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INTRODUCTION

The following pages explain your benefits under the Plumbers & Fitters Local No. 101 Health & Welfare Fund (“the Plan”). The Plan provides valuable health care coverage for you and your covered family members, however in order to receive maximum benefits available under the Plan you must comply with the Plan’s eligibility and enrollment requirements, including self-payment of contributions if applicable, and use HealthLink or USA health care providers whenever possible.

Although you may use any qualified health care provider you choose, benefits are reduced when you use physicians who are not members of the HealthLink or USA networks. Benefits payable under the Plan may also be reduced if you or your dependents are covered under another group health plan (see “Coordination of Benefits and Excess Coverage,” beginning on page 84) or if a third party is responsible for your illness or injury (see “Subrogation and Reimbursement,” beginning on page 90).

The Plan intends to provide the most comprehensive health care coverage possible, however due to financial constraints, some medical treatment is not covered under the Plan. Therefore under certain circumstances you and your medical provider might determine that such non-covered medical care is appropriate. All medical decisions should be made by you and your medical provider.

To help you understand your benefits under the Plan, certain terms are printed in bold type and are explained in the Definitions section of this booklet, which begins on page 73.

Helpful Telephone Numbers

For questions about your medical benefits

Benefit Consultants, Inc.1-800-434-4620

For Network (HMO or PPO) physician membership questions

HealthLink.....1-800-624-2356

USA Managed Care1-800-892-3860

To obtain a voluntary predetermination of benefits

HealthLink.....1-877-284-0102

For information about prescription drug benefits

WellPoint1-888-820-0287

GENERAL INFORMATION

Name and Address of Plan:

Plumbers & Fitters Local No. 101
Health & Welfare Fund
137 Iowa Avenue
Belleville, IL 62220

Employer Identification Number:

37-6146889

Plan Number:

PN 502

Type of Plan:

This is a welfare benefit plan that provides medical care, prescription drug, dental, vision, and death benefits from its own assets.

Plan or Fund Administrator:

The Board of Trustees is the Plan or Fund Administrator. The Board of Trustees is currently composed of the following Trustees:

Union Trustees

William Adrian
108 Sir Lawrence Dr.
Belleville, IL 62221

Leonard Rathke
21 Kirby Lane
Belleville, IL 62223

Michael Veath
1314 Union Ave.
Belleville, IL 62221

Scott Deitz (Alternate)
5656 Sandrock Rd.
Smithton, IL 62285

Management Trustees

Grant Ehret
66 Carnation Dr.
Belleville, IL 62223

Michael Ehret
14 Palmetto Drive
Belleville, IL 62220

James Lugge
1999 S. 59th St.
Belleville, IL 62223

Gary Vasquez (Alternate)
10912 Bee Hollow Road
Marissa, IL 62257

You may also communicate with the Board of Trustees by contacting them at the following address and phone number:

Board of Trustees
Plumbers & Fitters Local No. 101 Health & Welfare Fund
137 Iowa Avenue
Belleville, IL 62220
Phone: 618-234-5504

Type of Administration:

This Plan is administered by the Board of Trustees. The Trustees have retained the services of a qualified **claim administrator** to review and pay claims for medical benefits. That Claim Administrator is:

Benefit Consultants, Inc.
13515 Barrett Parkway Drive, Suite 265
Ballwin, MO 63021
(314) 822-7890 or (800) 434-4620

The Trustees have engaged the services of HealthLink to perform predetermination services. The Plan also uses HealthLink's and USA Managed Care's provider networks.

HealthLink, Inc.
12443 Olive Blvd.
St. Louis, Missouri 63141
(314) 989-6300 or (800) 624-2356

USA Managed Care Organization, Inc.
P.O. Box 971525
Dallas, TX 75397

The Trustees have retained the services of WellPoint to review and pay prescription drug benefits under the Plan. The Plan also purchases access to the WellPoint pharmacy network.

WellPoint Pharmacy Benefit Management
8407 Fallbrook Ave.
West Hills, CA 91304

Neither the **claim administrator**, HealthLink, USA nor WellPoint has any responsibility to actually provide any benefits. All of the benefits are paid directly out of the assets of the Plan.

Agent for Service of Legal Process:

Process may be served on the Plan or Fund by service on any of the Trustees at the address of the Plan.

Collective Bargaining Agreements:

This Plan is maintained pursuant to collective bargaining agreements between participating employers and Plumbers and Fitters Local Union 101. A copy of any collective bargaining agreement is available upon written request to the Board of Trustees. Copies of such agreements are also available for inspection.

Source of Contributions:

The Plan is funded by contributions from employers who are party to collective bargaining agreements or other agreements that require contributions to this Fund. The amounts of those contributions are set forth from time to time in those agreements. In addition, under limited circumstances, **participants** and beneficiaries are permitted to contribute to the Plan.

From time to time the Plan receives payments from health care or service providers which it is not administratively feasible to allocate to a specific claim or individual. Examples of such payments are performance guarantees and rebates. These payments are used to offset Plan expenses generally for the benefit of all **participants**.

Trust:

The assets of the Plan are held in Trust by the Board of Trustees. All benefits are paid directly from the assets of the Plan.

Plan Year:

January 1 through December 31

Authority to Interpret, Construe and Apply the Terms of Plan Documents:

The Board of Trustees has the authority and discretion to interpret, construe, and apply all of the terms of this summary plan description, the Trust Agreement and any other documents governing the operation of this Plan, including any ambiguous terms in such documents. The Trustees will, pursuant to the terms of the plan documents, make all final determinations regarding eligibility for benefits and the amount of benefits due **participants** and beneficiaries. The decisions of the Trustees will be binding. All decisions made by the Trustees are intended to be subject to the most deferential standard of judicial review.

Benefits are Not Vested:

None of the benefits provided by this Plan, including **retiree** benefits, are vested. The Trustees retain the authority to amend, alter, modify, reduce, or terminate any or all of the benefits provided by this Plan when, in their discretion, they deem such changes to be necessary.

Amendment of Plan:

The Trustees have the authority to amend the Plan at any time. Amendments are made by majority vote of the Trustees at a regular or special meeting of the Board of Trustees.

Distribution of Assets on Termination of Plan and Trust:

Should the Trustees determine to terminate the Plan and Trust, any assets remaining shall be used solely for purposes of providing benefits and defraying the reasonable cost of administering the Plan. No assets shall revert to the contributing employers.

ELIGIBILITY RULES

The following pages explain how **you** and **your dependents** become and remain covered under the Plan, as well as how and when coverage terminates.

EMPLOYEE ELIGIBILITY

Classes of Persons Eligible

You are eligible for coverage under this Plan if **you** are a member of one of the following classes.

Class 1: **You** are a member of a bargaining unit established by a collective bargaining agreement between a Local Union of the United Association of the Journeymen and Apprentices of the Plumbing Pipefitting Industry and an employer which is required by the collective bargaining agreement to contribute to this Fund and are actively employed or seeking employment within the geographic and craft jurisdiction of Local Union No. 101.

Class 2: **You** (a) retired at age 65 or older, while covered under Class 1 and prior to July 1, 1992, (b) are receiving benefits under the Local 101 Pension Plan and (c) had a minimum of 25,000 hours of credited service at the time of your retirement.

Class 3: **You** are an employee of this Fund or of Local Union No. 101.

If **you** are a member of Class 1 and are also employed by a corporation where the stock is owned in whole or in part by your spouse, your **child**, your brother or your sister, contributions must be made to the Fund on your behalf for at least 30 hours per week for 48 weeks of the calendar year.

When You Become Covered as a Member of Class 1 or Class 3

You will become covered on the first day of the month after **you** complete 500 hours of work in covered employment within a 12-month period. If **you** are a member of Class 3, your coverage will be continuous from your eligibility date provided that **you** meet the requirements shown in the subsection entitled "Continuation of Coverage" for Class 3 on page 11. If **you** are a member of Class 1, your initial eligibility period will be determined as follows:

- If **you** become eligible on the first day of a quarter (i.e., January 1, April 1, July 1 or October 1), **you** will remain eligible for that entire quarter;

- If **you** become eligible on any other date, **you** will remain eligible for the remainder of the quarter in which **you** become eligible as well as for the entire next quarter.

In order to remain covered after your initial eligibility period, **you** must meet the requirements described under “Continuation of Coverage” for Class 1 below.

“Covered Employment” is employment within the geographic and craft jurisdiction of Local 101 for which contributions have been made to this Fund by your employer(s); Covered Employment also includes work within the jurisdiction of a United Association Local Union which has a reciprocal agreement with this Plan for health and welfare coverage.

If **you** are (a) **totally disabled** on the date **you** become eligible under this Plan and (b) eligible for coverage for the disabling illness or injury under an extension of benefits provided under an insurance policy, this Plan will not provide benefits for such illness or injury to the extent benefits are provided under the extension of benefits.

Continuation of Coverage

Class 1

After you have met the requirements for initial eligibility, you need 300 hours each calendar quarter to continue your coverage. These hours may be obtained through active work or the use of banked hours as described below (or in some circumstances through self-payment as described on pages 25-26).

a. Hours Worked

You must work 300 hours* in Covered Employment during a calendar quarter in order to have coverage for the second following calendar quarter, as indicated in the following table:

<u>300 Hours Worked In This Quarter</u>	<u>Provides Coverage for This Quarter</u>
First Quarter (Jan. Through March)	Third Quarter (July Through Sept.)
Second Quarter (April Through June)	Fourth Quarter (Oct. Through Dec.)
Third Quarter (July Through Sept.)	First Quarter (Jan. Through March)
Fourth Quarter (Oct. Through Dec.)	Second Quarter (April Through June)

b. Hour Bank

After initial coverage is established, your Hour Bank account will be credited with all hours* worked over:

1. 600 hours from January 1 through June 30 of each calendar year and

2. 300 hours during each of the third and fourth quarters of the calendar year.

If **you** fail to work 300 hours in a quarter, **you** may use hours from your Hour Bank account to make up the difference between the hours you actually worked and the total number needed for eligibility. However, if you become covered under another group health plan by virtue of your own employment, you may not use banked hours to continue coverage under this Plan.

Banked hours will be carried over to succeeding quarters and will continue to accumulate to a maximum of 1,200 total banked hours. If **you** become unavailable for work for reasons other than **total disability** or if **you** work in non-covered employment, your banked hours will be permanently forfeited. If you become unavailable for work due to **total disability**, your banked hours will not be forfeited. They may be used to provide coverage during your disability as provided in the section entitled “Disabled Participants” on pages 29-30. Any banked hours that remain when you return to work following disability may be used to provide coverage until you work sufficient hours to requalify for active coverage.

***Important Note: In order for you to receive credit for hours worked, your employer must submit the applicable contribution amounts to the Fund.**

Class 2

Coverage continues until three months after the end of the month your last pension check was issued from the Plumbers & Fitters Local 101 Pension Plan.

Class 3

Coverage continues as long as **you** remain a Full-Time Employee of the Fund or Local Union No. 101. A “Full-Time Employee” is one who works at least 28 hours per week on a regular basis. However, if **you** transfer from Class 1 to Class 3 and later cease to be a Full-Time Employee, you will have no less an extension of coverage than you would have had had you remained in Class 1.

Reinstatement of Class 1 Coverage

If your coverage terminates and you work at least 300 hours in **covered employment** in a single calendar quarter within 18 months of your termination date, your coverage will be reinstated on the first day of the second following calendar quarter, according to the table on the next page:

300 Hours Worked In This Quarter
First Quarter (Jan. Through March)
Second Quarter (April Through June)
Third Quarter (July Through Sept.)
Fourth Quarter (Oct. Through Dec.)

Coverage Reinstated In This Quarter
Third Quarter (July Through Sept.)
Fourth Quarter (Oct. Through Dec.)
First Quarter (Jan. Through March)
Second Quarter (April Through June)

TERMINATION OF COVERAGE

Termination of Your Coverage

Your coverage under the Plan will terminate on the earliest of the following:

1. the date the Plan terminates;
2. the date **you** fail to qualify for continued coverage by means of worked or banked hours;
3. the date a change is made in the Plan to terminate coverage for your class;
4. if **you** fail to make a timely self-payment in accordance with the rules set forth by the Trustees, the end of the last period for which **you** last made a timely self-payment;
5. if **you** are a member of Class 1, the date **you** cease working or actively seeking work in the construction industry under the craft jurisdiction of the United Association for reasons other than retirement or disability;
6. if **you** are a member of Class 2, three months after the end of the month your last pension check was issued from the Plumbers & Fitters Local 101 Pension Plan;
7. if **you** are a member of Class 3, the date **you** cease active, full-time work for this Fund or Local Union No. 101, unless **you** have banked hours under **Continuation of Class 3 Coverage** above;
8. if **you** are eligible for coverage based on banked hours, the date you become covered under another group health plan by virtue of your own employment.

Special Provision for Employees in Active Military Service: If an employee is engaged in full-time active duty in one of the uniformed services of the United States, coverage for that employee and any covered dependents will be continued for a period of 31 days. If the period of military service exceeds 31 days, employees may continue their health coverage and/or that of any covered dependents by either: (a) using accumulated worked and/or banked hours or (b) electing and paying for continuation coverage for up to 24 months from the first

day of active military service, subject to the Plan's COBRA Continuation Coverage election and payment rules.

When an employee, whose eligibility for coverage terminated on account of entry into active duty in one of the uniformed services of the United States, returns from such service and is reemployed with a participating employer prior to the expiration of his period of re-employment rights under any applicable Federal or State law, any unused eligibility earned by virtue of worked/banked hours accumulated prior to the military leave will be immediately reinstated.

Any employee entering active duty in one of the uniformed services of the United States should notify the Fund Office before leaving for such duty, unless advance notice is impossible, unreasonable or precluded by military necessity. The Fund Office should also be notified upon return to work with a participating employer.

Extension of Medical Benefits Due to Total Disability

If **you** or one of **your dependents** is **totally disabled** on the date coverage under this Plan would otherwise terminate, benefits may be extended for covered charges incurred for the care and treatment of the condition that caused the disability if:

1. the expense would have been covered if the coverage had continued;
2. the **total disability** continues to the date such expense is incurred; and
3. the person who is **totally disabled** is not entitled to similar benefits under any other group plan when each such expense is incurred.

Benefits are extended and payable only for the treatment of the **illness** or **injury** that caused the **total disability**. The benefits payable will be subject to the same maximums, limitations, and exclusions that were in effect under this Plan at the time coverage would have terminated.

Benefits will continue until the earliest of:

1. the date the Plan terminates;
2. the date the **totally disabled** person is no longer **totally disabled**;
3. the date the **totally disabled** person becomes covered for benefits under another plan that provides similar benefits; or
4. 12 consecutive calendar months after active Plan coverage would have otherwise terminated.

Family and Medical Leave Act (FMLA) Coverage

Continuation of Coverage. Provided your employer continues to make the required contributions, **you** may continue Medical coverage for yourself and **your dependents** during a period of FMLA Leave as if **you** had not taken FMLA Leave, but had instead continued your employment and your participation in the Plan.

You will not have the right to continue coverage during a period of FMLA Leave however, if **you** inform your employer before beginning your leave that **you** do not intend to return to work for your employer at the conclusion of your leave. In that event, **you** may have a right to continue coverage under COBRA Continuation Coverage.

Termination of Coverage. If **you** elect to continue coverage during a period of FMLA Leave, your coverage (and that of **your eligible dependents**) will continue until the earliest of:

1. the date **you** notify your employer that **you** do not intend to return to work for your employer after the conclusion of the FMLA Leave;
2. the date your employment is terminated because **you** fail to return to work for your employer after the period of FMLA Leave; or
3. the date your employer's participation in the Plan terminates.

Restoration of Coverage. Any coverage **you** do not continue while on FMLA Leave will be reinstated upon your return from FMLA Leave. **You** and **your dependents** will receive the same coverage you had prior to the commencement of the FMLA Leave. Neither **you** nor **your dependents**, if you were covered under the Plan at the time the FMLA Leave commenced, will be subject to any new preexisting condition limitations. If **you** had been subject to the preexisting condition limitation previously, however, that limitation will remain in effect, applied as if coverage under the Plan had been in effect during the period of FMLA Leave.

Construction. The rules in this section will be interpreted and applied in a manner consistent with the provisions of the Family and Medical Leave Act of 1993.

YOUR ELIGIBLE DEPENDENTS

Your eligible dependents are your lawful spouse and each unmarried **child**, who:

1. has the same principal place of abode as **you*** for more than one-half of the calendar year; and
 2. receives over one-half of their support from **you*** during the calendar year; and
 3. is under the age of 19 or, if a full-time student (as described below), under the age of 23.
- * Or **you** and the child's other parent combined if **you** and the other parent are divorced, separated or living apart for the last six months of the year.

The term "**child**" means:

- your natural child (in order for a **child** of an unmarried male **participant** to be eligible for coverage under the Plan, the **participant** must be shown as the father of the child on the child's birth certificate. A copy of the birth certificate must be submitted to the Fund Office before that child will be added to the Plan);
- your adopted child, including a child lawfully placed with **you** in anticipation of legal adoption (A child is considered "adopted" only when he is adopted or placed for adoption, and only if the adoption or placement occurs before the child reached his 18th birthday. A child is placed for adoption when an employee assumes and retains a legal obligation for total or partial support of the child in anticipation of adoption.);
- your foster child of whom **you** have legal and physical custody pursuant to a court order or judgment; or
- your stepchild who lives with **you** in your home.

It is the responsibility of the Employee to notify the Fund Office of any changes in dependent status and all requests for coverage changes and/or additions of dependents must be in writing.

Full-Time Student Eligibility.

1. Full-time enrollment means a minimum of twelve semester or quarter hours, unless the school's definition of full-time attendance is different in which case the school's definition will control.
2. For purposes of this Plan, an "Educational Institution" includes accredited high schools, colleges, universities, and vocational schools; as well as licensed technical, beautician, automotive and similar technical schools. On the job training courses, correspondence schools, on-line schools and night schools not attended as part of a full-time degree program do not satisfy this definition.
3. For purposes of this Plan there are two coverage periods: the Spring coverage period is January 1 through September 7 and the Fall coverage period is September 8 through December 31.
4. It is the responsibility of the employee or student to provide proof of full-time student status for each coverage period. In order to assure no break in coverage, verification must be submitted to the **claim administrator** prior to the start of the coverage period. Full-time student verification forms which include pre-enrollment verification may be obtained from the **claim administrator** or Fund office or the **participant** or student may furnish a standard document issued by the school for the purpose of confirming full-time student enrollment, provided the school's document includes the following information: identification of the student by name, address and date of birth; the school's definition of full-time student; verification that the student is currently enrolled or pre-enrolled as a full-time student; the period for which the student is enrolled; and whether the student will be graduating at the end of the school term.
5. A dependent who has provided proof of enrollment prior to the start of the coverage period and meets the requirements of a full-time student for any part of a Plan coverage period will be covered for that full coverage period. Except that if a dependent graduates or drops out and is not enrolled or pre-enrolled in another Educational Institution then coverage ends at the actual end of the school term and does not continue until the end of the coverage period. For example, a student is enrolled full-time as a junior in an Educational Institution. Coverage will continue until September 7 of that year. The next year the student graduates on May 20, which is the end of the school's semester, and is not enrolled in graduate school. That year coverage ends on May 20. The child no longer meets the definition of dependent for this Plan but may be eligible for COBRA.
6. If verification is not furnished prior to the coverage period but is furnished within thirty (30) days after the beginning of the school's term or the coverage period then eligibility will be reinstated retroactively to the beginning of the applicable school term or coverage period. For example, if a dependent age 20 who has

been out of school since age 18 enrolls in a program beginning March 1, that child will again be an eligible dependent effective January 1 (the start of the coverage period) if the enrollment information is provided before February 1. If the enrollment information is not provided prior to February 1, but is provided prior to April 1 (30 days after the start of the school term), then eligibility will begin March 1 (the start of the school term). In either case coverage continues through September 7.

