICATION OF RESULT OF APPEAL

Group Health Appeals	**Group Health (Urgent)**	**Procedures (Post-Service)**
Time to Appeal 30 days	180 days	180 days

9) OPTIONAL SECOND LEVEL APPEAL

a) A full hearing and optional second level of appeal before the Board of Trustees shall be held when the Participant requests a full hearing before the Board of Trustees by written notice within fifteen (15) days after receipt of the Board of Trustees' decision on appeal. However, this voluntary appeal is only allowed after you have pursued your initial right to appeal any Notice of Claim Denial, as such rights are set forth above. Please keep in mind that this second level appeal is purely optional and shall be at no cost to you. You do not need to request such second level appeal prior to exercising your rights to bring a civil action (i.e. lawsuit) under Section 502(a) of ERISA. You shall be provided, upon request, information relating to this voluntary level of appeal so you can decide whether to pursue such appeal. This information should include:

1) a statement indicating that this voluntary second level appeal shall not affect your right to receive other benefit(s) from this Fund;

2) a statement that you have the right to utilize a personal or authorized representative during this voluntary second appeal process; and

3) a notice of any compelling circumstances that may affect the second level appeal and/or compromise the impartiality of the Board of Trustees.

b) Requests for a full hearing and optional second level appeal should be sent to the Fund's Administrative Manager at:

Board of Trustees

Plumbers & Pipefitters Local Union No. 94
Health & Welfare Fund
3660 Stutz Drive, Ste. 101
Canfield, OH 44406

c) The written notice needs to state only your name, address, and the fact that you are requesting a full hearing before the Board of Trustees, giving the date of the decision of the Board of Trustees. The date for the hearing above shall be set for the next regular quarterly meeting of the Board of Trustees following the receipt of the notice of appeal from a Notice of Benefit Determination on Appeal. However, if the appeal request is received within thirty (30) days before the date of the meeting, the benefit determination must be made by the date of the second meeting that immediately follows the Plan's receipt of the appeal request. If an extension of the time period for processing the second appeal is needed, the determination of a second appeal must be made by the date of the third meeting following the plan's receipt of the original appeal request.

d) The Hearing:

1) A full written report shall be kept of the proceedings of the hearing.

2) In conducting the hearing, the Board of Trustees shall not be bound by the usual common law or statutory rules of evidence.

3) You or your authorized representative shall have the right to review the written record of the hearing, make a copy of it and file objections to it.

4) There shall be copies made of all documents and records introduced at the hearing, attached to the record of the hearing, and made a part of it.

5) All information upon which the Board of Trustees based its original decision shall be disclosed to you at the hearing.

6) In the event that additional evidence is introduced by the Trustees which was not made available to you prior to the hearing, you shall be granted a continuance of as much time as you desire, not to exceed thirty (30) days.

7) You shall be afforded the opportunity of presenting any evidence on your behalf. If you offer new evidence, the hearing may be adjourned for a period of not more than thirty (30) days so the Trustees may, if they wish, investigate the accuracy of your new

evidence or determine whether additional evidence should be introduced.

8) After consideration of the appeal, the Trustees shall advise you of its decision in writing within five (5) days following the hearing at which the appeal was considered. The decision of the Trustees shall set forth specific reasons for their conclusions, shall be written in a manner calculated to be understood by you and shall contain the items set forth in Section II(M) above. This decision shall be final and binding upon you, subject to any rights you may have to bring a civil action under Section 502(a) of ERISA.

9) Effective August 28, 2014, no civil action under Section 502(a) of ERISA or any other action at law or equity can be filed against the Plan or Board of Trustees more than one (1) year after the Trustees' mailing to the Participant of the Trustees' final decision on the participant's benefit appeal as specified in Article XVIII(7)(d) or (9)(d)(8), whichever is later.

ARTICLE XIX - STATEMENT OF RIGHTS UNDER ERISA

1) As a Participant or Eligible Dependent in the Plumbers and Pipefitters Local 94 Health and Welfare Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

a) Examine, without charge, at the Plan Office or Office of the Administrative Manager and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

c) Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this Summary Annual Report.

d) Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description

and Plan document which governs the Plan on the rules for your COBRA continuation coverage rights.

e) Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the Participant's group health plan, if the Participant has creditable coverage from another plan. The Participant should be provided a certificate of creditable coverage, free of charge, from the Participant's group health plan or health insurance issuer when the Participant loses coverage under the Plan, when the Participant becomes entitled to elect COBRA continuation coverage, when the Participant's COBRA continuation coverage ceases, if the Participant requests it before losing coverage, or if the Participant requests it up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, the Participant may be subject to a pre-existing condition exclusion for twelve (12) months (eighteen (18) months for late enrollees) after the Participant's enrollment date in coverage.

2) 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 this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Participant and other Plan Participants and Dependents. No one, including the Participant's employer, the Participant's union, or any other person, may fire the Participant or otherwise discriminate against the Participant in any way to prevent the Participant from obtaining a welfare benefit or exercising the Participant's rights under ERISA.

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

4) Under ERISA, there are steps the Participant can take to enforce the above rights. For instance, if the Participant request a copy of plan documents or the latest annual report from the plan and do not receive them within thirty (30) days, the Participant 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 the Participant receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Participant and/or Dependent have a claim for benefits which is denied or ignored, in whole or in part, the Participant and/or Dependent may file a 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, the Participant 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, the Participant may seek assistance from the U.S. Department of Labor, or the Participant may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the Participant is successful, the court may order the person the Participant sued to pay these costs and fees. If the Participant loses, the court may order the Participant to pay these costs and fees, for example, if it finds the Participant's claim is

frivolous.

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

6) If the Participant and/or Dependent have any question about this Plan, the Participant and/or Dependent should contact the Plan Administrator (i.e. Office of the Administrative Manager or Plan Office). If the Participant and/or Dependent have any questions about this statement or about your rights under ERISA, the Participant and/or Dependent should contact the nearest Area Office of the Employee Benefits Security Administration at the following locations:

U.S. Department of Labor
Employee Benefits Security Administration
1885 Dixie Highway - Ste. 210
Ft. Wright, KY 41011-2664
Phone: (606) 578-4680

Or

U.S. Department of Labor
Employee Benefits Security Administration
1730 K Street - Ste. 556
Washington, D.C. 20006
Phone: (202) 254-7013

Or

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210.

The Participant and/or Dependent may also obtain certain publications about the Participant and/or Dependent's rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ARTICLE XX - ADDITIONAL INFORMATION REQUIRED BY ERISA

1) Name of Plan: Plumbers and Pipefitters Local Union No. 94 Health and Welfare Plan.

2) Plan Established and Maintained by:

Board of Trustees
Plumbers & Pipefitters Local Union No. 94 Health & Welfare Plan
BeneSys, Inc., Administrative Manager
3660 Stutz Drive, Ste. 101
Canfield, OH 44406
Phone: (330) 779-8874
Fax: (330) 270-0912

3) Sponsoring Employers: Upon written request to the Fund Office, the Participant and/or Dependents/Beneficiaries may obtain a complete list of employers sponsoring the Plan. Additionally, upon written request to the Fund Office, Participants and/or Dependents/Beneficiaries may receive from the Administrator information as to whether a particular employer is a sponsor of the Plan and, if the employer is a sponsor, its address.

4) Internal Revenue Service Employer Identification Number (EIN): 34-6594978

5) Plan Number: 501

6) Type of Plan: This Plan is maintained for the purpose of providing death and dismemberment, weekly income, hospitalization, surgical, medical and other related benefits.

7) Type of Administration of the Plan: Although this Plan technically is administered and maintained by the Joint Board of Trustees for the Plumbers and Pipefitters Local Union No. 94 Health and Welfare Fund, the Trustees have delegated certain administrative functions to a professional administrator.