7. Full-time student status as defined in this section need not be continuous. Eligibility is based on student status and verification for each coverage period.
8. It is the responsibility of the student and the Employee to inform the Fund Office of the student's graduation or other termination of enrollment. If the Fund Office is not informed and benefits are paid after graduation or termination of enrollment then the student and Employee are both responsible for reimbursing the Fund for any amounts paid on claims incurred after graduation or termination of enrollment. If necessary, the Plan has a right to recoup improperly paid benefits by withholding future benefits. Please see the subsection entitled, "Your Duty to Inform Plan of Termination of Dependent's Eligibility" on pages 19 for additional consequences of failing to notify the Fund Office of changes in dependent eligibility.

Disabled Children

An unmarried **child** whose coverage would otherwise terminate solely due to reaching the maximum age will continue to be eligible provided the **child**:

1. is incapable of self-sustaining employment due to mental retardation or physical handicap; and
2. became so incapable before reaching 19 years of age; and
3. is covered under the Plan on the date he or she reaches age 19.

The Trustees may inquire, at any reasonable time after such dependent **child** has reached the limiting age, if the dependent **child** is, in fact, incapable of self-sustaining employment by reason of mental retardation or physical handicap. Proof of such incapacity must be furnished within 31 days of the Trustees' inquiry. If the proof is satisfactory to the Trustees, coverage will continue for as long as the participant remains covered provided that all other eligibility rules of the Plan have been satisfied and provided the **child** remains incapacitated.

Ineligible Dependents

The following Dependents are excluded from coverage:

1. Any Dependent while that Dependent is engaged in a period of full-time active duty in the Armed Forces of any country; and
2. Any Dependent while that Dependent does not satisfy the definition of a Dependent under the Working Families Tax Relief Act of 2004 (WFTRA). Any conflict between this definition and the WFTRA or any other applicable provision of the law shall be reconciled in favor of compliance with the WFTRA or other applicable law. To the extent the law provides for a more restrictive definition of Dependent Child than contained in the Plan, the Plan's definition of Dependent Child shall be the definition provided by WFTRA as written and periodically amended.
3. Any **dependent** who is also eligible for benefits as a member under this Plan or under the Extension of Medical Benefits.

Effective Date of Dependents' Coverage

Normally, coverage for **your dependents** starts on the date your coverage starts or on the date **you** acquire an **eligible dependent**. If **your dependent** is (a) **totally disabled** on your date of eligibility under this self-funded plan and (b) eligible for coverage for the disabling **illness** or **injury** under an extension of benefits provided under an insurance policy, this Plan will not provide benefits for such **illness** or **injury** to the extent benefits are provided under the extension of benefits.

Coverage for a newborn dependent **child** will begin from birth for **injury** or **illness**. This includes **medically necessary** care for congenital defects, birth abnormalities and premature birth.

Enrollment of Dependents

Your **dependents** will be automatically enrolled in the Plan upon proper notice to Fund Office. If **you** acquire a new dependent or if an existing **dependent** becomes eligible for coverage under the Plan (e.g., a child's enrollment as a full-time student), coverage will be effective on the first day such eligibility requirements are met, provided that the Fund Office is notified of the dependent's eligibility. To ensure proper payment of benefits, **you** should notify the Fund Office within 31 days of any changes in **dependent** status (e.g., marriage, divorce, birth, adoption or placement for adoption, death, enrollment or termination of full-time student enrollment).

Termination of Your Dependents' Coverage

Your dependents' coverage will terminate on the earliest of the following:

1. the date your coverage terminates;
2. the date a **dependent** ceases to meet the Plan's eligibility requirements.

Your Duty to Inform Plan of Termination of Dependent's Eligibility

If any of the following occur, it is your responsibility to inform the Fund Office:

- **you** get divorced or legally separated;
- your **child** reaches the limiting age;
- your **child** gets married;
- your **child**, over 18, is no longer a full-time student; or
- your incapacitated **child** recovers.

If **you** fail to inform the Fund Office when one of these events occurs, **your dependent** may lose his or her right to COBRA continuation coverage. Further, if because **you** have failed to inform the Fund Office, the Plan pays out benefits for an ineligible **dependent**, the Plan will have the right to recover such benefits from **you**, **your dependent**, or any provider to whom such benefits were paid. The Plan may at its option withhold future benefits due to or on behalf of **you** and your other covered **dependents** in order to recoup amounts it paid on behalf of an ineligible **dependent**. If the Trustees bring a legal action to collect such benefits, the Trustees, upon prevailing, will be entitled to receive and you will be required to pay not only the overpayments, but also pre-judgment interest and the reasonable attorney's fees and costs the Trustees incur in such action.

HIPAA Certificates

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), the Plan will provide **you** and **your dependents** with a HIPAA certificate of creditable coverage when coverage under the Plan terminates. This certificate will show the length of time **you**, **your dependents**, or both were covered under this Plan. You or a **dependent** may need to show such a certificate to the next group health plan under which you or a **dependent** has coverage so that plan can determine whether it can apply a limit to any **pre-existing condition you** or a **dependent** may have.

This Plan will furnish such a certificate when regular coverage under this Plan ends, when COBRA coverage ends, and upon the request of (or on behalf of) the covered person within the two years following the termination of coverage. A detailed copy of the Plan's procedures for requesting a certificate of creditable coverage is available from the **claim administrator**.

COBRA CONTINUATION OF COVERAGE (SELF-PAY)

Introduction

The following paragraphs generally explain COBRA coverage, when it may become available to you and your family and what you need to do to protect the right to receive it.

The Plumbers and Fitters Local 101 Health and Welfare Plan provides continued health and welfare coverage on a self-pay basis pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as COBRA. Eligible employees and their dependents are offered the opportunity for a temporary extension of health coverage called "continuation coverage" in certain instances called "qualifying events," which would normally otherwise cause coverage to end.

You do not have to show that you are insurable to qualify for continuation coverage. However, you must pay the cost of the continuation coverage.

Things to Consider When Deciding Whether to Take COBRA Coverage

Your decision to elect or reject COBRA can have an effect on your rights regarding health benefits under federal law. First, under federal law, if you have had health coverage continuously for 12 (or in some cases 18) months and you have less than a 63-day gap in your health coverage when you become covered under another group health plan, that next group health plan cannot limit coverage of any pre-existing conditions you may have. Taking COBRA coverage may help you complete 12 (or 18) months of coverage under this Plan and may help you avoid a 63-day gap in coverage.

Second, federal law generally requires that insurance companies offer individual health insurance policies with no pre-existing condition limitations to individuals who have exercised their right to take COBRA continuation coverage from a group health plan for the maximum period. If you do not take COBRA, you will lose this protection.

Finally, it is important that you know that under the federal law, you have the special right to enroll in any other group health plan for which you may be eligible (such as a plan sponsored by your spouse's employer) within 30 days after your regular coverage under this Plan terminates due to a qualifying event. You will not have to wait until that other plan's next open enrollment period. If you elect COBRA continuation coverage under this Plan, you will have that same special right to enroll in another group health plan at the end of your COBRA coverage if you keep the COBRA coverage for the maximum period it is available to you.

What is COBRA Continuation Coverage?

COBRA continuation coverage is self-payment continuation of Plan coverage when coverage would otherwise end because of a qualifying event. Specific qualifying events are listed below in the section entitled, “Who is Entitled To Elect COBRA.”

After a qualifying event occurs and any required notice of that event is properly provided, COBRA continuation coverage will be offered to each person who is a “Qualified Beneficiary.” You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of a qualifying event. (Certain newborns, newly adopted children and alternate recipients under QMCSOs may also be Qualified Beneficiaries. This is discussed in more detail below.)

Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Who is Entitled To Elect COBRA—Qualifying Events

A Participant may elect Continuation Coverage at his own expense if his coverage under the Plan terminates because of a reduction in hours of employment or termination of employment (for reasons other than gross misconduct).

The spouse of a Participant who was covered under the Plan on the day before the qualifying event may elect Continuation Coverage if his coverage under the Plan terminates for any of the following reasons:

1. Death of the Participant;
2. Termination of the Participant’s employment (for reasons other than gross misconduct) or reduction in the Participant’s hours of employment;
3. Divorce or legal separation from the Participant; or

A Dependent child of a Participant who was covered under the Plan on the day before the qualifying event may elect Continuation Coverage if his coverage under the Plan terminates for any of the following reasons:

1. Death of the Participant;
2. Termination of the Participant’s employment (for reasons other than gross misconduct) or reduction the Participant's hours of employment;

3. The Participant's divorce or legal separation; or
4. Cessation of the child's status as an Eligible Dependent under the Plan.

If coverage ends because an employer stops making contributions to the Fund, a Qualifying Event has not occurred.

How to Elect COBRA

The events described above which might result in eligibility for Continuation Coverage are referred to as "Qualifying Events." The Participant, spouse or child who becomes entitled to Continuation Coverage as the result of a Qualifying Event is referred to as a "Qualified Beneficiary." A child born to, adopted by or placed for adoption with a Participant who is a Qualified Beneficiary is also a Qualified Beneficiary. No other Dependent is a Qualified Beneficiary.

To be eligible for Continuation Coverage under this section, the Qualified Beneficiary must inform the Fund Office of a divorce, legal separation or a child ceasing to be an Eligible Dependent under the Plan by written notice to the following address within 60 days of such Qualifying Event.

Notices should be sent or hand-delivered to:

Plumbers & Fitters Local No. 101
Health & Welfare Fund
137 Iowa Avenue
Belleville, IL 62220

Oral notice, including notice by telephone is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable. If mailed, the notice must be postmarked no later than the deadline described above. If hand-delivered, the notice must be received at the address specified above no later than the deadline described above.

The notice must include the following information:

- The name and address of the Participant or former Participant who is or was covered under the Plan;
- The name(s) and address(es) of all Qualified Beneficiary(ies) who lost coverage due to the Qualifying Event;
- The Qualifying Event (divorce, legal separation or child's loss of dependent status);
- The date the divorce, legal separation or child's loss of dependent status happened; and

- The signature, name and contact information of the individual sending the notice.

The Plan will notify the Qualified Beneficiary that he has the right to elect Continuation Coverage within 14 days after timely receipt of proper notification that a Qualifying Event has occurred (or the date that a Participant loses coverage for failure to acquire the required number of Contribution Hours). The Qualified Beneficiary must then make a written election of Continuation Coverage by returning the election form included with the notice. Such election must be postmarked to or received by the Fund Office within 60 days after the later of (a) the date the notice of the right to elect Continuation Coverage is provided or (b) the date coverage would otherwise terminate as a result of the Qualifying Event.

Any Qualified Beneficiary who would lose coverage under this plan as a result of a Qualifying Event is entitled to independently elect continuation coverage under this plan. If any Qualified Beneficiary does not elect Continuation Coverage within the time limits described above, his terminated coverage will not be reinstated.

If the Qualified Beneficiary elects Continuation Coverage, the Plan will provide him with Medical, Prescription Drug and Dental Benefits, which, as of the time coverage is being provided, are identical to such coverage provided under the Plan to similarly situated active Covered Individuals.

Continuation Coverage must commence the day following termination of the Participant's (and/or Dependent's) active coverage under the Plan and must be continuous.

Example: A Participant whose coverage terminates November 30 because of a Qualifying Event must elect Continuation coverage starting December 1. He cannot skip December and start coverage January 1. Nor can he skip any later months after he starts Continuation Coverage without losing his right to continue coverage.

Duration of Continuation Coverage

Continuation Coverage may be continued for a maximum of:

1. 18 months from the date of the Qualifying Event if coverage was lost because of termination of employment or reduction in hours.

If a Qualified Beneficiary is continuing coverage as a result of this qualifying event and is determined by the Social Security Administration to have been disabled anytime during the first 60 days of continuation coverage (measured from the later of the date of the

qualifying event or date coverage would have terminated in the absence of a COBRA election), then any or all of the qualified beneficiaries who have coverage as a result of the qualifying event, are entitled to 11 additional months of continuation coverage, for a maximum of 29 months. In order to qualify for the additional 11 months, the qualified beneficiary seeking the extension must provide the Fund Office with a copy of the Social Security determination before the end of the original 18-month maximum coverage period and within 60 days of the later of:

- the date of the disability determination
- the date of the qualifying event; or
- the date the qualified beneficiary would lose coverage under the Plan.

If the disabled qualified beneficiary elects this 11-month extension, the Plan may charge up to 150% of the regular premium during the 11-month extension. If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, the qualified beneficiary must notify the plan within 30 days of that determination.

Note: If the Participant was eligible for Medicare prior to this qualifying event, his Dependents' maximum coverage period will end on the later of 36 months from the date he became eligible for Medicare or 18 months from the date of the Qualifying Event if the Qualifying Event is loss of hours or termination of employment.

If, during the first 18 or 29 months of Continuation Coverage, a Dependent experiences another Qualifying Event, coverage may be extended, but in no case may the total amount of Continuation Coverage be more than 36 months. In order to qualify for extended coverage, the Dependent must notify the Fund Office in writing within 60 days of the date coverage would otherwise terminate due to that qualifying event.

2. 36 months* from the date of the original Qualifying Event if a spouse's or child's coverage was lost because of divorce or legal separation, the death of the Participant or a child ceasing to be an Eligible Dependent under the Plan.

*The COBRA period cannot be extended more than 36 months beyond the date that the Participant began Continuation Coverage. Example: Because of reduced work hours an Employee started Continuation Coverage for himself and his Dependent wife and child on January 1, 2008. His child reaches the maximum age for eligibility as a Dependent in December 2008 and elects Continuation Coverage; the child can

continue coverage only through December 2010 (36 months from January 1, 2008).

In no event will Continuation Coverage be continued beyond the earliest of the following:

1. The date the Self-Pay contribution for Continuation Coverage is not paid by the end of the 45 or 30-day grace period described below;
2. The date, after the Continuation Coverage election date, on which the Qualified Beneficiary becomes covered under another group health plan which does not limit or exclude coverage for any preexisting health conditions of such Qualified Beneficiary.
3. The date, after the Continuation Coverage election date, on which the Qualified Beneficiary becomes entitled to Medicare;
4. For coverage that is extended due to disability, the first day of the first month that begins more than 30 days after the date that a disabled qualified beneficiary is finally determined by the Social Security Administration to be no longer disabled.

If an employer stops making contributions to the Fund, and makes group health plan coverage available to (or starts contributing to another multiemployer plan that is a group health plan with respect to) a class of the employer's employees formerly covered by the Fund, the plan maintained by the employer (or the other multiemployer plan), from that date forward, has the obligation to make COBRA continuation coverage available to any qualified beneficiary who was receiving coverage under the Fund on the day before the cessation of contributions and who is, or whose qualifying event occurred in connection with, a covered employee whose last employment prior to the qualifying event was with the employer.

Self-Payment for Continuation Coverage

Qualified Beneficiaries who elect Continuation Coverage must pay directly to the Plan such amounts as the Trustees shall from time to time require in accordance with regulations governing the amounts, frequency and manner of such payment. Contact the Fund Office to obtain this information. The Trustees will determine annually the premium rates applicable to Continuation Coverage. This rate cannot exceed 102% of the cost of benefits (150% for qualified beneficiaries receiving the 11-month disability extension of coverage).

A grace period of 45 days from the election date will be allowed for the initial payment of the premium for Continuation Coverage and a grace period of 30 days from the beginning of each month of coverage will be allowed for payment

of each subsequent Continuation Coverage premium. If the first premium is not postmarked or received by the end of the 45-day grace period, Continuation Coverage will not take effect and the right to Continuation Coverage is forfeited. If any subsequent premium is not postmarked or received by the end of the 30-day grace period, Continuation Coverage will be terminated as of the end of the period for which the last timely premium was received **and will not be reinstated.**

Premiums are required in full each month, however if a timely payment is made in an amount that is not significantly less than the amount required, the Qualified Beneficiary will be notified and will have 30 days to pay the deficient amount due. This 30-day period will be measured from the original due date or the date of the notice, whichever is later.

During the first 18 months of Continuation Coverage, if the combination of the hours **you** work in any one quarter plus the hours available in your hour bank account is insufficient to earn continued eligibility, **you** must self-pay in order to continue your coverage for the second following quarter. **You** will be required to pay the lesser of: (a) the full COBRA contribution rate; or (b) the amount of the employer contribution which would have been made had **you** worked the minimum number of hours required to earn continued eligibility, reduced by the amount of the employer contributions actually made for the hours **you** worked during the second prior quarter (for example, self-pay contributions for the July through September quarter will be reduced by employer contributions for hours worked during the January through March quarter) and your remaining banked hours.

If **you** wish to continue coverage beyond the initial 18-month period, **you** will be required to pay the amount of the employer contribution which would have been made had **you** worked the minimum number of hours required to earn continued eligibility, reduced by the amount of the employer contributions actually made for the hours **you** worked during the second prior quarter and your remaining banked hours.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, **you** should keep the Fund Office informed of any changes in the addresses of family members. **You** should also keep a copy, for your records, of any notices **you** send to the Fund Office or Claim Administrator.

Contact for COBRA Questions

If you have any questions regarding this Plan's COBRA continuation coverage, you should call or write, the Claim Administrator:

Benefit Consultants
13515 Barrett Parkway Drive, Ste. 265
Ballwin, MO 63021
Telephone: 1-800-434-4620 or 314-822-7890

Special COBRA Rules For Individuals Eligible For Trade Adjustment Assistance

1. Trade Act – Generally

The Trade Act of 2002 provides that certain workers whose employment is adversely affected by international trade (increased imports or a shift in production to another country) may be determined by the United States Department of Labor or other government agency to be eligible for "trade adjustment assistance" or "TAA." TAA consists primarily of career counseling, up to two years of training, income support during training, job search assistance, and relocation allowances.