8) Address all communications with the Board of Trustees to:

Board of Trustees
Plumbers & Pipefitters Local Union No. 94 Health & Welfare Plan
3660 Stutz Drive, Ste. 101
Canfield, OH 44406
Phone: (330) 779-8874

9) Agent for Service of Legal Process: Service of legal process may be made upon the Board of Trustees through Fund counsel at the following address:

Macala & Piatt, LLC
601 South Main Street
North Canton, Ohio 44720

Additionally, service of legal process may be made upon a Plan Trustee or the Plan Administrator.

10) Name, Title and Address of Principal Place of Business of each Trustee:

Brett McElfresh
3919 13th Street S.W.
Canton, Ohio 44710

Doug Houtz
3919 13th Street S.W.
Canton, Ohio 44710

Dave Poole
3919 13th Street S.W.
Canton, Ohio 44710

Darren Elliott
1225 Industrial Ave. SW
Massillon, Ohio 44647

Eric Seifert
11197 Cleveland Ave. NW
Uniontown, OH 44685

Ben Griffith
7257 Fulton Dr. NW
Canton, OH 44718

11) Collective Bargaining Agreement: This Plan is maintained pursuant to a collective bargaining agreement between the participating local unions and the various participating employers. You may obtain a copy of the collective bargaining agreement by writing to the Plan's Administrator or you may examine it at the Fund Office.

12) Sources of Contributions: This Plan is funded as follows:

a. Contributions by the employers on behalf of their employees under the terms of a collective bargaining agreement;

b. Contributions of the employers on behalf of the full-time employees of

Plumbers & Pipefitters Union Local No. 94 under the terms of an assent of participation;

c. Self-contributions by Participants; and

d. Investment income.

13) The Plan is subject to periodic actuarial review to assure that the relationship between income and benefits costs meets the funding standards required by ERISA.

14) Funding Medium for the Accumulation of Plan Assets: Assets are accumulated and medical benefits are provided by the Trust Fund. Some Plan assets are invested in accordance with the investment directives by the Board of Trustees.

15) Date of the Plan's Fiscal Year End: April 30th.

16) Network/Provider information: Accidental death and dismemberment benefits are self-insured and administered by the Plumbers and Pipefitters Local Union No. 94 Health and Welfare Fund, 3660 Stutz Drive, Ste. 101, Canfield, OH 44406, Phone: 330-779-8874.

17) The vision and dental benefits provided to participants in the active plan and to retired participants are self-insured and administered by the Plumbers and Pipefitters Local Union No. 94 Health and Welfare, 3660 Stutz Drive, Ste. 101, Canfield, OH 44406 Phone: 330-779-8874.

18) The prescription drug benefits are self-insured and administered by the Plumbers and Pipefitters Local Union No. 94 Health and Welfare Fund. The preferred pharmacy network and mail order services are provided through CVS Health/Caremark, 695 George Washington Highway, Lincoln, Rhode Island 02865.

19) Weekly accident and sickness benefits are self-insured by the Plumbers and Pipefitters Local Union No. 94 Health and Welfare Fund, 3660 Stutz Drive, Ste. 101, Canfield, OH 44406, Phone: 330-779-8874.

20) All medical benefits for eligible Participants are self-insured and administered by the Plumbers and Pipe fitters Local Union No. 94 Health and Welfare Fund. The hospital (facility), medical and surgical benefits are administered through a provider network operated by Medical Mutual of Ohio, 2060 East Ninth Street, Cleveland, Ohio 44115. Medical claims are administered by Medical Mutual Services, LLC, a wholly owned subsidiary of Medical Mutual of Ohio (“Medical Mutual”) P.O. Box 6018, Cleveland, Ohio 44101-1018. The Plumbers & Pipefitters Local 94 Health & Welfare Fund provides Participants with the option of seeking medical/surgical and other major medical care through providers that have contracted with Medical Mutual. As you know, a PPO is a network of doctors, diagnostic facilities and other health care providers who discount their charges in exchange for prompt payment of claims and more patient volume. Your Plan is not an HMO. There are no referrals nor is it necessary to select a primary care

physician. Medical Mutual was added to our Plan in an effort to save hard earned contribution dollars and to reduce your out-of-pocket expenses. If you seek care from a provider that is participating in Medical Mutual's PPO on the date of service, the provider's charge will be discounted in accordance with the PPO allowance.

- Medical claims are to be submitted via electronic submission or paper claims by the provider of service or you may submit them directly to Medical Mutual of Ohio, P.O. Box 6018, Cleveland, Ohio 44101-1018.

- You may obtain a provider list (free of charge) upon your request to Medical Mutual. However, Medical Mutual's provider network is always growing. Therefore, new providers are regularly being added to the program. It is also possible that a provider is listed in the directory but since the print of that directory may not have renewed their contract with Medical Mutual. As such, providers are advised to call Medical Mutual at (800)362-1279 before providing medical procedures. In addition, if a provider is not listed in your directory, you may obtain a more current list of medical care providers by accessing Medical Mutual's website at www.medmutual.com., or by calling the Medical Mutual over-the-phone directory ordering system at (888) 241-2583.

ARTICLE XXI - GENERAL DEFINITIONS

1) Where the following terms appear in this Plan Document, they shall have the meanings set forth in this section unless the context clearly indicates to the contrary.

a) Accidental Bodily Injury and Sickness - An unanticipated or unintentional occurrence which results in bodily harm, injury, damage or loss. The terms "Accidental Bodily Injury", "Sickness", or "Illness", with respect to an Eligible Participant or Dependent. do not include accidental bodily injury, sickness or illness which arises out of or in the course of employment, except that this provision shall not apply to Death Benefits and Dismemberment Benefits.

b) Amendments - The provisions of the Trust Agreement and the Plan Document may be amended from time to time by the Trustees. Such amendments shall be effective when approved by a majority of such Trustees, provided such amendments are in writing and consistent with the objectives and purposes of the Trust.

c) Benefit - The term "Benefit" shall mean the payment or reimbursement of a medical expense incurred by a Participant or a Participant's Dependents, the establishment and crediting of a Reserve Bank for Participants; and any death and dismemberment benefits payable under the Plan. However, the death benefit offered by the Plan is not a benefit to which a surviving spouse and/or eligible Dependent is entitled. The term "Benefit" also includes reimbursements or payments by this Plan or any other plan, including federal or state governments or the plan of another Employer.

d) Claims Administrator - The term "Claims Administrator" shall mean the person who is appointed Claims Administrator by the Plumbers & Pipefitters Local Union No. 94 Health & Welfare Plan.

e) Claims Payor - The term "Claims Payor" hall mean a third-party administrator who is responsible for the receipt, administration and payment of claims.

f) Collective Bargaining Agreement - The Collective Bargaining Agreement between the Union and the various participating employers. You may obtain a copy of the collective bargaining agreement by writing to the Plan Administrator or Local Union. Or you may examine it at the Fund Office.

g) Co-Insurance - A payment that represents the portion of the allowed charges that you are responsible to pay to any out-of-network providers after you have met your deductible or made your co-payment. The covered services which require a coinsurance payment are specified in the Schedule of Benefits, subject to Article I(B)-(E) which applies to you and your Dependents.

h) Contracting - The status of a Hospital or Other Facility Provider which has an agreement with the Claims Payor about payment for Covered Services; or which is designated by the Claims Payor as Contracting.

i) Co-Payments - A co-payment is an out-of-pocket charge paid by you directly to the provider or Physician at the time the services are rendered. A co-payment does not apply to your calendar year deductible or any co-insurance which may apply. The covered services which require a co-payment are specified in the Schedule of Benefits, subject to Article I (B)-(E) which applies to you and your Dependents.

j) Covered Charges - The billed charges for Covered Services, except that the Claims Payor reserves the right to limit the amount of Covered Charges for non-emergency Covered Services provided by a Non-Contracting Institutional Provider, subject to Article I (B)-(E).

k) Covered Service - A Provider's service or supply for which the Claims Payor will provide benefits, as listed in the Schedule of Benefits and subject to Article I (B)-(E).

l) Deductible - A deductible is the amount of covered medical expenses that you are required to pay each calendar year before benefits are paid by the Plan. A family deductible can be satisfied through any combination of individual deductibles.