2. Special Election Period

If **you** do not take COBRA during the normal election period and are determined to be eligible for TAA, you will be entitled to a second 60-day COBRA election period. That second 60-day period will begin on the first day of the month in which you are determined to be eligible for TAA, but you must make your election no later than six months after your active coverage under the Plan ends.

3. Commencement of Premiums and Coverage

If you elect to take COBRA during this second special election period, your COBRA coverage will begin the first day of the special second 60-day election period. Your first payment will be due within 45 days after **you** make your election and must include all payments due between the first day of the second election period and the date of payment.

4. Pre-Existing Condition Rules

If you elect coverage under these rules, the period of time between your original loss of coverage and the date your coverage recommences under

these special rules will not be counted for purposes of determining whether you have had a 63-day gap in coverage for purposes of applying this Plan's (or any other plan's) **pre-existing condition** limitations.

5. Possible Help in Paying Costs of COBRA

The Trade Act of 2002 created a new tax credit for TAA-eligible individuals. **You** may 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 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 is available online at:

www.doleta.gov/tradeact/2002act_index.asp.

SUBSIDIZED CONTINUATION COVERAGE FOR CERTAIN GROUPS OF PARTICIPANTS AND DEPENDENTS

In addition to Continuation Coverage required by COBRA, which is explained above, continuation of coverage is also offered to certain participants and dependents at reduced rates in the following special circumstances.

Because the rates outlined below are subject to change, **you** should contact the Plan Administrator to determine the specific rate applicable to **you**.

Subsidized coverage under the following classifications will terminate when any person no longer meets the requirements or fails to make the required payment.

Disabled Participants

If **you** are totally disabled, your coverage and that of your **eligible dependents** may be continued as provided below. "Total Disability" for purposes of this continuation of coverage section means the inability due to **illness or injury** to perform the duties of your job.

Coverage may only be continued under this provision for eligible persons who are not covered under another group health plan or entitled to Medicare. If such other coverage terminates due to your spouse's termination of employment or retirement during the maximum coverage periods described below, your coverage and that of **your dependents** may be reinstated with no **preexisting condition** limitations.

The duration of time **you** may continue coverage under this provision and the amount **you** will be required to pay, are determined by the number of hours of **covered employment you** have attained.

- If **you** have less than 10,000 hours, **you** may continue coverage under this Plan for yourself and **your dependents** for a period of 29 months. Any banked hours **you** have will be used to provide continued coverage. If **you** have no banked hours or if your banked hours become exhausted, **you** may continue coverage for yourself and **your dependents** for the remainder of the 29-month period by paying the Plan's full COBRA rate.
- If **you** have at least 10,000 hours, but less than 20,000 hours, **you** may continue coverage under this Plan for yourself and **your dependents** for a period of 29 months. Any banked hours **you** have will be used to provide continued coverage. If **you** have no banked hours or if your banked hours become exhausted, **you** may continue coverage under this Plan for yourself and **your dependents** for the remainder of the 29-month period by paying a monthly premium equal to one-half of the Plan's COBRA rate.

- If **you** have 20,000 or more hours, coverage for **you** and your **eligible dependents** will be continued at no cost to **you** for 29 months. At the expiration of this 29-month period, **your dependents** may continue coverage by paying a monthly premium equal to one-half of the Plan's COBRA rate during the next 36 months and the full COBRA rate thereafter.

Non-Medicare Retirees

If your coverage under this Plan would otherwise terminate due to retirement, **you** may be eligible to continue coverage for yourself and **your eligible dependents**, provided that **you** meet the following qualifications:

- a. **you** retired from active employment with sufficient coverage and/or banked hours to continue your coverage to or beyond age 62 (not available for previously vested terminated employees);
- b. **you** have a minimum of 40,000 hours of **covered employment**; and
- c. **you** (and any **dependents** whose coverage **you** wish to continue) are not eligible under another group health plan or entitled to Medicare. If **you** lose other group health coverage due to your spouse's termination of employment or retirement, your coverage and that of **your dependents** may be reinstated under this Plan with no **preexisting condition** limitations.

You may use any hours in your Hour Bank account to meet the 300-hour requirement to continue coverage for Class 1 employees. After your banked hours are exhausted, **you** must self-pay to continue your coverage. The applicable rate will be set by the Trustees and will not exceed the Fund's COBRA rate.

Your coverage under this provision terminates when **you** reach the age of 65. If, at that time, your spouse is at least 52 years of age, but under age 65, your spouse may continue coverage up to age 65 by paying the full COBRA rate (above) until reaching the age of 62 and then paying the reduced retiree self-payment rate described under this provision.

Survivors of Deceased Participants

Surviving eligible **dependents** of deceased active participants may be entitled to continue their coverage under the Plan at a reduced rate for the first 36 months. Coverage may be continued beyond the initial 36-month period by paying the full COBRA rate. In order to be eligible for continued coverage under this provision, the following qualifications must be met:

- a. The surviving **dependents** are not covered under another group health plan or entitled to Medicare. If such other coverage terminates due to termination of employment or retirement, coverage may be reinstated with no **preexisting condition limitations**.
- b. The deceased participant must have attained 20,000 or more hours in **covered employment**. Surviving **dependents** of participants with less than 20,000 hours will be entitled to 36 months of Continuation Coverage at the full COBRA rate as provided above.

Continuation of coverage at the reduced rates offered under this provision will terminate upon remarriage of the surviving spouse. If the surviving spouse remarries within the first 36 months of Continuation Coverage, however, coverage may be continued for the remainder of the 36-month period allowed under COBRA by paying its full monthly premium rates.

DEATH BENEFITS

Schedule of Benefits

Death Benefits: **\$10,000 Per Eligible Employee**

If **you** die while covered under this Plan, \$10,000 will be paid in one lump sum to your named beneficiary.

Total Disability Benefits

While **you** are covered, if **you** become **totally disabled** before you reach the age of 60 and coverage for death benefits would otherwise terminate, a death benefit will nevertheless be payable if **you** die before reaching age 65, provided that all of the following requirements are fulfilled:

- the **total disability** began while **you** were covered under this Plan;
- **you** have been **totally disabled** for nine consecutive months;
- **you** remain continuously **totally disabled** until death; and
- **you** submit written proof of the disability within 12 months of the date your coverage would terminate and each year thereafter. (The Plan may also require a physical examination.)

“**Totally Disabled**” for the purposes of this Total Disability Benefit means that **you** are unable, due to **injury** or **illness**, to engage in any business, occupation or employment for which you are qualified or become qualified for by reason of education, training or experience for pay, profit or compensation.

Beneficiary

Payment of your death benefits will be made to the beneficiary **you** choose. **You** may name one or more people to receive the benefits. If **you** name more than one beneficiary, each survivor will share equally unless you otherwise specify. **You** may change your beneficiary(s) at any time by filling out a “Change of Beneficiary” form and filing it with the Fund Office.

If **you** do not designate a beneficiary, payment will be made in the following order:

- to your spouse, if living;
- otherwise equally to your surviving children, if any;
- otherwise equally to your surviving parents, if any;
- otherwise equally to your surviving brothers and sisters, if any;
- otherwise to your estate.

SHORT TERM DISABILITY INCOME BENEFITS

Schedule of Benefits

Weekly Benefit Maximum Amount:	\$500 per week
When Benefits Begin:	On the first Working Day after 30 Working Days of Disability
Maximum Duration of Benefits:	52 weeks per Disability Period but not more than 52 weeks in any 24-month period

When Benefits Are Payable

Short Term Disability Income Benefits are payable if you become Disabled by an Injury or Illness while you are covered under the Plan. Confinement to your home is not necessary; however, treatment by a legally qualified Physician or Surgeon (Doctor of Medicine or Doctor of Osteopathy) is required.

The day on which Short Term Disability Income Benefits begin is shown in the “Schedule of Benefits” above.

Amount Of Benefits

The Weekly Benefit Amount and the maximum Duration of Benefits are shown in the “Schedule of Benefits” above. If Benefits are due for less than a full week, one-fifth of the Weekly Benefit Amount will be paid for each Covered Day of Disability. In no event will Benefits be payable for longer than the maximum Duration of Benefits during any one Disability Period.

Weekly benefits will be reduced by:

- The amount you receive, or are entitled to receive, as total disability benefits under the Federal Social Security Law (excluding any benefits attributable to your Dependents); you have an obligation to take all necessary steps to secure all Social Security Disability benefits due you; you and your attorney, if you engage an attorney to assist you in recovering Social Security Disability benefits, will be required to sign a reimbursement agreement, in a form approved by the Trustees, which will protect the Fund’s right to recover from your Social Security Disability benefits; the amount of Social Security Disability benefits by which your benefits from the Fund are reduced will be the amount you receive net of the attorney fees you incur (but not more than the amount allowed under the Social Security law) to obtain Social Security Disability benefits; and

- The amount of Social Security normal or early retirement benefits you actually receive, after the first six months of your disability; and
- The amount of unemployment compensation benefits you receive during your disability.

FICA and Medicare tax will be withheld from your disability benefits as required by law.

Exclusions And Limitations

No benefits will be paid for any day of Disability:

- Prior to the first day on which you are personally treated by a legally qualified physician for the Injury or Illness causing your Disability.
- With respect to which you receive a pension benefit under the Plumbers and Fitters Local 101 Pension Fund.

No benefits will be paid for any Disability:

- Due to an Injury arising out of or in the course of any occupation for wage or profit or an Illness for which you are entitled to benefits under any Workers' Compensation or Occupational Disease Law, or any such similar law.
- Due to an intentionally self-inflicted Injury or Illness, unless such Injury or Illness results from a medical condition (including both physical and mental conditions).
- Due to an Injury or Illness resulting from your driving under the influence of alcohol in excess of the legal limit or an illegal controlled substance.
- Due to an Injury or Illness resulting from your conduct that constitutes a felony under applicable law, whether or not you are charged or convicted.
- Unless you were covered under this Fund based on active hours (not banked hours) for at least one of the two calendar quarters immediately preceding commencement of the Disability.

The Plan's Rights to Subrogation and Reimbursement described beginning on page 90 apply to these short term disability benefits as well as the other benefits provided by the Plan.

Definitions

For purposes of the Short Term Disability Benefit provisions of the Plan:

“**Covered Day of Disability**” means each Working Day, which is not excluded from the payment of Benefits by the Limitations and Exclusions provision, beginning with the day on which Benefits begin for any one Disability Period.

“**Disability**” or “**Disabled**” means your inability due to illness or injury to perform the duties of your own job.

“**Disability Period**” means:

- a) any one absence from work because of Disability due to one or more causes;
- b) any two or more absences from work because of Disability due to the same or related causes, except that any two such absences from work which are separated by your return or medical release to return to active work on a full-time basis for at least four weeks will be considered to have occurred in separate Disability Periods; or
- c) any two or more absences from work because of Disability due to entirely unrelated causes, except that any two such absences from work which are separated by your return or medical release to return to active work on a full-time basis for at least one full day will be considered to have occurred in separate Disability Periods.

“**Injury**” means only an accidental bodily Injury caused by a sudden and unforeseen event, definite as to time and place.

“**Illness**” means only a deviation from the normal healthy state resulting from disease, which requires treatment by a Physician and is not otherwise excluded from coverage under the Plan; or from pregnancy.

“**Weekly Earnings**” means your current straight-time hourly rate of pay times the average number of hours you worked per week during the 36-month period (or your full period of bargaining unit employment if less than 36 months) immediately prior to the date your Disability began.

“**Working Day**” means a day on which you are normally scheduled to work.

MEDICAL BENEFITS

SCHEDULE OF MEDICAL BENEFITS

Eligibility Waiting Period: Coverage takes effect on the first of the month following the date of eligibility as provided herein.

Benefit Period: January 1 through December 31

The Plan provides benefits through the HealthLink Open Access III program. Under this arrangement, benefit levels vary with the network status of the provider **you** use. The highest benefits are paid when **you** use Health Maintenance Organization (HMO) providers, while slightly lower benefits are paid when **you** use Preferred Provider Organization (PPO) providers. Benefits are further reduced when **you** use Non-Network providers.

Although the highest level of benefits in the HealthLink Open Access III program is payable when using "HMO" Providers, it is not a traditional HMO. **You** do not have to select a primary care physician or obtain referrals to see specialists. **You** do not have to choose to be in the HMO or PPO; **you** are free to use any provider at any time.

In addition to its contract with HealthLink, the Fund has a contract with the USA Managed Care's PPO for geographic areas not serviced by HealthLink. Benefits for covered services obtained from USA network providers will be paid at the PPO benefit level shown in the Schedule of Benefits.

The "Out of Area" benefit level will be payable when there are no HMO or PPO providers available within 50 miles to provide necessary treatment.

A separate listing of HMO and PPO providers will be provided to **you** automatically without charge, however in order to ensure that **you** obtain the most up-to-date information available, **you** should contact HealthLink or USA at the telephone number listed on your medical identification card to determine whether your Physician, Hospital or other health care provider is a participating member of the network. Participating provider listings are also available on the Internet at www.healthlink.com or www.usamco.com.

Covered services obtained from a non-network provider will be covered at the PPO benefit level if treatment is for an accident or **emergency** medical condition as defined in this Plan and care cannot be obtained from an HMO or PPO provider without jeopardizing the patient's health.

Plan **Lifetime** Medical Maximum: \$1,000,000 per individual

The above maximum is applicable to all benefits for expenses listed as covered medical expenses under this Plan. The term “lifetime” refers to the time a person is actually covered under this Plan and is not intended to suggest benefits beyond an individual's termination date or the Plan’s termination date.

The following Plan benefits will vary depending on whether services are obtained from an HMO, PPO or Non-Network provider.

Cash Deductible (Per Calendar Year):

	<u>HMO</u>	<u>PPO</u>	<u>Non-Network</u>	<u>Out-of-Area</u>
<i>Individual</i>	\$150	\$150	\$200	\$200
<i>Family</i>	\$300	\$300	\$400	\$400

The cash **deductible** is the amount of covered expenses which must be incurred in a calendar year before benefits are payable for covered medical expenses incurred during the remainder of that year. It is in excess of any amount paid under any other benefit provisions of this Plan.

Although each covered expenses for each individual are subject to the **deductible**, the total amount required for **you** and all of **your dependents** combined will not be more than the "family" amount shown above.

Note: Expenses applied to the **deductible** for any provider category will also be applied to the **deductible** requirement for the other provider categories. For example: If you incur expenses of \$100 from a PPO Provider, your remaining deductible will be \$50 for HMO and PPO Providers and \$100 for Non-Network and Out-of-Area Providers. If you incur \$200 in expenses from a Non-Network provider your deductible will be satisfied for all other providers.

Out-Of-Pocket Maximum (Per Calendar Year Including the Deductible):

	<u>HMO</u>	<u>PPO</u>	<u>Non-Network</u>	<u>Out-of-Area</u>
<i>Individual</i>	\$1,000	\$2,000	Unlimited	\$2,000
<i>Family</i>	\$1,000	\$2,000	Unlimited	\$2,000

Once **you** and/or **your dependents** have paid the **out-of-pocket maximum** amount shown above during any calendar year, the Plan will pay eligible covered expenses incurred during the remainder of that calendar year at 100%.

The **out-of-pocket maximum** does not include mental and nervous/substance abuse treatment expenses, expenses incurred due to reduction to the **UCR** payment level or other non-covered expenses.

Note: No matter which provider **you** or **your dependents** use (HMO, PPO, Non-Network or Out of Area), all **co-payments** and **co-insurance** will be used to satisfy any Out-Of-Pocket limit (e.g., HMO **co-payments** will apply towards the PPO **out of pocket maximum**).

Medical Benefits Payable

The following table is a summary of medical benefits payable under the Plan. For a complete description of covered medical expenses, as well as any exclusions and limitations, please refer to the "Covered Medical Expenses" and "Medical Exclusions and Limitations" sections. All services are subject to the applicable calendar year deductible, unless otherwise noted.

Services	Limitations	Benefit Percentage			
		<u>HMO</u>	<u>PPO</u>	<u>Non-Network</u>	<u>Out of Area</u>
Hospital Services:					
Inpatient	Semi-Private Room	100%	90%	70%	90%
Outpatient		100% after \$25 Co-pay	90% after \$25 Co-pay	Not Covered	90% after \$25 Co-pay
Emergency Room*		100% after \$50 Co-pay (waived if admitted)	90% after \$50 Co-pay (waived if admitted)	70% after \$50 Co-pay (waived if admitted)	90% after \$50 Co-pay (waived if admitted)
Physician Services:					
Office Visits		100% after \$10 Co-pay	100% after \$20 Co-pay	70%	90%
Other Physician Services*		100%*	90%*	70%*	90%*
Wellness Benefit: Includes: --Routine Physical Exam --Breast and Pelvic Exam --Routine Mammogram --Immunizations --Well Child Care --PSA Test for Men over age 40	\$250 Calendar Year Max. up to age 50; \$500 Calendar Year Max. age 50 and over	100% No Deductible	100% No Deductible	Not Covered	100% No Deductible
Chiropractic Care	\$1,000 Calendar Year Max.	100%	90%	70%	90%
Private Duty Nursing		100%	90%	70%	90%
Skilled Nursing Facility	Semi-Private Room	100%	90%	70%	90%
Rehabilitation Facility	Semi-Private Room	100%	90%	70%	90%
Physical Therapy		100%	90%	70%	90%
Occupational Therapy		100%	90%	70%	90%

Services	Limitations	Benefit Percentage			
		<u>HMO</u>	<u>PPO</u>	<u>Non-Network</u>	<u>Out of Area</u>
Speech Therapy		100%	90%	70%	90%
Home Health Care		100%	90%	70%	90%
Hospice Care	Semi-Private Room	100%	90%	70%	90%
Treatment of Infertility	\$2,500 Max. per Calendar Year \$10,000 Max. Lifetime	100%	90%	70%	90%
TMJ Treatment	\$1,500 Max. per Calendar Year	100%	90%	70%	70%
Mental Health & Substance Abuse Treatment:	\$10,000 Maximum per Calendar Year for Substance Abuse Treatment (Combined Inpatient and Outpatient)				
Inpatient	Limited to 30 Days per Calendar Year	N/A	90%	70%	90%
Outpatient	Limited to 40 visits per Calendar Year	N/A	80%	50%	80%
Participant Vision Benefit	\$150 Max. Benefit per Calendar Year; For Participants Only	100% No Deductible	100% No Deductible	100% No Deductible	100% No Deductible
All Other Covered Expenses (except as otherwise noted)		100%	90%	70%	90%

***Charges made by an emergency room physician, radiologist, pathologist or anesthesiologist will be paid based on the network participation of the facility at which services are received.**

Prescription Drug Schedule of Benefits

	Benefit Percentage	
	Participating Pharmacy	Nonparticipating Pharmacy
Retail Pharmacy <i>Up to 34-day supply</i>		
Per Generic Drug	100% after \$5.00 Co-pay	70% after \$5.00 Co-pay
Per Brand Name Drug	100% after \$15.00 Co-pay	70% after \$15.00 Co-pay
Mail Order <i>Up to 100-day supply</i>		
Per Generic Drug	100% after \$10.00 Co-pay	N/A
Per Brand Name Drug	100% after \$30.00 Co-pay	N/A

MEDICAL BENEFIT PAYMENT PROVISIONS

Covered Expenses

Covered/Eligible medical expenses means the expenses incurred by **you** or **your dependents** for the **hospital** or other medical services listed below, which meet the following criteria:

- a. The expenses must be for a service or supply prescribed by a **physician**.
- b. The expenses must be for a service or supply which is **medically necessary** in connection with the diagnosis or therapeutic treatment of an **injury** or **illness**. In determining whether a service or supply, what portion of a service or supply or what length of **hospital** confinement or amount of treatment is included in this provision, a service or supply must be ordered by a **physician** and be commonly and customarily recognized by the **physician's** profession in the United States as safe, effective, appropriate and reasonably necessary treatment of the diagnosed **injury** or **illness**. It must not be educational, **experimental** or **investigatory** in nature, or provided primarily for research. It must neither be for **custodial care** nor **maintenance care**.
- c. The expenses must not exceed: (1) the **usual, customary and reasonable (UCR)** charges for such treatment, or (2) in the case of **HMO** or **PPO Providers**, the discounted fee negotiated between the **Managed Care Organization** and the Provider.
- d. The expenses must not be excluded under the Exclusions and Limitations sections of this Plan.

Managed Care Benefits

The Plan from time to time enters into special arrangements with one or more **Managed Care Organizations (MCOs)** which provide favorable pricing for the Plan and/or favorable **deductibles** and **co-payment** limits for **you** and **your dependents** when you use **HMO** or **PPO** network providers. Benefits payable by the Plan for covered expenses for services, treatments, or drugs and medicines provided by an **HMO** or **PPO provider** will be determined in accordance with the agreement then in effect with such **MCO** as set forth in the Schedule of Benefits.

Allocation and Apportionment of Benefits

The Plan reserves the right to allocate the **deductible** amount to any eligible charges and to apportion the benefits to **you** and any assignees. Such allocation and apportionment will be conclusive and will be binding upon **you** and all assignees.

Lifetime and Plan Year Maximum Amounts

The maximum amounts payable for all covered expenses incurred during your or **your dependent's** lifetime and per Plan year are noted in the Schedule of Benefits. The word "**Lifetime**" as used herein, means the duration of participation in this Plan.

Benefit Restoration and Reinstatement

If your plan **lifetime** medical maximum or that of **your dependents** is reduced because of benefits paid, up to \$1,000 of that amount will be automatically reinstated each January 1. However, no benefits paid for infertility treatment, **substance abuse, preexisting conditions** or under the Extension of Benefits provision will be reinstated.

If the **lifetime** maximum for a covered member of your family is not fully restored by the automatic reinstatement provision above, **you** may apply for reinstatement of the balance if at least \$1,000 in covered expenses has been paid.

Common Accident

If two or more persons in the same family are injured in a common **accident**, the cash **deductible** applicable in the calendar year of the **accident** will be limited to a single **deductible** amount for that calendar year for covered expenses related to that **accident** which are incurred by all family members.

Cost Containment Features

Voluntary Predetermination Program

This Plan does not require precertification prior to receiving services or supplies. The Plan, however, does provide a voluntary predetermination program as to the medical necessity of certain services and supplies. If **you** participate in this program and the service or supply is determined to be **medically necessary** then, when your claim is submitted after the services are rendered, the claim will not be denied on that basis, assuming the facts are as represented during the predetermination process. (A request for predetermination will not be considered a claim. To file a claim under this Plan, there must be a written request for payment for services or supplies that have already been provided to you. See the "Claim Procedures" section for details on how to file a claim.)

There is no penalty simply because a predetermination of medical necessity is not requested or obtained. However, when a claim is submitted after the services or supplies have been received, the Plan will review the claim in accordance with the plan requirement that services and supplies be **medically necessary** in connection with the diagnosis or therapeutic treatment of an **injury** or **illness** (see requirements for Covered Expenses on page 42). Thus, if you receive services or supplies without a predetermination, **you** risk discovering after receiving such services or supplies, that they are not considered necessary

and are, therefore, not covered under the Plan. **Unless you use voluntary predetermination, medical necessity will be decided when the claim is filed after the service is provided. In such a case, you may be entirely responsible for the cost of any non-covered services or supplies.**

If **you** wish to participate in the Voluntary Predetermination Program, follow the instructions below.

To determine the patient's eligibility and whether the service or supply is covered or excluded under the terms of the Plan, contact the **claim administrator**. Neither HealthLink nor any medical consultant has the authority to determine whether the service or supply is covered or to what extent benefits are payable. Even after a determination of medical necessity, the **claim administrator** will review the claim for eligibility and coverage only after it is submitted after services are rendered. Thus, a claim for **medically necessary** services could be denied on other grounds.

Neither HealthLink, the Plan, nor any independent medical consultant will make any decisions regarding your medical treatment or the receipt of health care services. **You** should make all final decisions about your medical care after consultation with your **physician**.

Voluntary Predetermination of Surgical Procedures, Other Outpatient Procedures and Home Health Care

To predetermine whether any scheduled surgical procedure, other outpatient procedure or home health care service is considered medically necessary, call Benefit Consultants toll-free at (800) 434-4620. Benefit Consultants may then refer your case to HealthLink or contact an independent medical consultant to determine the medical necessity of the initial treatment program and continued care. **You** and your **physician** will be notified of the decision.

Hospital Admissions

Before **you** or a family member enters a hospital for non-emergency inpatient admission, your physician may contact HealthLink toll-free at (877) 284-0102 to initiate the review process. HealthLink and/or an independent medical consultant will determine the medical necessity of the hospitalization and **you** and your **physician** will be notified of the decision.

Voluntary Concurrent Review

If **you** elected voluntary predetermination of hospital admission, HealthLink's nurses will perform periodic reviews of your medical progress and will check with your Physician and Hospital. If HealthLink approves the continued stay as **medically necessary**, your claim will not be denied on that basis.

In the event of an **emergency** admission, **you** or your **physician** may contact HealthLink within 48 hours following the admission to participate in the

voluntary concurrent review program.

Review of Voluntary Predetermination

If **you** or your **physician** disagree with a predetermination that a hospitalization, length of stay, surgery or outpatient procedure is not **medically necessary**, you or your Physician may contact HealthLink toll-free at (877) 284-0102 or Benefit Consultants at (800) 434-4620 to review the situation. Because the Plan does not recognize a claim until after the services are rendered, there is no appeal procedure. If **you** disagree with the predetermination decision, **you** may obtain the services and, when the claim is submitted after the services have been performed, the claim will be reviewed by the Plan without deference to the negative predetermination decision made by HealthLink or another consultant.

Second Surgical Opinion (Voluntary)

Benefits will be payable at 100% of the **usual, customary and reasonable fee** for all charges relating to a second surgical opinion for any elective surgical procedures including related expenses. The **deductible** will not apply. The second opinion must be rendered by a board-certified surgeon who is not professionally or financially associated with the **physician** or the surgeon who rendered the first surgical opinion. The surgeon who gives the second surgical opinion may not perform the surgery. If the second opinion disagrees with the first, a third opinion will also be payable at 100%, provided the opinion is obtained before the procedure is performed. The conditions that apply to a second surgical opinion also apply to the third surgical opinion.

If special tests or procedures are required to render a second opinion, the second opinion **physician** must obtain approval from the **claim administrator** before ordering or performing the tests or procedures.

Case Management/Alternate Treatment under Case Management

In cases where the patient's condition is expected to be or is of a serious nature, the **plan administrator** may arrange for review and/or case management services from a professional qualified to perform such services. The **plan administrator** will have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost-effective result without a sacrifice to the quality of patient care.

Fees for case management services are medical benefits and will be reimbursed at 100% with no calendar year deductible required. Benefits paid for case management fees will not be applied towards an individual's **lifetime** plan maximum. Treatment services and supplies recommended by the case manager are subject to all other Plan provisions (deductible, coinsurance and lifetime maximum). Benefits for alternative treatment will be determined on the merits of each individual case and any benefits for care or treatment provided will not

be considered as setting any precedent or creating any future liability, with respect to **you** or **your dependents** or with respect to other persons who participate in the Plan.

High-Risk Pregnancy Benefit

If **you** or **your dependent** is pregnant and **you** comply with all of the following requirements and deliver a well baby, the Plan will pay \$200 of the baby's **hospital** charges at the rate of 100%.

- a. **You/your dependent** must notify the **claim administrator** within two (2) weeks following a positive pregnancy test.
- b. **You/your dependent** must have the obstetrician complete the high-risk pregnancy questionnaire furnished by the **claim administrator**.
- c. **You/your dependent** must not smoke during the pregnancy.
- d. If the pregnancy is classified as "high risk," **you/your dependent** must comply with all the recommendations of the case management organization selected by the Trustees.

COVERED MEDICAL EXPENSES

To the extent that the following charges meet all of the elements of “Covered Expenses” set forth beginning on page 42, benefits will be payable for these charges as shown in the Schedule of Benefits.

Ambulance Transportation

The Plan will pay for **ambulance transportation** to the **hospital** where treatment is given or between medical facilities when **medically necessary**. Benefits will be paid based on the network participation level of the facility to which the patient is transported.

Anesthesia

The Plan will pay for charges for **anesthesia services** for surgical procedures covered by the Plan.

Case Management/Medical Review Fees

The Plan will pay fees for case management and medical consultant review services as a medical benefit under the Plan. Those charges will be paid at 100% and will not be subject to the calendar year deductible nor will the amount paid for these services be applied towards your individual lifetime maximum. Charges for medical treatment services and supplies recommended by the case manager will continue to be subject to regular Plan benefits (deductible, coinsurance and lifetime maximum).

Chiropractic Care

The Plan will pay charges for chiropractic treatment including tests and therapy ordered by a chiropractor, limited to \$1,000 per calendar year for each covered individual.

Dental Services

The Plan will pay charges for dental services rendered by a **physician** for treatment of **injury** to natural teeth if:

- The **injury** is caused by an **accident**;
- All treatment is rendered within six (6) months of the **accident**; and
- All treatment is rendered while covered by this Plan.

Diagnostic Testing

The Plan will pay for the following diagnostic testing:

- X-rays, microscopic tests, diagnostic tests and monitoring, and laboratory tests.

- Electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally approved by **physicians** throughout the United States.

Durable Medical Equipment

The Plan will pay for rental of a wheelchair, **hospital** bed, ventilator, or other **durable medical equipment** required for therapeutic use, or the purchase of this equipment if economically justified.

Foot Orthotics

The Plan will pay charges for foot orthotics prescribed by a **physician** and their repair when **medically necessary**, subject to the following limits:

- Covered charges are limited to \$200 per foot.
- Foot orthotics are limited to one pair per year.
- Foot orthotics are not covered for corns, calluses and hammertoes.

Home Health Care

The Plan will pay charges made by a **home health care agency** for care in accordance with a **home health care plan**. Such expenses include:

- Part-time or intermittent nursing care by a registered **nurse** (R.N.), a licensed practical **nurse** (L.P.N.), a vocational **nurse**, or public health **nurse** who is under the direct supervision of a registered **nurse**.
- Home health aides.
- Medical supplies, drugs and medicines prescribed by a **physician**, and laboratory services provided by or on behalf of a **hospital**, but only to the extent that they would have been covered under this Plan if **you** or **your dependent** had remained in the **hospital**.

Specifically excluded from coverage under the home health care benefit are the following:

- Services and supplies not included in the **home health care plan**.
- Services of a person who ordinarily resides in the home of **you** or **your dependent**, or is a **close relative** of **you** or **your dependent**.
- Services of any social worker.
- Transportation services.

- **Custodial care** and housekeeping.
- Charges for services in excess the maximum shown on the Schedule of Benefits.

“Home health care visit” means a visit by a member of a home health care team. Each such visit that lasts for a period of four (4) hours or less is treated as one home health care visit. If the visit exceeds four (4) hours, each period of four (4) hours is treated as one visit and any part of a four (4) hour period that remains is treated as one home health care visit.

Hospice

The Plan will pay charges relating to **hospice** care provided that the person has a life expectancy of six months or less. **Hospice** care may extend beyond the initial six months if the attending **physician** certifies that the person is still terminally ill. Covered **hospice** expenses are limited to:

- Room and board for confinement in a **hospice**.
- Charges for ancillary services and supplies furnished by the **hospice** while the patient is confined therein, including rental of **durable medical equipment** which is used solely for treating an **injury** or **illness**.
- Medical supplies prescribed by the attending **physician**, but only to the extent such items are necessary for management of the terminal condition;
- **Physician** services and/or nursing care by registered **nurse**, a licensed practical **nurse**, or a licensed vocational **nurse** (L.V.N.).
- Home health aide services.
- Home care charges for home care furnished by a **hospital** or **home health care agency**, under the direction of a **hospice**, including **custodial care** if it is provided during a regular visit by a registered **nurse**, a licensed practical **nurse**, or a home health aide.
- Medical social services by licensed or trained social workers, psychologists, or counselors.
- Nutrition services provided by a licensed dietitian.
- Respite care.
- Bereavement counseling. Bereavement counseling is a supportive service

provided by the **hospice** team to the deceased's immediate family after the death of such terminally ill person. Such visits are to assist the family in adjusting to the death. Benefits will be payable up to the bereavement care maximum shown in the Schedule of Benefits provided:

- On the date immediately before his death, the terminally ill person was in a **hospice** care program and covered under the Plan; and
- Charges for such services are incurred within twelve (12) months of the terminally ill person's death.

Hospital Services

The Plan will pay for the following charges by a **hospital**:

Inpatient

- Room and Board--expenses incurred for a ward or semi-private room or 90% of the most common private room rate for a **hospital** that does not have semi-private accommodations.
- Expenses incurred for confinement in an intensive care unit, cardiac care unit or burn unit.
- Miscellaneous **hospital** services and supplies.
- Charges for a well newborn baby for nursery room and board, and for professional service required for the healthy newborn. Eligible expenses will also include charges for pediatric services and circumcision.
- Benefits will be payable from the date of birth until the earliest of: the date the mother is released; the date the **child** is released; or the **child's** fifth day of age. (Newborns of **dependent** children are not covered.)

Outpatient

- Charges for services and supplies by a **hospital** or **ambulatory surgical center** for a surgical operation or services or supplies provided in connection with the surgery within 48 hours after the surgery is performed, or
- Charges by a **hospital** or minor emergency medical clinic for **emergency** treatment for injuries provided within 48 hours after the **accident**.

Infertility Treatment

The Plan will pay charges for **you** or your spouse related to or in connection with fertility studies, sterility studies, procedures to restore or enhance fertility, artificial insemination, or in-vitro fertilization, uterine embryo lavage, embryo transfer, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer. Benefits are limited to \$2,500 per calendar year and \$10,000 **lifetime** for all infertility treatment.

Kidney Dialysis

Charges for **kidney dialysis** treatment will be payable on the same basis as any other **illness** or **injury** covered under the Plan.

Maternity Care

The Plan will pay charges for the following:

- Maternity care, on the same basis as any **illness** covered under this Plan. Benefits for **dependent** children are limited to one pregnancy per daughter.

The Plan will not restrict benefits for any Hospital stay in connection with childbirth for the mother or newborn Child, following a vaginal delivery, to less than 48 hours, or to less than 96 hours in the case of a cesarean section. The mother's or newborn's provider, after consulting with the mother, may discharge the mother or her newborn before the expiration of the 48-hour (or 96-hour as applicable) period.

- Charges for elective abortions, including medications prescribed to bring about abortion, for **you** or **your dependents**. Benefits are limited to one abortion per **dependent** daughter.

Mental Health and Substance Abuse Treatment

The Plan will pay charges for mental health and **substance abuse** treatment. Inpatient benefits will be limited to 30 days per calendar year and outpatient treatment will be limited to 40 visits per calendar year. Substance Abuse benefits for inpatient and outpatient treatment will be subject to a calendar year maximum benefit of \$10,000.

Miscellaneous Covered Expenses

The Plan will also pay for the following charges:

- Injectable drugs and for syringes and needles for home administration other than for insulin.
- Radiation therapy or treatment, and **chemotherapy**.
- Processing and administration of blood or blood components, but not for the cost of the actual blood or blood components if replaced.

- Oxygen and other gases and their administration.
- Hyper alimentation or Total Parenteral Nutrition (TPN) for persons recovering from or preparing for surgery.
- Dressings, sutures, casts, splints, trusses, crutches, braces, or other necessary medical supplies, with the exception of dental braces or corrective shoes.
- Vaccines for Human Papilloma Virus (HPV) when administered in accordance with generally accepted medical guidelines by an HMO or PPO provider.
- Birth control devices (diaphragms and IUDs)

Occupational Therapy

The Plan will pay charges for the treatment and services rendered by a registered occupational therapist under the direct supervision of a **physician** in a home setting or at a facility or institution whose primary purpose is to provide medical care for an **illness** or **injury**, or at a free standing, outpatient facility, up to the maximum shown in the Schedule of Benefits.

Organ Transplants

The Plan will pay organ transplant expenses incurred in conjunction with the transplant of a human organ or tissue in accordance with the rules described in the table below.

<u><i>Situation</i></u>	<u><i>Coverage</i></u>
The recipient is covered under this plan and receives the organ from a cadaver.	The recipient's expenses, including the charge for the organ, are covered.
The recipient is covered under this plan and receives the organ from a bank.	The recipient's expenses, including the charge for the organ, are covered.
The recipient and the donor are both covered under this plan.	The expenses of both are covered under the donor's claim. Eligible donor's charges are limited to \$20,000.

Situation

The recipient is covered under this plan and the donor's expenses are not covered under any other plan.

The recipient is covered under this plan and the donor's expenses are covered under another plan.

The donor is covered under the plan but the recipient is not.

Coverage

The expenses of both are covered under the recipient's claim. Eligible donor's charges are limited to \$20,000.

Only the recipient's expenses are covered.

The expenses of neither are covered unless the recipient is a parent, sibling or child of the donor, in which case only the donor's expenses are covered.

Organ Transplant Expenses include: pre-transplant testing and consultation; all services and supplies incurred for the transplant procedure; postoperative care in the **hospital** (inpatient or outpatient); extended care in a facility or at home; pharmaceuticals and their administration (only while hospitalized), including but not limited to high-dose **chemotherapy** or anti-rejection drugs; **durable medical equipment**; and, to the extent provided above, the donor's expenses.

The Trustees of the Plan strongly encourage covered individuals to contact the **claim administrator** before undergoing any inpatient procedure, including an organ transplant procedure. If **you** do not contact the **claim administrator**, **you** run the risk of discovering that the procedure is not covered by the Plan, after expenses have been incurred.