m) Eligible Member or Eligible Participant or Participant - The term "Eligible Member or Eligible Participant" or “Participant” shall mean all persons eligible for benefits as set forth in the eligibility rules adopted by the Trustees.

n) Eligible Dependents - The term "Eligible Dependent" or "Dependents"

shall mean the following members of the Eligible Participant's family:

1) Legal Spouse – The term "Spouse" shall mean the lawful wife of a male Participant or the lawful husband of a female Participant. In addition to the foregoing, the term “spouse” includes any individuals who are lawfully married under any state law, including any individuals married to a person of the same gender who were legally married in a state that recognizes such marriages, but who are domiciled in a state that does not recognize such marriages. The term “marriage” as used in the preceding sentence, includes a same-gender marriage that is legally recognized as a marriage under any state law. Provided, however, the terms “spouse” and “marriage” do not include individuals in a formal relationship recognized by a state where that relationship is not designated a marriage under state law, such as a domestic partnership or a civil union, regardless of whether the spouses are same-gender or opposite-gender.

2) An Eligible Participants’ children and stepchildren in any of the following categories:

i) from date of birth until the end of the month the child reaches age twenty-six (26);

ii) children over the age of 26 who are incapable of self-sustaining employment, regardless of age, due to mental retardation or physical handicap prior to attainment of the maximum age, provided the Participant furnishes proof of the child's incapacity within thirty-one (31) days of the child's attainment of such maximum age;

iii) legally adopted children and children placed for adoption, from the date of birth until the end of the month the child reaches age 26 (in the event the child is placed in the home within sixty (60) days) or from the date the child is placed in the home of the Eligible Participant by a state agency or order of a court of competent jurisdiction if the child is not placed in the home within sixty (60) days;

iv) other children until the end of the month the child reaches age 26 and for whom the Eligible Participant or his Spouse are the legal guardians;

3) Coverage for a stepchild shall not be effective unless and until the Fund has been given written notice by the Eligible Participant that the stepchild is not covered through another plan until the Eligible Participant furnishes to the Fund certified copies of pertinent divorce orders and/or death certificates to aid the Fund in the determination of eligibility. If the natural parents of the eligible stepchild are divorced, the Fund shall be subrogated to the rights of the reimbursement pursuant to the court order

and/or separation agreement through which the stepchild's natural parents were divorced. No coverage shall be effective for the stepchild by the Fund until a subrogation agreement acceptable to the Fund has been provided.

4) A child/stepchild shall not be entitled to coverage under the Plan for so long as the child/stepchild is eligible for coverage under a plan provided by the child's/stepchild's employer which is not also an employer of the child's/stepchild's parent.

o) Employer or Participating Employer - The term "Employer or Participating Employer" shall mean an Employer who is, or has been, obligated under a collective bargaining agreement with the Union or an assent of participation to make payments for Health and Welfare benefits.

p) Expense Incurred - The term "Expense Incurred" includes those charges made for services and supplies which a prudent person would consider to be reasonably priced and reasonably necessary in the light) for the injury or sickness being treated.

q) Fiscal Year - The Fiscal Year shall be May 1 to April 30.

r) Funding Medium for the Accumulation of Plan Assets - Assets are accumulated and medical benefits are provided by the trust Fund. Commercial insurance may be secured to provide any or all benefits under he Plan. Some Plan assets are invested in accordance with the investment directives established by the Board of Trustees.

s) Hospital - The word "Hospital" shall mean my institution which meets one of the following requirements:

1. Is an approved and accredited Hospital recognized by the American Hospital Association and is primarily engaged in providing diagnostic and therapeutic facilities for the medical care of injured and sick persons on a basis other than as a rest home, nursing home, convalescent home, a place for the aged, a place for drug addicts, or a place for alcoholics; or