Physical Therapy

The Plan will pay charges for the treatment or services rendered by a physical therapist under direct supervision of a **physician** in a home setting or a facility or institution whose primary purpose is to provide medical care for an **illness** or **injury**, or at a free standing duly licensed outpatient therapy facility, up to the maximum shown in the Schedule of Benefits. Treatment received from a **physical therapy** assistant will be covered if it is administered in a **hospital**, under the direction of a **physician** and under the supervision of a registered physical therapist.

Physician Assistant/ Nurse Practitioner Services

The following services rendered by a **physician assistant** or nurse practitioner are covered provided (a) the **physician assistant** or nurse practitioner is employed by a licensed **physician** or clinic, which also employs supervisory **physician**, (b) services are rendered under the supervision of the employing **physician** or clinic and (c) the employing **physician** or clinic and **physician**

assistant or nurse practitioner are **HMO or PPO providers**. Drugs, medications, devices, therapies or services rendered, furnished or prescribed by a **physician assistant** or nurse practitioner must be rendered, furnished or prescribed pursuant to a **supervision agreement** that is specific to the clinical condition diagnosed and treated by the supervising **physician**.

Covered Physician Assistant/ Nurse Practitioner Services:

- Taking patient histories.
- Performing physical examinations.
- Performing or assisting in the performance of routine laboratory and patient screening procedures.
- Performing routine therapeutic procedures.
- Recording diagnostic impressions and evaluating situations calling for attention of a **physician** to institute treatment procedures.
- Instructing and counseling patients regarding mental and physical health using procedures reviewed and approved by the employing **physician**.
- Assisting the supervising **physician** in institutional settings, including review of treatment plans, ordering tests and diagnostic laboratory and radiological procedures and ordering of therapies, using procedures reviewed and approved by the employing **physician**.
- Assisting at surgery.

Physician Assistant/ Nurse Practitioner Services Not Covered by the Plan:

- Services or tasks prohibited by law.
- Services not rendered under the supervision of a **physician**.
- Services that the **physician assistant** or nurse practitioner has not adequately been trained or is not proficient to perform.
- Abortion.
- Lenses, prisms and contact lenses for the aid, relief or correction of vision or the measurement of visual power or acuity.
- Administration or monitoring of general or regional block anesthesia during diagnostic tests, surgery or obstetrical procedures.
- Expenses for surgical assistance to **physicians** who participate in the Plan's HMO or PPO are covered only when billed by the HMO or PPO **physician**. No expenses for surgical assistance billed by a **hospital** or surgical facility or an independent **physician assistant**, nurse practitioner or non-Network physician are covered.

Level of Reimbursement for Physician Assistant/ Nurse Practitioner Services:

Covered expenses for services rendered by a **physician assistant** or nurse practitioner are limited to 85% of the amount that would have been allowed as a covered expense had a **physician** rendered the services. Such covered expenses

are subject to the Plan's applicable HMO or PPO reimbursement levels and subject to all of the Plan's limitations and exclusions.

Physician Services

The Plan will pay charges for the services of a legally qualified **physician** for medical care and/or surgical treatments including office, home visits, **hospital** inpatient care, **hospital** outpatient visits/exams, clinic care, and surgical opinion consultations.

Private Duty Nursing

The Plan will pay fees of registered **nurses** (R.N.'s) or licensed practical **nurses** (L.P.N.'s) for private duty nursing.

Prosthetics

The Plan will pay for artificial limbs, eyes or larynx, to replace lost limbs or eyes and for the replacement of such prosthetics if necessary because of physiological changes.

Rehabilitation Facility

The Plan will pay charges incurred for confinement in a **rehabilitation facility**. Room and board charges are limited to semi-private room charge.

Skilled Nursing Facility

The Plan will pay charges incurred for confinement in a **skilled nursing facility**. Room and board charges are limited to semi-private room rate.

Specialty Drugs

The Plan will pay charges payable for certain specialty drugs dispensed or administered by a **physician** or **hospital**, however benefits are limited to the lowest available cost to the Plan from a specialty pharmacy (as determined by case management). The Plan will pay 100% of the cost of the drug from the specialty pharmacy.

Specialty drugs are drugs that are used in treating serious illnesses and conditions such as cancer, hemophilia, growth hormone deficiency and rheumatoid arthritis and are sometimes administered by injection or infusion. These drugs can be very expensive. If your doctor or **hospital** proposes to directly administer or dispense any drug to you, for example by an injection or infusion in the office or Hospital, please contact the **claim administrator**, Benefit Consultants, at (314) 822-7890 or (800) 434-4620. The **claim administrator** can tell you whether the drug is a specialty drug subject to this limitation. If it is, case management will direct you to a specialty pharmacy where you can obtain the drug at a lower cost to you and to the Plan.

A complete list of the medications to which this limit currently applies is available from Benefit Consultants. The list, however, is subject to change at

any time and you should check with Benefit Consultants every time your physician or **hospital** proposes a new specialty drug.

Speech Therapy

The Plan will pay fees of a licensed speech therapist under direct supervision of a **physician** for restorative **speech therapy** for speech loss or impairment due to an **illness** or **injury**, or due to surgery performed on account of an **illness** or **injury**, other than a functional nervous disorder, up to the maximum shown on the Schedule of Benefits.

Surgical Procedures

The Plan will pay charges for the following:

- **Medically Necessary** surgical procedures
- Oral surgical procedures as follows:
 - Excision of impacted teeth;
 - Open or closed reduction of a fracture or dislocation of the jaw.
- **Cosmetic** procedures or treatment rendered for **cosmetic** purposes only in the following situations:
 - The treatment of an **accidental** bodily **injury**, provided the treatment is rendered within six months after the **injury**;
 - The surgical correction of a congenital anomaly in a **dependent child**;
or
 - Reconstructive surgery following surgery due to an illness, including the following mastectomy-related expenses:
 - Reconstruction of the breast on which the mastectomy was performed,
 - Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
 - Protheses and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of the lymph nodes).
- Services for voluntary sterilization, such as vasectomy or tubal ligation, for **you** and **your dependent** spouse.
- Routine colonoscopies when performed by an HMO or PPO provider in accordance with generally accepted medical age and frequency guidelines.

Temporomandibular Joint Syndrome (TMJ) Treatment

The Plan will pay charges for Temporomandibular Joint Syndrome (TMJ) Treatment and related care including x-rays, injections, surgery and appliances, payable to the maximum shown in the Schedule of Benefits.

Vision Benefits–Participants Only

The Plan will pay charges for the following vision services for **participants** only, up to the limit shown in the Schedule of Benefits:

- Routine eye examinations performed by a licensed optometrist or ophthalmologist.
- Eyeglass lenses and frames or contact lenses prescribed by a licensed optometrist or ophthalmologist.

Wellness Care

The Plan will pay benefits for the following wellness care obtained from an HMO or PPO provider (or from an Out-of-Area provider, if the covered person resides outside of the network service area). The Plan's "wellness benefit" as shown in the Schedule of Benefits is limited to \$250 per calendar year for each covered person up to age 50 and \$500 per calendar year for each covered person age 50 and over and covers the following services:

- Physical examinations which may include tests such as complete blood count, urinalysis, VDRL, tine test, screener, pap test, stool culture and sigmoidoscopy;
- Breast and Pelvic exams;
- Routine mammograms;
- Inoculations and immunizations;
- Physician's charges for well-child care;
- Annual PSA test for men age 40 and over.

Exceptions:

- Services such as electrocardiogram or chest x-rays, are not covered unless symptoms warrant the tests.
- Wellness benefits are not provided for examinations or inoculations required for employment, insurance or licensing, camp or marriage.
- **Services rendered by non-network providers are not covered.**

MEDICAL EXCLUSIONS AND LIMITATIONS

No benefits of any kind will be provided under this Plan to your dependent spouse or child who has medical benefits provided by or through his or her own employer or union, or in the case of a child, his or her parent's employer or union, unless the type of benefits provided by or through that employer or union, when that plan of the other employer or union is primary under this Plan's coordination of benefits rules, are not affected by the fact that the dependent is also covered under this Plan.

The following exclusions and limitations apply to expenses incurred by **you** and **your dependents**:

1. Charges incurred prior to the effective date of coverage under the Plan, or after coverage is terminated;
2. Charges for any services covered under a "terminal liability," "extension of benefits" or similar provision of a previous Medical Care carrier program which was replaced by this Plan until such a time as the extended coverage has terminated;
3. Charges incurred as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country;
4. Injuries arising out of or in the course of any occupation for wage or profit, or an **illness** for which **you** or **your dependent** is entitled to benefits under any Workers' Compensation or Occupational Disease Law, or any such similar law;
5. **Hospital** confinement, medical or surgical services or other treatment furnished or paid for by or on behalf of the United States, or any state, province or other political subdivision unless there is an unconditional requirement to pay such charges whether or not there is insurance or medical benefits;
6. Charges incurred for which **you** or **your dependents** are not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage;
7. **Injuries** or **illnesses** resulting from the covered individual's driving under the influence of alcohol in excess of the legal limit or an illegal controlled substance;

8. **Injuries** or **illnesses** resulting from the covered individual's conduct that constitutes a felony under applicable law, whether or not charged or convicted;
9. Charges incurred in connection with any intentionally self-inflicted **injury** or **illness**, unless such **injury** or **illness** results from a medical condition (including both physical and mental conditions);
10. Charges incurred for services or supplies which constitute personal comfort or beautification items, television or telephone use, or charges in connection with **custodial care**, education or training, or expenses actually incurred by other persons;
11. Charges incurred for **cosmetic** procedures or in connection with care or treatment rendered for **cosmetic** purposes except as specifically provided under "Covered Medical Expenses";
12. Charges incurred in connection with services and supplies which are not necessary for treatment of an active **illness** or **injury** or are in excess of **usual, customary and reasonable** charges, or are not recommended and approved by a **physician**;
13. Charges for services, supplies or treatment not commonly and customarily recognized throughout the **physician's** profession or by the American Medical Association as generally accepted and **medically necessary** for the diagnosis and/or treatment of an active **illness** or **injury**; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value;
14. Charges for services rendered to **you** or **your dependents** by a **physician, nurse** or licensed therapist who is a **close relative**, or resides in the same household.
15. Charges incurred outside the United States if **you** or **your dependents** traveled to such a location for the sole purpose of obtaining medical services, drugs or supplies;
16. Charges for inpatient confinement primarily for x-rays, laboratory, diagnostic study, physiotherapy, hydrotherapy, medical observation, convalescent or rest care, or any medical examination or test not connected with an active **illness** or **injury**, unless otherwise provided under any wellness benefits covered under this Plan.
17. Charges for **physicians'** fees for any treatment that is not rendered by or provided under the supervision of a **physician**;

18. Charges incurred in connection with eye refractions, the purchase or fitting of eyeglasses, contact lenses, hearing aids, or such similar aid devices unless specifically included in the Medical Expenses section. This exclusion will not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery, nor does it apply to the initial purchase of a hearing aid if the loss of hearing is a result of a surgical procedure;
19. Charges incurred for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes; however, benefits will be payable for charges incurred for treatment required because of **accidental injury** to natural teeth, or for any oral surgical procedure listed under this Plan's covered expenses. Such expenses must be incurred within six (6) months of the date of **accident**. This exception will not in any event be deemed to include charges for treatment for the repair or replacement of a denture;
20. Charges for **experimental** procedures, drugs, or research studies, or for any services or supplies not considered legal in the United States;
21. Charges for callus or corn paring or excision; toenail trimming; any manipulative procedure for weak or fallen arches, flat or pronated foot, or foot strain, except for open cutting operations; orthopedic shoes or other devices for support of the feet;
22. Any surgical procedure for the correction of a visual refractive problem, including radial keratotomy and LASIK;
23. Any inpatient **hospital** charges incurred on a Friday, Saturday, or Sunday if admission is made on one of these days unless surgery is performed within 24 hours of the admission or the admission is necessitated by an **emergency**;
24. Charges for **maintenance care**. Unless specifically mentioned otherwise, the Plan does not provide benefits for services and supplies intended primarily to maintain a level of physical or mental function;
25. Charges for weight reduction. This exclusion does not apply to **medically necessary** treatment of morbid obesity (a body weight that is 100% over the weight given in standard tables); endogenous obesity (caused within the body) including but not limited to metabolic factors such as hyper insular, hyper interrenal, hypogonad, hypothyroidism, hypercholesterolemia, and obesity due to hypothalamic lesions; or exogenous obesity (caused by overeating) if: a diagnosis of morbid obesity is given and a separate medical condition is present which is

aggravated by obesity (e.g., high blood pressure, chronic back conditions, varicose veins, etc.). It is recommended that you use the Plan's voluntary predetermination program for weight reduction treatments to ensure **medical necessity**;

26. Charges incurred as a result of or in connection with more than one pregnancy of a **dependent** daughter;
27. Charges for Prescription Drugs, except as for specialty drugs as described under "Covered Medical Expenses" on pages 55-56. (For a description of the Fund's prescription drug benefits, refer to the "Prescription Drug Benefits" section, which begins on page 64);
28. Vocational rehabilitation services;
29. Charges related to sex transformation procedures and/or treatments;
30. Charges for services not covered by **Medicare** because you and your health provider have entered into a "private contract" (under the Balanced Budget Act of 1997 or otherwise) which exempts the services from **Medicare**, its regulations and its price controls.
31. Expenses incurred in a non-network outpatient surgery center.

Preexisting Condition Exclusion

Preexisting Conditions

Expenses incurred in connection with a **preexisting condition** are excluded from coverage under the Plan until the end of the **preexisting condition exclusion period**. The **preexisting condition** exclusion applies to the following persons:

- persons who have never had creditable coverage;
- persons who have previously had creditable coverage for less than twelve (12) consecutive months;
- persons who have been without creditable coverage for 63 days or more upon enrollment in the Plan.

Creditable Coverage

Upon the Plan's receipt of a **Certificate of Creditable Coverage**, credit will be given toward the **Preexisting Condition Exclusion Period** equal to the number of months in which a **preexisting condition** exclusion is satisfied under any one of the following plans:

- an insured or self-insured group health plan
- health insurance coverage
- **Medicare**

- Medicaid and Title X
- Indian Health Service Program
- state high risk pools
- public health plans
- Peace Corps benefits
- State Children’s Health Insurance Programs (S-CHIP)

The credit does not apply to coverage periods preceding lapses in coverage of 63 days or more. Benefit **waiting periods** do not count as lapses in coverage.

You and your dependents have the right to request a Certificate of Creditable Coverage from any prior plan. This Plan will provide assistance in obtaining a certificate upon request. There are also other ways that you can show you have creditable coverage. Please contact the Fund Office if you need help demonstrating creditable coverage.

Preexisting Condition Definitions

Preexisting Condition: A condition is preexisting if medical advice, diagnosis, care or treatment for the condition was recommended or received from an individual licensed or similarly authorized to provide medical service within the six (6) month period ending on the person’s **enrollment date** in the Plan. Pregnancy and genetic information are not considered **preexisting conditions**.

Enrollment Date: The first day of coverage or, if there is a **waiting (or probationary) period**, the first day of the **waiting period**. The **enrollment date** (not the coverage effective date, if different) is used to mark the end of a break in coverage, and is used to start the six month “look back” period for determining whether a condition is preexisting.

Preexisting Condition Exclusion Period: A period of 12 months (365 days) from the **enrollment date**.

Waiting or Probationary Period: The time between the date of employment and the date coverage is effective. This period does not count as creditable coverage but does count toward satisfying the **preexisting condition exclusion period**.

Certificate of Creditable Coverage: A form showing the length of time a person had Creditable Coverage with a carrier or plan, and indicating the **waiting period** starting date and the coverage effective and termination dates without a break of 63 days or more.

Exceptions to the Preexisting Condition Exclusion

The exclusion of coverage due to this **preexisting condition** exclusion shall be modified as follows:

1. This paragraph shall not apply to restrict your or **your dependent's** coverage under the Plan if coverage was terminated during a period of **FMLA Leave** and then reinstated after the conclusion of the **FMLA Leave**.
2. For those persons covered on the effective date of this Plan and covered on the immediately preceding day under the policy or plan this Plan replaced, whether such replaced policy or plan was written by an insurer or under a similar but not insured plan:
 - a. If **you** or **your dependents** incur expenses which would be eligible for payment hereunder except for the **preexisting condition** provision and such expense would have been eligible for payment under the replaced policy or plan had that policy or plan been continued in force rather than replaced by this Plan, this Plan will pay the lesser of the amount payable for such expenses under:
 - i) The replaced policy or plan, and
 - ii) This Plan disregarding the **preexisting condition** provision.
 - b. No item of expense incurred before the effective date of this Plan shall be payable under this Plan.
 - c. In no event shall the term "this Plan" be construed to include the policy replaced.
3. No preexisting condition limitation will apply to a child adopted or who is first placed with **you** or your spouse for adoption while **you** or your spouse is covered under this Plan. Further no pre-existing limitation will apply to a child who is covered under any creditable coverage within 30 days after the date of his adoption or placement with the employee or spouse, unless such child subsequently had a gap in creditable coverage of at least 63 days. This exception applies only to children adopted or placed for adoption prior to attaining the age of 18.
4. No preexisting condition limitation will apply to a child who was covered under any creditable coverage within 30 days after his birth unless that child has had a gap in creditable coverage of at least 63 days.

PRESCRIPTION DRUG BENEFITS

Benefit Payable

Benefits are provided through your WellPoint prescription drug card program. Charges that **you** or **your dependents** incur as a result of an **illness** or **injury** while covered under the Plan, will be paid at 100% for covered **medically necessary** prescription drugs in excess of the co-payment required for each prescription or refill as shown in the Schedule of Benefits.

If **you** purchase a brand name medication when a generic is available, **you** must pay the generic co-pay plus the entire cost difference between the brand name and generic drug. This additional payment will not be required if your **physician** prescribes the brand name medication for specific medical reasons.

If **you** are a member of Class 2, **you** are no longer eligible for Prescription Drug Benefits after exhausting the hours in your Hour Bank account.

No prescription drug benefits will be payable under this Plan for individuals who have prescription drug coverage under another plan that is primary. For details on determining primary plan coverage, please refer to the section entitled, "Coordination of Benefits and Excess Coverage," beginning on page 84.

Participating Pharmacies

Prescriptions may be filled at any pharmacy. However, only pharmacies designated by WellPoint will accept your retail prescription card and entitle **you** to the lower participating pharmacy co-payment amount shown in the Schedule of Benefits. The co-payment must be paid directly to the pharmacy. If **you** obtain a prescription at a non-participating pharmacy, **you** must pay in full when **you** receive the prescription and submit your receipt by mail to WellPoint for review and reimbursement.

Prior Authorization

Some drugs are covered only for the treatment of certain conditions as **medically necessary**. Such drugs require prior authorization before you may fill a prescription. To obtain Prior Authorization, **you** should contact WellPoint at 1-888-820-0287.

Covered Prescriptions

Drugs are limited to a 34-day supply per prescription or refill, except maintenance drugs (prescriptions dispensed through the mail order program to treat chronic or long-term conditions), which are limited to a 100-day supply for each prescription or refill.

All drugs must be obtained from a licensed pharmacy with a **physician's** written prescription.

A covered charge is considered incurred on the date the prescription is dispensed by the pharmacist.

The following drugs are covered under the Plan's prescription drug benefits:

1. Prescription legend drugs (Any drug whose label must bear the legend: "Caution Federal Law Prohibits Dispensing Without a Prescription");
2. Any other drug which under applicable state law may only be dispensed with a prescription;
3. Compound medications with at least one prescription legend or state restricted drug ingredient;
4. Injectables and insulin (one copayment per type of insulin for 34-day supply);
5. Diabetic Supplies;
6. Legend prenatal, pediatric, single entity and injectable vitamins;
7. Vitamin D and Niacin (including Niaspan);
8. Oral contraceptives;
9. Plan B, emergency contraception for covered individuals under age 18, for which a prescription is required;
10. Erectile dysfunction drugs (such as Viagra, Cialis and Levitra) limited to 8 pills per 34-day supply;
11. Fluoride products, including Peridex.

Prescription Drug Benefits Exclusions and Limitations

Except as noted, no benefits will be paid for the following:

1. Injectable contraceptives and contraceptive implants;
2. Drugs, including vitamins, which do not require a **physician's** prescription (legend or over-the-counter pre-natal vitamins and insulin are the only exceptions to this);
3. Hypodermic needles and syringes for administration of injectable drugs other than insulin, covered injectable drugs or vitamins;
4. Charges for the administration of any prescription drug;
5. Drugs labeled "Caution - limited by law to investigational use" or **experimental** drugs, even if a charge is made for them;
6. Prescriptions refilled in excess of the number of times specified by the doctor, or any refill dispensed after one year from the date of the original prescription;
7. Drugs dispensed during confinement in a hospital, rest home, extended care facility, skilled nursing facility, or similar institution that has on its premises a facility for dispensing pharmaceuticals;
8. Specialty Drugs dispensed or administered by a physician or hospital (these drugs are covered under the Plan's medical benefits and are limited to the lowest available cost to the Plan from a specialty pharmacy as determined by case management—see pages 55-56 for details);
9. Any drug that may be provided without charge under local, state or federal programs;
10. Immunization agents, biological sera, blood or blood plasma;
11. Smoking cessation products or drugs;
12. Replacement prescriptions;
13. Appetite suppressants, except Adderall, Desoxyn and Dexedrine are covered with Prior Authorization for Attention Deficit Disorder and Narcolepsy;
14. Medications for **cosmetic** purposes, such as rogaïne or topical monoxidil;

15. Retin-A and Avita , except for the treatment of acne through age 25; beyond age 25, coverage is subject to Prior Authorization;
16. Accutane, unless Prior Authorization is obtained;
17. Fertility drugs;
18. Relenza and Tamiflu;
19. Renova;
20. Charges for any prescription drugs for the treatment of a medical condition that is excluded from coverage under the Plan (see Medical Exclusions and Limitations on pages 58-61).

DENTAL BENEFITS

Individual Calendar Year Deductible: **\$50**

Before Plan benefits are paid for many dental expenses, you must pay a **deductible**, which is the first \$50 of eligible charges incurred each calendar year. The **deductible** does not apply to preventive services.

Maximum Family Calendar Year Deductible: **\$150**

The calendar year **deductible** will be limited to \$150 for members of any one family. The family calendar year **deductible** amount can be accumulated through charges incurred by any combination of family members.

Benefit Percentages

The Plan will pay the following percentages of usual, customary and reasonable charges for covered services:

<i>Preventive Services</i>	100%
<i>Basic Services</i>	80%*
<i>Major Services</i>	50%*
<i>Orthodontic Services</i>	50%*

*After satisfaction of the **deductible**

Maximum Benefits

Calendar Year Maximum \$1,200 per individual

Dental benefits for preventive, basic and major dental care combined are limited to \$1,200 payable per covered individual in a calendar year.

Orthodontic **Lifetime** Maximum \$1,500 per individual

The **lifetime** maximum payable for orthodontic expenses is \$1,500 per covered individual. Payments for orthodontic expenses are not included in calculating the calendar year maximum benefit.

Predetermination of Benefits

If the proposed dental treatment plan will cost over \$200, you or your **dentist** may contact the **claim administrator** to voluntarily predetermine the necessity of services and the allowable amount. This will enable you to estimate in advance, the amount that will be paid by the Plan and the amount for which you

may be responsible. When the post-service claim is received by the **claim administrator**, benefits will be determined without giving deference to the predetermination.

Covered Expenses

The following are covered expenses under this plan. Benefits for these covered expenses are payable at the applicable **benefit percentage** and are subject to the **deductibles** and maximums shown above.

Preventive Services

- Preventive cleaning and scaling of teeth (above the gum line), but not more than twice in any calendar year;
- Fluoride application for individuals under age 19, but not more than twice in any calendar year;
- Space maintainers and their fitting for children age 13 and under;
- Diagnostic services to determine necessary care limited to:
 - Full mouth x-rays, not more than once in any three calendar year period, or more frequently if required in connection with the diagnosis of specific conditions;
 - Bitewing x-rays, but not more than twice in any calendar year;
 - Diagnostic oral examinations, but not more than twice in any calendar year;
 - X-rays and exams for emergency office visits, provided that charges for other dental services are not incurred during the same visit.

Basic Services

- Extracting one or more teeth, cutting procedures in the mouth, treating fractures and dislocations of the jaw;
- Treating gums and the supporting structure of the teeth;
- Periodontal scaling of teeth (below the gum line);
- Root canals and other endodontic treatment;
- General anesthetics and their administration in connection with oral surgery, periodontics, fractures or dislocations;

- Antibiotics injected by a **dentist** or **physician** in conjunction with treatment of a covered dental expense;
- Fillings other than gold fillings (for gold fillings, see Major Services);
- Repairing existing dentures and fixed bridges (replacing such dentures and fixed bridges is described under Major Services);
- Adding teeth to an existing denture or fixed bridge, if required by the loss of natural teeth;
- Tooth sealants for children age six through 13. Coverage will be provided for the treatment of each permanent molar no more often than once every three calendar years;

Major Services

- One full or partial denture or fixed bridge. Replacing an existing device is covered if two conditions are met:
 - The existing device cannot be made serviceable; and
 - The device is more than five years old.
- Implants as an alternative to a bridge or other covered service. Benefits for implants will be limited to the amount payable under the Plan for the other service.
- Gold fillings and crowns necessary to restore the structure of teeth broken down by decay, injury, or severe attrition;
- Replacing a crown or gold filling (if the covered individual is charged for both temporary and permanent crowns or dentures, only the permanent charge is covered).

Orthodontic Services

- Orthodontic care includes treatment necessary for the proper alignment of teeth.
- Orthodontic coverage is provided only to individuals who are under age 19 at the time services are rendered.

Dental Exclusions and Limitations

Benefits are not payable for or in connection with:

1. Services or supplies partially or wholly **cosmetic** in nature;
2. Facings on pontics or crowns behind the second bicuspid. The cost to improve the **cosmetic** appearance for rear teeth is not covered;
3. Services or supplies furnished or reimbursed by any government or government program or law, unless payment is legally required;
4. Injuries arising out of or in the course of any occupation for wage or profit, or an **illness** for which **you** or **your dependent** is entitled to benefits under any Workers' Compensation or Occupational Disease Law, or any such similar law;
5. Specialized or personalized services;
6. Services or supplies not furnished by a **dentist** except x-rays ordered by a **dentist** and services of a Licensed Dental Hygienist under the **dentist's** supervision;
7. Training in, or supplies used for, dietary counseling, oral hygiene or plaque control;
8. Procedures, restoration and appliances to increase vertical dimension or restore occlusion, including treatment of Temporomandibular Joint dysfunction (TMJ);
9. Services or supplies due to war or act of war, declared or undeclared;
10. Services for which the covered individual would not be required to pay if there were no insurance;
11. Charges for removing stitches and post-operative examinations that have been included in the initial charge for a procedure listed in the Covered Expenses section;
12. Charges for adjusting dentures or bridges within six months of installation;
13. Failure to keep a scheduled visit with the **dentist**;
14. Services or supplies which do not meet accepted standards of dental practice, including those which are **experimental** in nature;

15. Orthodontic services for covered individuals other than **dependent** children;
16. Completion of insurance forms.
17. Expenses that are incurred while you are not covered under this plan. For this purpose, an expense is incurred at the time the service or supply.

DEFINITIONS

The following definitions, whether or not in bold type, will have the meanings indicated below.

Accident: An event that is external, sudden, direct and unforeseen and exact as to time and place.

Accidental Injury: A bodily **injury** caused exclusively by an **accident**.

Ambulance Transportation: The term “**Ambulance Transportation**” means local transportation in a specially-equipped certified vehicle from your home, scene of an **accident** or medical **emergency** to a **hospital**, between **hospitals**, between a **hospital** and **skilled nursing facility** or from a **skilled nursing facility** or **hospital** to your home. If there are no facilities in the local area equipped to provide the care needed, “**Ambulance Transportation**” then means the transportation to the closest facility that can provide the necessary service.

Ambulatory Surgical Center: The term “**Ambulatory Surgical Center**” means an institution or facility, either free standing or as a part of a **hospital**, with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures and admits and discharges the patient within a twenty-four (24) hour period. An office maintained by a **physician** for the practice of medicine or dentistry, or for the primary purpose of performing terminations of pregnancy, will not be considered to be an **Ambulatory Surgical Center**.

Amendment: The term “**Amendment**” means a formal document that changes the provisions of the documents that govern this Plan, duly signed by the authorized person or persons as designated by the **plan administrator**.

Anesthesia Services: The administration of anesthesia and the performance of related procedures by a **physician** or a **Certified Registered Nurse Anesthetist** which may be legally rendered by them respectively.

Benefit Percentage: The term “**Benefit Percentage**” means that portion of eligible expenses to be paid by the Plan in accordance with the coverage provisions as stated in the Plan. It is the basis used to determine any out-of-pocket expenses in excess of the annual **deductible** which are to be paid by **you** or **your dependents**.

Benefit Period: The term “**Benefit Period**” refers to the time period shown on the Schedule of Benefits. Such **benefit period** will terminate on the earliest of the following dates:

- a. The last day of the period so established; or

- b. The day the maximum **lifetime** benefit applicable to **you** or **your dependent** becomes payable; or
- c. The day **you** or **your dependent** ceases to be covered for medical expense benefits.

Certified Registered Nurse Anesthetist: The term refers to a **nurse** who: (a) is a graduate of an approved school of nursing and is duly licensed as a registered **nurse**; (b) is a graduate of an approved program of **nurse** anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; (c) has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and (d) is recertified every two years by the Council on Recertification of Nurse Anesthetists.

Chemotherapy: The treatment of malignant conditions by pharmaceutical and/or biological anti-neoplastic drugs.

Claim Administrator: The term “**Claim Administrator**” means the person or firm employed by the Fund to provide consulting services to the Fund in connection with the administration of the Plan and any other functions, including the processing and payment of claims.

Close Relative: The term “**Close Relative**” includes **you** or **your dependent’s** spouse, mother, father, sister, brother, **child**, or in-laws.

Co-insurance: The portion of covered expenses you must pay, after the Plan pays the applicable benefit percentage for covered services, as shown in the Schedule of Benefits.

Co-payment (Co-pay): The amount **you** must pay to the provider at the time of service. Services requiring a co-payment are not subject to the calendar year **deductible**, unless otherwise noted in the Schedule of Benefits.

Cosmetic: A procedure or treatment performed solely for the improvement of appearance rather than for the improvement or restoration of bodily function.

Covered Employment: The term “**Covered Employment**” means employment within the geographic and craft jurisdiction of Local 101 for which contributions have been made to and actually received by this Fund by your employer(s). **Covered employment** also includes work within the jurisdiction of a United Association Local Union which has a reciprocal agreement with this Plan for health and welfare coverage. Finally, **covered employment** includes, full-time employment with Local 101.

Custodial Care: The term “**Custodial Care**” means that type of care or

service, wherever furnished and by whatever name called, which is designed primarily to assist a person, whether or not **totally disabled**, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

Deductible: The term “**Deductible**” means a specified dollar amount of covered expenses which must be incurred during a specified period before any other covered expenses can be considered for payment according to the applicable **benefit percentage**.

Dentist: The term “**Dentist**” means a licensed dentist legally entitled to practice dentistry at the time and in the place services are provided.

Dependent: Your: (1) lawful spouse; (2) unmarried **child** under age 19; (3) unmarried child age nineteen (19) or older but under age twenty-three (23), if such unmarried child is a full-time student at an accredited school; and (4) unmarried **child** age nineteen (19) or older who is incapable of self-sustaining employment and dependent upon **you** for support due to a mental or physical **illness** or handicap.

The term “**Child**” will include your natural **child**, stepchild, adopted **child** and foster **child**, provided such **child** is in custody of and financially dependent upon **you**, provided that this requirement is waived if **you** are required to provide health care coverage pursuant to a **Qualified Medical Child Support Order**.

“Foster Child” means a child for whom **you** are the legal guardian, who resides in your household, and for whom **you** provide parental care, including health care.

A **child** is considered “adopted” only when he is legally adopted or placed for adoption, and only if the adoption or placement occurs before the **child** reached his eighteenth (18th) birthday. A **child** is placed for adoption when **you** assume and retain a legal obligation for total or partial support of the **child** in anticipation of adoption. The **child’s** placement with **you** terminates upon the termination of such legal obligation.

Durable Medical Equipment: The term “**Durable Medical Equipment**” means equipment that is:

- a. Able to withstand repeated use;
- b. Primarily and customarily used to serve a medical purpose;
- c. Not generally useful to a person in the absence of **illness** or **injury**.

Elective Surgical Procedure/Elective Surgery: A non-emergency surgical procedure which is scheduled at a person's convenience without endangering the person's life or without causing serious impairment to the person's bodily functions.

Eligible Dependent(s): **Your dependent(s)** who meet the requirements for eligibility under this Plan.

Emergency/Emergency Medical Condition: A sudden, unexpected acute medical condition that, without medical care within 48 hours of onset, could result in death or cause serious impairment to bodily functions.

ERISA: The term "ERISA" refers to the Employee Retirement Income Security Act of 1974 or portion referred to in this booklet, as such Act, portion may be amended from time to time.

Experimental or Investigative: Any **experimental or investigative** drug, device, medical or dental treatment or procedure. A drug, device, medical or dental treatment or procedure is **experimental or investigative**:

- a. in the case of a drug or device, if it cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and if such approval has not been given at the time the drug or device is provided to the patient; or
- b. if the drug, device, medical or dental treatment or procedure, or the patient informed consent document used with any of them, was reviewed and approved by the treating facility's institutional review board or any other body serving a similar function, or if federal law requires such review or approval; or
- c. if the drug, device, medical or dental treatment or procedure is the subject of an ongoing Phase I or Phase II clinical trial, is the research, experimental, study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or how any of these factors compares with standard means of treatment or diagnosis; or
- d. in the case of a drug or device, if it is prescribed or used "off label," i.e., dispensed for a use for which it is not approved by the U.S. Food and Drug Administration; or
- e. if the drug, device, medical or dental treatment or procedure is considered by the U.S. Department of Health and Human Services Health Care Financing Administration to be investigational, not

reasonable and necessary, not primarily medical in nature or not verified as effective by scientific controlled studies.

The **plan sponsor** may, from time to time, retain a medical consultant, who may, in the exercise of judgment, waive the exclusion of a drug, device, medical treatment or procedure described in subparagraph (b) or (d) above, or in subparagraph (c) above (but may not waive the exclusion of a drug, device, medical treatment or procedure that is the subject of an ongoing Phase I clinical trial).

Fiduciary: The Fund Administrator, the Trustees, or the **plan administrator**, but only with respect to the specific responsibilities of each with respect to the administration of the Plan.

FMLA Leave: **FMLA Leave** means leave granted to **you** by your employer under the Family and Medical Leave Act of 1993.

HMO Provider: A participating health care provider that has entered into an agreement with the health maintenance organization, HealthLink HMO Inc., to provide certain health care services, supplies or accommodations to **participants** and eligible **dependents**.

Home Health Care Agency: The term “**Home Health Care Agency**” means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions:

- a. It is primarily engaged in and licensed by the Community Health Accreditation Program (CHAP) to provide skilled nursing services and other therapeutic services.
- b. It has policies established by a professional group associated with the agency or organization. This professional group must include a least one **physician** and at least one registered **nurse** (R.N.) to govern the services provided and it must provide for full-time supervision of such services by a **physician** or registered **nurse**.
- c. It maintains a complete medical record on each individual.
- d. It has a full-time administrator.

Home Health Care Plan: The term “**Home Health Care Plan**” means a program for care and treatment of a person which is established and approved by the person’s attending **physician**, which is in lieu of continued confinement as an inpatient in a **hospital** that would be required in the absence of the services and supplies provided as part of the **home health care plan**.

Hospice: The term “**Hospice**” means a health care program providing a coordinated set of services rendered at home, in outpatient settings or in institutional settings for a person suffering from a condition that has a terminal prognosis. A **hospice** must have an interdisciplinary group of personnel including at least one **physician** and one registered **nurse**, and it must maintain central clinical records on all patients. A **hospice** must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

Hospital: The term “**Hospital**” means an accredited institution which is approved as a **hospital** by the Joint Commission on the Accreditation of Health Care Organizations or the American Osteopathic Association, and which meets all of the following criteria:

- a. it is primarily engaged in providing, for compensation from its patients and on an inpatient basis, diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons by or under the supervision of a staff of **physicians**. If primarily a facility for the treatment of mental health conditions, or substance abuse, such facility must have a bona fide arrangement by contract or otherwise with a **hospital** to perform such surgical procedures as may be required;
- b. it continuously provides twenty-four (24) hours per day nursing service by registered **nurses** under the supervision of **physicians**; and
- c. it is not, other than incidentally, a place for rest, the aged, or a nursing home, a hotel or the like.

The term “**hospital**” includes a **rehabilitation facility** for inpatient care only.

Illness: The term “**Illness**” means a bodily disorder, disease, physical sickness, or psychiatric disorder of a person.

Incurred Expenses: The term “**Incurred Expenses**” means expenses for those services and supplies rendered to a person. Such expenses will be considered to have been incurred at the time or date the service or supply is actually provided.

Injury: An **injury** means a bodily injury that is caused by an **accident**.