2. Any institution which meets all of the following requirements:

a) maintains permanent and full-time facilities for bed care of five (5) or more resident patients;

b) has a physician in regular attendance;

c) continuously provides 24-hour-per-day nursing service by registered nurses;

d) is primarily engaged in providing diagnostic and therapeutic

facilities for medical and surgical care of injured and sick persons on a basis other than a rest home, nursing home, convalescent home, a place for the aged, a place for drug addicts, or a place for alcoholics;

e) is operating lawfully in the jurisdiction where it is located.

t) Illness - The term "Illness" shall mean a sickness, injury, pregnancy, or accidental bodily injury. For purposes of the Plan's "WEEKLY ACCIDENT AND SICKNESS BENEFITS COVERAGE", illness is a disabling accident or sickness.

u) Immediate Family - A Participant's spouse, parent, child, brother, sister, mother or father-in-law, stepparents, stepchildren, foster parents and children, grandparents and any bona fide member of a Participant's household.

v) Injury - Any bodily harm or damage.

w) Incurred Date - The "Incurred Date" of a claim shall be the first date on which the Eligible Participant or Eligible Dependent is under the care of a Physician and/or has expenses which would be payable by the Fund.

x) Inpatient - The term "Inpatient" means a person who is a resident patient using and being charged for room and board by a hospital.

y) Lesser Amount - For Contracting and Participating Providers, the Lesser Amount Deans the Lesser of the Negotiated Amount or the Covered Charges. For Non-Participating Physicians and Other Professional Providers, the Lesser Amount Deans the Traditional Amount.

z) Medically Necessary - The term "Medically Necessary" shall mean that a service or supply is ordered by a physician, is commonly and customarily recognized throughout the physician's profession as appropriate in the treatment or diagnosis of the illness or injury, and is not furnished primarily for the purpose of medical or other research.

aa) Negotiated Amount - The amount the Provider has agreed with the Claims Payor to accept as payment in full for covered services.

- The Negotiated Amount for Institutional Providers does not include adjustments and/or settlement due to most favored nations rate violations, prompt payment discounts, guaranteed discount corridor provisions, maximum charge increase limitation violations or any settlement, incentive, allowance or adjustment that does not accrue to a specific claim.

- The Negotiated Amount for Prescription Drugs does not include any share of formulary reimbursement savings, volume based credits or refunds or discount guarantees.

- The Negotiated Amount for Contracting Institutional Providers may exceed the Covered Charges.

- The Negotiated Amount for Participating Physicians and Other Professional Providers does not include any performance withhold adjustments.

- In certain circumstances, the Claims Payor may have an agreement or arrangement with a vendor who purchases the services, supplies or products from the Provider instead of the Claims Payor contracting directly with the Provider itself. In theses circumstances, the Negotiated Amount will be based upon the agreement or arrangement the Claims Payor has with the vendor and not upon the vendor's actual negotiated price with the Provider, subject to the further conditions and limitations set forth herein.

bb) Non-Contracting - The status of a Hospital or Other Facility Provider which does not meet the definition of a Contracting Institutional Provider.

cc) Out-of-Pocket Expense Limit - The Out-of-Pocket expense limit applies to covered benefits and eligible charges of providers and physicians such as deductibles and coinsurance payments. These unpaid expenses are your responsibility until the annual out-of-pocket maximum limit is reached as specified in the Schedule of Benefits which applies to you and your Dependents.

dd) Outpatient - The term "Outpatient" means a person who receives services and treatments at an approved medical facility, but not as an inpatient.

ee) Physician or Surgeon - The term "Physician" or "Surgeon" shall mean a person who is duly licensed to prescribe and administer all drugs and/or to perform all surgery, and shall include osteopaths, chiropractors, optometrists, podiatrists, dentists, psychologists and physical therapists when operating within the scope of their license.

ff) Plan - The term "Plan" shall mean the Plan established and maintained pursuant to this document or any predecessor documents which set forth the rights and obligations of the persons entitled to benefits under the Plan and the procedures by which Plan fiduciaries may be identified.

gg) Sources of Contributions - This Plan is funded as follows:

A. contributions by Employers on behalf of their employees, under the terms of a collective bargaining agreement;

B. contributions by the Employer on behalf of the full-time employees of the Plumbers & Pipefitters Local Union No. 94 under the terms of an Assent of Participation;

C. self-contributions by Eligible Participants; and

D. investment income.

hh) Traditional Amount (or "TA") – criteria: The Traditional Amount means the maximum amount determined and allowed for a covered service based on factors, including the following:

- the actual amount billed by a Provider for a given service;
- Centers for Medicare and Medicaid Services (CMS)'s Resource Based Value Scale (RBRVS);
- other fee schedules;
- input from participating physicians and wholesale prices (where applicable); and
- other economic and statistical indicators and applicable conversation factors.

ii) Trust Agreement - The term "Trust Agreement" shall mean the Agreement and Declaration of Trust as originally entered into between the Local Union No. 94 of the United Association of Journeymen and Apprentices of the Plumbing, Pipefitting, and Refrigeration Industry of the United States and Canada and the Stark Association of Plumbing, Heating and Cooling Contractors, and as from time to time amended.

jj) Trust Fund - The term "Trust Fund" shall mean the amounts contributed to the Trustees by Employers, such additional sums as the Trustees receive as dividends, rate refunds and/or recoveries on insurance policies held by the Trustees, either paid to the Trustees or left by the Trustees with an insurance company, all investments of Trust Agents selected by the Trustees and income thereon, the insurance policies held by the Trustees and any other money or property received by the Trustees in connection with the administration of the Trust Agreement.

kk) Trustees - The term "Trustees" shall mean the individuals who from time to time act as Trustees of the Plumbers and Pipefitters Local Union No. 94 Health and Welfare Fund and as appointed in accordance with the Trust Agreement.

ll) Union - The term "Union" shall mean United Association of Journeymen and Apprentices of the Plumbing, Pipefitting, and Refrigeration Industry of the United States and Canada, Local Union No. 94. The Union shall also be deemed an "Employer" under this Plan for purposes of extending coverage hereunder to its employees.

mm) Welfare Fund or Fund - The term "Welfare Fund" or "Fund" shall mean the Trust Fund for the Plumbers and Pipefitters Local Union No. 94 Health and Welfare Fund.

Plumbers and Pipefitters Local Union #94
Fringe Benefit Funds

3660 Stutz Drive, Ste. 101
Canfield, Ohio 44406
Phone: 330-779-8874
Fax: 330-270-0912

AUTHORIZATION FOR DISBURSEMENT
FROM MEDICAL REIMBURSEMENT ACCOUNT
REQUEST FOR REIMBURSEMENT OF MEDICAL EXPENSES

EMPLOYEE NAME _____

ADDRESS _____

PHONE NO. _____

SOCIAL SECURITY NUMBER _____

I am requesting payment for the following charges for which I have not been reimbursed, and for which I have not and will not be claiming a federal income tax deduction:

AMOUNT OF DEDUCTIBLE $_____

AMOUNT OF CO-INSURANCE $_____

VISION CARE (**attach receipts)** $_____
(Not covered by the Health & Welfare Fund)

DENTAL CARE (**attach receipts**) $_____
(Not covered by the Health & Welfare Fund)

OTHER MEDICAL EXPENSES (**attach receipts)** $_____
(Not covered by the Health & Welfare Fund)

SELF PAYMENT BILLING (**attach copy of billing**) $_____

_____ Check here if you elect to have your self-payment remitted directly to your health fund.

Please complete the above, attach a copy of your EOB (Explanation of Benefits) from the Health & Welfare Plan where applicable, and receipts showing payments were made for expenses not covered by the Health & Welfare Plan, sign and return this form to:

PLUMBERS AND PIPEFITTERS LOCAL UNION #94
FRINGE BENEFIT FUNDS
3660 Stutz Drive, Ste. 101
Canfield, OH 44406

All expenses submitted (other than self-payments) will be reimbursed monthly. Please call first to check the status of your account before filing large dollar claims and **PLEASE MAKE A COPY FOR YOURSELF OF ALL CHARGES SUBMITTED IN THE EVENT OF LOSS.**

EMPLOYEE SIGNATURE _____ DATE _____

Not valid unless signed and dated by Employee