Kidney Dialysis: Hemodialysis, all forms of peritoneal dialysis, including continuous ambulatory peritoneal dialysis (CAPD), continuous cycling peritoneal dialysis (CCPD), intermittent peritoneal dialysis (IPD), hemofiltration and hemoperfusion, therapeutic pheresis and ultrafiltration, whether rendered as an inpatient, an outpatient (including at an ambulatory dialysis facility) or at home and includes: facility charges; charges for services, supplies, equipment, support equipment and support services; laboratory, multi-channel chemistry;

and drugs and biologicals (including EPO and drugs used for immunosuppressive therapy), intravenous iron therapy and other pharmacy approved by the FDA as essential to the dialyzing patient's treatment.

Lifetime: The term “**lifetime**” refers to the time a person is actually covered under this Plan and is not intended to suggest benefits beyond an individual's termination date or the Plan's termination date.

Maintenance Care: All services, equipment and supplies that are provided solely to maintain a patient's condition at the level to which it has been restored or stabilized and from which no practical improvement can be expected.

Managed Care Organization (MCO): A panel of licensed **physicians** and/or a group of participating health care institutions which provide medical services to contracted groups.

Medically Necessary/ Medical Necessity: Health care services, supplies or treatment must be necessary in connection with the diagnosis or therapeutic treatment of an **injury** or **illness**. In determining whether a service or supply, what portion of a service or supply or what length of **hospital** confinement or amount of treatment is included in this definition, a service or supply must be ordered by a **physician** and be commonly and customarily recognized by the **physician's** profession in the United States as safe, effective, appropriate and reasonably necessary treatment of the diagnosed **injury** or **illness**. It must be neither educational, experimental nor investigatory in nature, nor provided primarily for research. It must be neither for **custodial care** nor **maintenance care**. Such treatment must be performed in the most cost-efficient manner and type of setting that can be safely provided to the patient and must not be performed principally for the convenience of the provider or patient.

Medicare/Medicare Benefits: All benefits under Parts A and/or B of Title XVIII of the Social Security Act of 1965, as amended, from time to time.

Mental Health Care/Treatment: Such term includes treatment for mental health disorders or conditions, as accepted by the general psychiatric community.

Non-Network Provider: An individual or organization not under contract with a **Managed Care Organization** with which the Plan has an agreement to provide medical or other services at discounted fees.

Nurse: The term “**Nurse**” means an individual who has received specialized nursing training and is authorized to use the designation “R.N.”(Registered Nurse) or “L.P.N.” (Licensed Practical Nurse) and who is duly licensed by the state or regulatory agency responsible for such license in the state in which the individual performs the nursing services.

Occupational Therapy: A program of care which focuses on the physical, cognitive and perceptual disabilities that influence the patient's ability to perform functional tasks. The therapist evaluates the patient's ability to use his fingers and hands, (fine motor skills), perceptual skills, cognitive functioning and eye-hand coordination. Therapy sessions may also involve physical movement exercises. Functional tasks also may be used. The therapist may also perform splinting of the patient's arms or hands and may provide the patient with special equipment. Therapy that is intended to address primarily vocational rehabilitation issues (i.e., return to work skills) will not be considered covered services under this Plan.

Out-of-Area: More than 50 miles outside an area serviced by an **HMO** or **PPO** provider.

Out of Pocket Maximum: The maximum dollar amount **you** will pay for medical expenses in any one **benefit period**, unless otherwise specified in the Schedule of Benefits.

Participant: An employee covered under the Plan.

Physical Therapy: A plan of care provided to return a patient to the highest level of motor functioning possible. The physical therapist extensively evaluates the patient's muscle tone, movement, balance, endurance, ability to ambulate, and ability to plan motor movements, strength and coordination. If the patient requires special equipment (such as a wheelchair, walker or splint) the therapist evaluates the patient's ability to use the equipment and determines the correct size and type of equipment for the specific patient. The therapist constructs a program of exercises and movements to maximize the patient's motor skills.

Physician Assistant (PA): A person who (a) has graduated from a **Physician Assistant** program accredited by the American Medical Association's Committee on Allied Health Education and Accreditation (or by its successor agency), (b) has passed the certifying examination administered by the National Commission on Certification of Physician Assistants, (c) has active certification by the National Commission on Certification of Physician Assistants and (d) provides health care services delegated by a licensed physician. A person who has been employed as a physician assistant for three years prior to August 28, 1989 and who has passed the National Commission on Certification of Physician Assistants examination and has an active certification of the National Commission on Certification of Physician Assistants is also included in this definition. In order to meet this definition a **physician assistant** must clearly identify him/herself as a **physician assistant** and shall not refer to him/herself as a doctor, a **physician** or a surgeon.

Physician: The term "**Physician**" means only a legally qualified physician or surgeon (Doctor of Medicine or Doctor of Osteopathy); with respect to certain covered expenses under the Plan, the term "**Physician**" shall also include a duly

licensed dentist, podiatrist, chiropractor, licensed clinical psychologist, licensed social worker or licensed professional counselor practicing within the scope of his profession. The term “**Physician**” does not include optometrists, naturopaths, **nurse** midwives, speech therapists or Christian Science practitioners.

Plan Administrator: The term “**Plan Administrator**” means the Board of Trustees. The **plan administrator** is responsible for the day-to-day functions and arrangements of the Plan and may employ persons or firms to process claims and perform other Plan-connected services.

Plan Sponsor: The term “**Plan Sponsor**” means the Board of Trustees. The **Plan Sponsor** is responsible for the day-to-day functions and arrangements of the Plan. The **Plan Sponsor** may employ persons or firms to process claims and perform other Plan-connected services.

PPO Provider: An individual or organization which is under contract with the **Preferred Provider Organization** with which the Plan has an agreement to provide medical or other services at discounted fees.

Pre-admission Testing: The term “**Pre-admission Testing**” means the actual charges made by a **hospital** for services rendered on an outpatient basis prior to a scheduled inpatient confinement at the same facility.

Qualified Medical Child Support Order (QMSCO): An order, typically issued in a divorce or state child support proceeding, which may create or recognize the right of your **child** to be covered under this Plan. Such an order must be qualified and issued by a court of competent jurisdiction, or through an administrative process having the force and effect of law, for this Plan to be bound by it. Upon request, the **plan administrator** will provide guidelines used to determine whether a medical child support order is qualified.

Rehabilitation Facility: A legally operating institution or distinct part of an institution which has a transfer agreement with one or more **hospitals**, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, **hospital** and rehabilitative inpatient care and is duly licensed by the appropriate government agency to provide such services. It does not include institutions which provide only minimal care, **custodial care**, ambulatory or part-time care services, or an institution which primarily provides treatment of mental disorders, chemical dependency or tuberculosis unless such facility is licensed, certified or approved as a **rehabilitation facility** for the treatment of medical conditions or drug addiction or alcoholism in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission the Accreditation of Health Care Organizations or the Commission for the Accreditation of Rehabilitation Facilities.

Retiree: The term **retiree** means an individual who is receiving retirement benefits pursuant to the Plumbers and Fitters Local 101 Pension Plan. Further,

any such person who is receiving such benefits must have accumulated at the time of retirement not less than 10,000 hours of **covered employment** for which contributions to the Health & Welfare Fund were made by a contributing employer.

Skilled Nursing Facility: The term “**Skilled Nursing Facility**” means an institution or distinct part thereof which meets all of the following conditions:

- a. It is approved by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) and/or **Medicare**; and
- b. It provides nursing services by licensed staff under the 24-hour per day direction of a registered **nurse**; and
- c. It maintains a complete medical record for each individual patient; and
- d. The patient’s plan of care is prescribed by a **physician** and updated at least every 30 days; and
- e. Skilled nursing or skilled rehabilitation services are provided on a daily basis by appropriately licensed personnel; and
- f. The facility is not a place for rest, the aged, drug addicts, alcoholics, the mentally incapacitated or for the care of mental disorders, nor is the facility meant for **custodial care** that is provided for the primary purpose of assisting an individual in meeting the basic activities of daily living.

Speech Therapy/Pathology: A program of care which evaluates the patient’s motor-speech skills, expressive and receptive language skills, writing and reading skills, and determines if the patient requires an extensive hearing evaluation by an audiologist. The therapist also evaluates the patient’s cognitive functioning, as well as his social interaction skills such as the ability to maintain eye contact and initiate conversation. Therapy may also involve developing the patient’s speech, listening and conversational skills, and higher-level cognitive skills such as understanding abstract thought, making decisions, sequencing etc. Therapy may be considered medically appropriate even for patients who do not have apparent speech problems, but who do have deficits in higher-level language functioning as a result of trauma or identifiable organic disease process.

Substance Abuse/Chemical Dependency: The physiological and psychological addiction to a controlled drug or substance, or to alcohol. Dependence upon tobacco, nicotine, and caffeine are not included in this definition.

Supervision Agreement: A written agreement with jointly agreed-upon protocols or standing orders between a supervising **physician** and a **physician assistant**, which provides for the delegation of health services from a

supervising **physician** to the **physician assistant** and the review of the **physician assistant's** services by the supervising **physician**. The supervising **physician** must accept responsibility for the oversight of the **physician assistant's** activities and the health care services rendered by the **physician assistant**.

Total Disability (Totally Disabled): The term “Total Disability” means:

- a. In the case of an employee:
 1. during the first six months after commencement of disability, the inability due to an **illness** or **injury** to perform your own job, as determined by the Trustees or their designated representative;
 2. after the first six months of disability, the inability due to an **illness** or **injury** to engage in any and every business or occupation and to perform any and all work for compensation or profit, as determined by the Trustees or their designated representative; or
 3. at any time, receipt of Social Security Disability benefits.
- b. In the case of a dependent, a COBRA beneficiary, or a retiree, the inability due to an illness or injury to perform the normal activities of a person of that age and sex in good health, as determined by the Trustees or their designated representative.

Usual, Customary and Reasonable Fee (UCR): The lesser of (1) the usual fee - the charge most frequently made for the covered services or supplies by a **physician**, or **hospital**; (2) the customary fee - the charge made for covered services or supplies by those of similar professional standing in the same geographic area; (3) the reasonable fee—the charge determined by considering the complexity involved, the degree of professional skill required and other pertinent factors, if (1) and (2) above cannot be easily determined.

You: Means a member who is covered by virtue of his employment or former employment with an employer who contributes to the Plan.

Your Dependent: Means a **dependent** of a member who is covered by virtue of his employment or former employment with an employer who contributes to the Plan.

COORDINATION OF BENEFITS AND EXCESS COVERAGE

The **coordination of benefits** provision is intended to prevent the payment of benefits which exceed expenses. It applies when **you** or any eligible **dependent** covered by this Plan is also covered by any other plan or plans. When more than one coverage exists, one plan normally pays its benefits in full and the other plan pays a reduced benefit. This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of **allowable expenses**. Only the amount paid by this Plan will be charged against the Plan maximums.

Coordination of Benefits Definitions

Allowable Expense: The usual, customary and reasonable expense for medical care or treatment. **Allowable expenses** are limited to those expenses that are covered under this Plan, except that private room and board expenses will not be subject to this limitation if the expenses are covered in whole or in part under at least one of the **plans** covering **you** or **your dependent**.

Coordination of Benefits: The way benefits are payable under more than one health **plan**. Under **coordination of benefits**, **you** or **your dependent** will not receive more than 100% of the **allowable expenses** for a loss.

Plan: A form of coverage with which coordination is allowed. The definition of plan in a contract or description of benefits must state the types of coverage that will be considered in applying the COB provisions of that contract or plan of benefits. The right to include a type of coverage is limited by the rest of this definition. Separate parts of a plan for members of a group that are provided through separate contracts or arrangements that are intended to be part of a coordinated package of benefits are considered one plan, and there is no coordination with the separate parts of the plan. For example, if an employer-provided plan of medical benefits is made up of a base plan or contract and a major medical plan or contract, this Plan will treat those two components as a single coordinated plan for purposes of these COB rules. The term “plan” includes any of the following that provide medical, dental, prescription drug, vision or other benefits provided by this Plan:

- This Plan.
- Any group, blanket or franchise health insurance.
- A group contractual prepayment or indemnity **plan**.
- A Health Maintenance Organization (HMO), whether group practice or individual practice association.
- A labor-management trustee plan or a union welfare **plan**.
- An employer or multi-employer plan or employee benefit **plan**.
- A government program.
- Insurance required or provided by statute.

- Insurance provided by a school or school district to cover injuries incurred as a result of school sponsored athletic activities, whether or not the eligible **dependent** was enrolled in the program or if application was made for such enrollment.
- Medical payments coverage under automobile (including uninsured or underinsured motorist coverage), homeowners and general liability insurance policies, regardless of whether individual or group, fault or no fault.

“**Plan**” does not include any individual or family policies or contracts or public medical assistance programs. Eligibility for coverage will not be affected by the fact that a person is eligible for or is provided medical assistance under Medicaid, that is, a state plan for medical assistance approved under Title XIX of the Social Security Act. In addition, this **Coordination of Benefits** provision will not apply to benefits a person is entitled to receive under Medicaid.

Primary Plan/Secondary Plan: When this Plan is primary, its benefits are determined before those of the other **plan**. The benefits of the other **plan** are not considered. When this Plan is secondary, its benefits are determined after those of the other **plan**. Its benefits may be reduced because of the other **plan's** benefits. When there are more than two **plans** this Plan may be primary as to one and may be secondary as to another.

Order of Determination

This Plan determines which **plan** is primary using the first of the following which applies:

1. **General:** A **plan** that does not coordinate with other **plans** is always the **primary plan**.
2. **Non-dependent/Dependent:** The benefits of the **plan** which covers the person as an employee, member or subscriber (other than a **dependent**) is the **primary plan**; the **plan** which covers the person as a **dependent** is the **secondary plan**.
3. **Dependent Child/Parents Not Separated or Divorced:** Except as stated in (4) below, when this Plan and another **plan** cover the same **child** as a **dependent** of different parents:
 - a. The **primary plan** is the **plan** of the parent whose birthday (month and day) falls earlier in the year. The **secondary plan** is the **plan** of the parent whose birthday falls later in the year, but

- b. If both parents have the same birthday, the benefits of the **plan** which covered the parent the longer is the **primary plan**; the **plan** that covered the parent the shorter time is the **secondary plan**.
 - c. If the other **plan** does not have the birthday rule, but has the gender rule and if, as a result, the **plans** do not agree on the order of benefits, the birthday rule will determine the order of benefits.
4. **Dependent Child/Separated or Divorced Parents:** If two or more **plans** cover a person as a **dependent child** of divorced or separated parents, benefits for the **child** are determined in this order:
- a. First, the **plan** of the parent with custody of the **child**;
 - b. Then, the **plan** of the spouse of the parent with custody;
 - c. Finally, the **plan** of the parent without custody of the **child**.

However, if there is a **Qualified Medical Child Support Order** or other court order specifying that one parent is responsible for the health care expenses of the **child**, then that parent's **plan** is the **primary plan**.

5. **Active/Inactive Employee:** The **primary plan** is the **plan** which covers the person as an employee who is neither laid off nor retired (or as that employee's **dependent**). The **secondary plan** is the **plan** which covers that person as a laid off or retired employee (or as that employee's **dependent**). If the other **plan** does not have this rule, and if, as a result, the **plans** do not agree on the order of benefits, this rule does not apply.
6. **Longer/Shorter Length of Coverage:** If none of the above rules determines the order of benefits, the **primary plan** is the **plan** which covered an employee, member or subscriber longer. The **secondary plan** is the **plan** which covered that person the shorter time.

Excess Coverage

If one or more of the other **plans** involved (as defined in this Coordination of Benefits and Excess Coverage provision) provides benefits on an Excess Insurance or Excess Coverage basis, this Plan will pay as excess coverage.

Medical Payments under Automobile, Homeowners and General Liability Insurance Policies

This Plan will always be secondary to medical payments coverage under automobile, homeowners and general liability insurance policies.

Coordination of Benefits When Primary Plan's Requirements Not Met

When this Plan's benefits are secondary to another plan or to Medicare (traditional Medicare, Medicare HMOs and other Medicare + Choice plans) and the participant or patient elects not to follow the primary plan's requirements to receive maximum benefits, this plan will coordinate benefits as though those requirements had been met and this plan's benefits will be offset by the amount that would have been payable under the primary plan's benefits had the primary plan's requirements been met. This restriction will not apply in the case of an emergency, as defined in this Plan.

Example:

The spouse of a participant in this Plan is covered under an employer plan that provides coverage under a closed panel HMO. The spouse decides to go outside that plan's HMO network for services resulting in non-coverage by the HMO plan. This Plan will coordinate as though the spouse met the requirements of the HMO plan and received services from one of the HMO's network providers. The spouse incurs \$15,000 for inpatient hospital, surgical and medical services.

Had the spouse met the requirements of the employer's HMO plan and used in-network providers, the spouse would have been responsible for \$275 in co-pays: \$150 for hospital confinement, \$100 for inpatient surgery and \$25 for doctor visit. However, no benefits will be paid by the spouse's plan since the spouse elected to go outside the HMO plan's provider network. This Plan will reduce its benefits by the amount of benefits payable under the spouse's HMO plan. Only those co-pays listed above are reimbursable under this Plan. The result is this Plan pays \$275. The patient is responsible for the remaining \$14,725.

Special Rules for Plans that Attempt to Shift Liability

- (a) When a primary plan is a group health plan containing a sub plan/no loss provision, this Plan will not pay as the secondary plan until the primary plan has exhausted its benefits under any no loss or similar provisions.
- (b) If another plan is primary under this Plan's rules, and it contains a provision that has the effect of capping its benefits for an individual covered under this Plan and of shifting coverage liability to this Plan in a manner designed to avoid the usual operation of this Plan's coordination of benefits rules, this Plan shall not be liable to provide benefits until the other plan provides its customary benefits as the primary plan without regard to such cap.
- (c) As indicated in the definitions for these COB provisions, a plan includes one with separate contracts or arrangements that are intended to be part of a package of benefits. If more than one carrier or entity provides benefits under such a plan with component parts, this Plan will not deal separately

with multiple carriers or entities; rather, those multiple carriers or entities will be required to select one of their number to comply with these coordination of benefits rules on behalf of all of the carriers or entities that provide any part of the benefits under the package of benefits that has separate components.

Medicare

If **you** are an active employee age 65 or over and your employer has 20 or more employees **you** must elect either:

- the Plan as your primary medical coverage and **Medicare** as your secondary medical coverage, or
- **Medicare** as your only medical coverage.

The spouse, age 65 and over, of any active **participant**, must also make such an election.

If **you** elect **Medicare** as your medical coverage, your spouse will also have **Medicare** as his/her only medical coverage. If **you** elect the Plan as your primary medical coverage your spouse may elect **Medicare** as his/her only medical coverage or he/she may continue coverage under the Plan.

As an active employee, unless **you** made an election to choose **Medicare** as your only coverage, coverage will automatically continue under the Plan, and this Plan's benefits will be primary, if your employer has 20 or more employees. If **Medicare** is elected, coverage under the Plan will terminate.

If **you** are an active employee of an employer with 20 or more employees or the spouse of such an employee and are entitled to **Medicare** for reasons other than kidney dialysis or end stage renal disease this Plan will pay its regular medical benefits. **Medicare** may supplement the benefits **you** receive under this Plan.

When **Medicare** is primary and the Plan is secondary, **Medicare** (Parts A and B) will be considered a **plan** for the purposes of **coordination of benefits**. The Plan will coordinate benefits with **Medicare** whether or not **you** or **your dependents** are actually receiving **Medicare** benefits.

Medicare is your only coverage and coverage under the Plan will terminate if **you** are age 65 or over, no longer eligible as a Class 1 or Class 3 employee, and are retired or the spouse of a retired **participant**. **Medicare** is primary and this Plan is secondary if **you** are an active employee of an employer with less than 20 employees or the spouse of such an employee and entitled to **Medicare** for reasons other than kidney dialysis or end stage renal disease.

Medicare for Disabled Beneficiaries under Age 65

A. Your Status --Currently Employed

The Plan is primary and **Medicare** is secondary for **you** and **your dependent(s)** if **you/they** are under age 65 and eligible for **Medicare** due to disability.

If **you** are an active employee of an employer with less than 20 employees or the spouse of such an employee and are covered by **Medicare** for reasons other than kidney dialysis or end stage renal disease, the preceding paragraph does not apply to **you**. **Medicare** is primary and the Plan is secondary for **you**.

B. Your Status -- Not Currently Employed

Medicare is your only coverage and coverage under the Plan will terminate if **you** are under age 65 and eligible for **Medicare** due to disability.

Medicare for Persons with End Stage Renal Disease (ESRD)

For **you** or **your dependents** under age 65, if **you** are in Class 1 or Class 2 and **Medicare** eligibility is due solely to End-Stage Renal Disease, (ESRD) this Plan will be primary only during the first thirty (30) months of **Medicare** coverage. Thereafter, this Plan will be secondary with respect to **Medicare** coverage. If **you** or **your dependent** is age 65 or over, and you are no longer working or covered under the Plan based on banked hours, and **you** or **your dependent** previously qualified for **Medicare** based on age or disability, this Plan will continue to pay secondary to **Medicare** if the individual subsequently qualifies for **Medicare** based on ESRD.

Right of Recovery

If payment made under this Plan is in excess of the total amount required to satisfy the intent of the **coordination of benefits** provision, the Plan has the right to recover any excess amount from one or more of the following:

1. Any person to whom, for whom, or with respect to whom such payment is made.
2. Any insurance company.
3. Any other organization.
4. Future benefits payable under the Plan for **you** or **your dependents**.

SUBROGATION AND REIMBURSEMENT

The following Subrogation and Reimbursement provisions apply to all medical benefits payable under the Plan, including prescription drug benefits.

Introduction

Notwithstanding any other provision in this Plan to the contrary, but subject to the Plan's coordination of benefits rules, this Plan does not pay otherwise covered charges incurred for treatment of any Sickness or Injury which is, or in the opinion of the **claim administrator** is likely to become, the subject of a claim by or on behalf of the covered person against any person or plan, whether by civil lawsuit or otherwise. For example, when a covered person is hurt in an accident and it appears someone else was at fault and may be liable to the covered person, this Plan will not pay benefits for that injury. However, benefits may be conditionally paid in this circumstance, solely at the discretion of any one management and any one union Trustee, but in that case the covered person agrees, by accepting such payment (whether made to or on behalf of the covered person) and in consideration of the Plan's conditional payment, to reimburse the Plan, to the extent of the Plan's payment, from any monies paid to or on behalf of the covered person by any other person or plan as compensation for the Sickness or Injury. The covered person, by accepting such payments, also agrees the Plan shall become subrogated to the covered person's claims against any third parties for that injury or illness.

Subrogation Generally

If a covered person is injured or becomes sick and another person is responsible for the Injury or Sickness, this Plan is "subrogated" to the covered person's claims against that responsible person. This means that, to the extent of the benefits the Plan has paid out for the Injury or Sickness, it has the same right as the injured or sick person to recover from the person responsible for the Injury or Sickness, or from any other person or plan. The Plan "stands in the shoes" of the covered person.

Reimbursement Generally

If the covered person recovers monies from the person responsible for an Injury or Sickness or from any other person or plan, the covered person is obligated to reimburse the Plan for all benefits the Plan has paid out with respect to that Injury or Sickness.

Definitions

For purposes of these subrogation and reimbursement rules, the term "covered person" shall mean the person to whom or on whose behalf this Plan paid benefits for the treatment of an Injury or Sickness and his guardians, his estate, his executors, his heirs, or other representatives. The term shall also include any family member who recovers any amounts from a person or plan as a result of the injury or sickness of the covered person.

For purposes of these Subrogation and Reimbursement provisions, the term “person or plan” shall include, but is not limited to:

- a. any person, insurance company or other entity that is in any way responsible for the Sickness or Injury, or is in any way responsible for providing compensation, indemnification, or benefits for the Sickness or Injury;
- b. any law or policy of insurance or accidental benefit plan providing no-fault, uninsured, underinsured or general group or individual liability coverage;
- c. any medical reimbursement insurance coverage whether or not purchased by the covered person submitting the claim or on whose behalf the claim is submitted; and
- d. any specific homeowner’s medical reimbursement coverage and student, student-athletic or student-team coverage or insurance.

Rejection of Make Whole Rule

This Plan does not recognize the “make whole” rule. This Plan’s rights to subrogation and reimbursement apply whether or not the monies paid or payable from the other person or plan are sufficient to fully compensate the covered person for his loss occasioned by the Sickness or Injury. Further, the characterization of any amounts paid or payable to or on behalf of a covered person, whether under a settlement agreement, judgment, plan as defined herein, or otherwise, shall not affect the priority given this Plan under these provisions with respect to such amounts.

Required Execution of Documents

As a condition of making the conditional payments, the Trustees may require the covered person, as defined above, to sign a subrogation and reimbursement agreement reflecting:

- a. the covered person’s obligation to reimburse the Plan;
- b. assignment to the Plan of all rights, claims or causes of action such covered person (or any person or entity acting on his behalf) has against any plan or person to the extent of benefits paid or payable under the Plan;
- c. authorizing (but not requiring) the Plan to sue, enforce, compromise or settle (in such covered person’s name or otherwise) all such rights, claims or causes of action; and

- d. warranting that such covered person (and any person or entity acting on his behalf) has not settled, discharged or released any such right, claim or cause of action against any person or plan, and shall not do so.

The execution of such a subrogation and reimbursement agreement by or on behalf of the covered person shall not, however, bind the Plan to make the conditional payments described in the preceding paragraph. The Plan's failure to request a subrogation and reimbursement agreement in no way limits or waives the Plan's rights under these subrogation and reimbursement provisions.

Future Claims for Benefits for Same Injury or Sickness

After the Plan has recovered, either by reimbursement or through exercise of its subrogation rights, amounts it paid out for treatment of an Injury or Sickness for which a third person was responsible, it will not pay any further benefits for treatment of that condition, until the total covered expenses the covered person incurs for the treatment of the Injury or Sickness exceed the amount paid to or on behalf of the covered person by any other persons or plans.

Characterization of Covered Person's Recovery is Irrelevant

The characterization of any amounts paid to or on behalf of a covered person, whether under a settlement agreement, judgment, or "plan" as defined in the Plan's subrogation and reimbursement provisions above, or otherwise, shall not affect this Plan's right to reimbursement and to treat otherwise covered charges as excludable charges pursuant to the provisions of these subrogation and reimbursement provisions. For example, suppose you are the covered person and are involved in an auto accident caused by another person. A settlement agreement provides the other person will pay you damages but indicates those damages are for lost wages rather than for your physical injury. That characterization of the damages is irrelevant and the Plan nevertheless is entitled to be reimbursed for the benefits it paid out.

Reimbursement Due on Recovery from Other Person or Plan

The covered person (and any person or entity acting on his behalf) shall hold in trust for the benefit of the Plan

- a. any amounts recovered to the extent of benefits paid by the Plan and
- b. all rights of recovery against any person or plan by reason of the Sickness or Injury which occasioned the payment of benefits under the Plan, and upon receipt of amounts paid by another person or plan, the covered person shall immediately notify the Plan and pay to the Plan all amounts due the Plan.

Failure to make such reimbursement shall entitle the Plan to sue the covered person in order to recover the amounts due the Plan under these subrogation and reimbursement provisions, and if the Plan is successful in whole or in part, the

Plan shall also be entitled to reimbursement from the covered person of all costs of collection, including reasonable attorney's fees.

Where this Plan is entitled to reimbursement pursuant to these provisions and the covered person fails or refuses to provide complete reimbursement, in addition to any other remedies the Plan may have, the Plan may terminate coverage of the covered person with respect to pending and future claims, and may set-off the reimbursement due the Plan against claims, whether related or unrelated to the injury or sickness giving rise to this Plan's reimbursement rights, payable by the Plan to or on behalf of the covered person and any covered member of the covered person's family.

Plan Does Not Participate in Attorney's Fees

This Plan shall not be responsible for any costs or expenses, including but not limited to attorney's fees, incurred by or on behalf of a covered person in connection with any recovery from any other person or plan, unless this Plan agrees in writing to pay a part of these expenses.

Exercise of Subrogation Rights

Upon written notification to such covered person, the Plan may (but shall not be required to) directly collect any claim the covered person (or any person or entity acting on his behalf) may have against any person or plan relating to the Sickness or Injury which occasioned the payment of benefits under the Plan. The Trustees may proceed in any manner they determine and without such covered person's consent or the consent of any person or entity acting on behalf of such person. Any monies the Trustees recover shall first be applied to the Plan's reasonable collection costs and expenses (including attorneys' fees), then to payments made under this Plan, and any remaining balance will be paid to or on behalf of the covered person as soon as administratively practicable.

Negotiation of Plan's Claim

In any subrogation or reimbursement claim, the Trustees may agree to recover less than the full amount of reimbursement if the Trustees determine in their discretion that the Plan has made such reasonable collection efforts as are appropriate under the circumstances and the terms of such agreement are reasonable under the circumstances, based upon the likelihood of collecting such amounts in full or the approximate expenses the Plan would incur in an attempt to collect such amounts. The Trustees, in their sole discretion, shall determine which of the Plan's rights and remedies are in the Plan's best interests and may take such action against any person or plan as they determine to be appropriate under the circumstances. Any failure by the Plan, its Trustees or its agents to exercise any right under these subrogation and reimbursement provisions shall not constitute a waiver of such right or affect the parties' rights and obligations.

Covered Person's Cooperation Required

A covered person (and anyone acting on behalf of the covered person) has a duty to cooperate with this Plan and, at the request of the Trustees or their designee, to take any action, give information and assistance, and execute such documents as are deemed by the Trustees necessary to enforce the Plan's rights under these subrogation and reimbursement provisions. The Plan will make no payments to a covered person or on a covered person's behalf until the Trustees are satisfied that the covered person has complied with the requirements of this subsection. The Trustees or their designee, without the consent of or notice to any person, may release to or obtain from any person any information, with respect to any person, which the Trustees or their designee deem necessary to implement these provisions.

The covered person, or anyone acting on his behalf, shall take no action to prejudice the subrogation or reimbursement rights of this Plan, and shall not settle or compromise any claim against any person or plan with respect to monies payable to or on behalf of the covered person by such person or plan, without the express, written consent of the Trustees or their designee. Where the Trustees determine that the covered person, or anyone acting on behalf of the covered person, has in the opinion of the Trustees so prejudiced the Plan's rights, the covered person shall be required to reimburse the Plan as though the covered person had received payment of amounts equal to the amount of the benefits paid by the Plan.

Conditional Payments in Case of Wrongful Death

1. Where a covered person dies as a result of the Injury or Sickness, and another covered person, in the judgment of the Trustees, has as a result of such death a cause of action for the deceased person's wrongful death, the otherwise covered expenses incurred by or on behalf of the deceased person prior to his death shall not be considered covered expenses under this Plan. However, such expenses may nevertheless be treated as conditionally covered expenses and be paid in this circumstance, solely at the discretion of the Trustees, but in that case the covered person with the cause of action agrees, in consideration of the Plan's payment of such expenses, to reimburse the Plan, to the extent of the Plan's payment, from any monies paid to such covered person by any other person or plan as compensation for the deceased person's death. Failure to make such reimbursement shall entitle the Plan to sue the covered person or, as applicable, his heirs, guardians, executor, or other representative in order to recover the amounts due the Plan under this provision, and where in that case the Plan is successful in whole or in part the Plan shall also be entitled to reimbursement from the covered person of all costs of collection, including reasonable attorneys fees.

2. In addition to the foregoing the Trustees may, as a condition of making the conditional payments described in the preceding paragraph, require the covered person with the cause of action to sign a subrogation or reimbursement agreement reflecting the covered person's obligation to reimburse the Plan, and in such event the agreement shall operate to the same extent as the agreement described in the preceding subsection. The execution of such a subrogation agreement by such covered person shall not, however, bind the Plan to make the conditional payments described in the preceding paragraph.

3. Where this Plan makes the conditional payments described above and the covered person with the cause of action elects not to pursue the cause of action, but some other person related to the deceased person pursues the cause of action and recovers monies from the person or plan who is or may be responsible for the deceased person's wrongful death, this Plan is nevertheless entitled to reimbursement from the covered person. If the covered person fails or refuses to provide complete reimbursement, in addition to any other remedies the Plan may have, under the Plan or otherwise, the Plan may terminate coverage of the covered person with respect to pending and future claims, or may set-off the reimbursement due the Plan against claims, whether related or unrelated to the injury or sickness giving rise to this Plan's reimbursement rights, payable by the Plan to or on behalf of the covered person and any covered member of the covered person's family, or the Plan may do both of these things.

ERISA

As a participant in the Plumbers & Fitters Local No. 101 Health & Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

CLAIM PROCEDURES

The Filing of a Claim

IMPORTANT NOTE REGARDING “CLAIMS”: In order to file a “claim”, a request for the payment of benefits for services or supplies that have already been provided by a physician, hospital, pharmacy or other provider must be submitted in writing on an authorized form to the appropriate address shown below in the subsection entitled, “How to File a Claim.” However, claims from physicians and other providers submitted in electronic format will also be accepted to the extent permitted by the Plan or required by law.

For claims related to prescriptions submitted to a retail or mail order pharmacy, the procedure is different. Submission of a prescription to a pharmacy does not constitute the filing of a claim. If **you** or **your dependent** is denied a drug or receives a prescription drug from a WellPoint pharmacy and believe that the co-payment amount charged by the pharmacy is incorrect, that the pharmacy otherwise charged too much, or that the pharmacy inappropriately indicated the person or the drug was not covered, **you** may then submit a written claim to the Claim Administrator requesting review of the denial or reimbursement of any amounts **you** believe were overcharged.

Claims and appeal procedures for medical, prescription drug, dental, participant vision, and death benefits are described below.

Time for Filing a Claim

Written proof of claim for each eligible expense must be given to the **claim administrator** or the **plan administrator** within one year following the date the expense was incurred, unless it is not reasonably possible to give proof sooner, in which case proof must be given as soon as reasonably possible.

Assignment of Benefits

Benefits for medical, dental, prescription drug and vision claims are automatically paid directly to the provider of services, unless **you** submit proof of payment. Death benefits are payable to your designated beneficiary. If **you** die before all benefits have been paid, the remaining benefits may be paid to any of your relatives or to any person appearing to the **plan administrator** to be entitled to payment. The **plan administrator** will fully discharge its liability by such payments.

Plan's Right to Recover Overpayments or Mistaken Payments

If a payment for a claim filed by or for **you** or one of **your dependents** is found to be more than the amounts payable under the terms of the Plan or is found to

have been made in error, then a refund of the excess or erroneous payment may be requested. If a requested refund is not paid or if none is requested, the Trustees of the Health and Welfare Fund may take whatever action they deem necessary to recover the overpaid or mistakenly paid amounts, including, but not limited to, reducing benefits payable for future claims filed by or for **you** or **your dependents** to offset the overpaid or mistakenly paid amounts or bringing a legal action against you to collect the overpayment. If it is necessary for the Trustees to institute legal proceedings to collect an overpayment and they prevail, **you** will be responsible for paying pre-judgment interest and the reasonable attorney's fees and costs they incur in connection with such action.

HOW TO FILE A CLAIM

Generally

A fully completed and signed claim form must be submitted to the **claim administrator**: (a) once each calendar year for each participant; (b) when a claim is due to an **accidental injury**; or (c) when there is a change in information, including changes in a spouse's employment or other insurance coverage for any covered persons. No claims will be paid until the **claim administrator** has received all requested information. Claim Forms are available from the **claim administrator** or the Fund Office.

For Medical, Dental and Vision Benefits

A provider of medical, dental or vision services may submit a claim electronically in accordance with the Electronic Data Interchange (EDI) rules or via a standard industry billing statement that includes employee's name and identification number, patient's name, date of service, type of service and amount of charge. Any other person seeking benefits must submit a written request for benefits to the **claim administrator**, which includes all of the information required for provider claims.

You and **your dependents** should always show your identification card at the time services are rendered.

In some instances, a provider may wish to obtain patient eligibility details, check on the status of a claim, request a service review or obtain a remittance advice in electronic format. Conducting these electronic transactions should be handled as described on your identification card or by having the provider contact the **claim administrator**.

Claims for medical benefits should be submitted to HealthLink:

Electronic Claims: EDI Vendor #90001
EDI Clearinghouse
Web MD

Written Claims: Benefit Consultants, Inc./HL
P. O. Box 419104
St. Louis, MO 63141

Electronic dental and vision claims may be submitted as shown on your identification card or by contacting Interactive Clearinghouse. Written dental and vision claims should be submitted as described on your identification card or mailed to the **claim administrator**:

Benefit Consultants, Inc. (BCI)
13515 Barrett Parkway Dr., Ste. 265
Ballwin, MO 63021

Claims for death benefits should be submitted to the Fund Office:

Plumbers & Fitters Local No. 101 Health & Welfare Fund
137 Iowa Avenue
Belleville, IL 62220
Phone: 618-234-5504

Voluntary predetermination of a hospital admission, surgical or outpatient procedure is described in the section entitled “Voluntary Predetermination of Benefits.”

If you have any questions regarding the level of benefits payable, or how your claim was calculated, contact BCI at 314-822-7890 or, if you reside outside the St. Louis area, 1-800-434-4620.

For Prescription Drugs

Prescription drugs are covered under your WellPoint prescription drug card plan. You should always show your prescription drug card when purchasing prescription drugs. If you obtain a prescription from a non-participating pharmacy, you should complete a WellPoint reimbursement form, attach your receipt and submit to WellPoint for reimbursement. Filing instructions are printed on the prescription drug reimbursement forms, which can be obtained from the Fund Office. If you receive a prescription drug from a WellPoint pharmacy and believe that the co-payment amount charged by the pharmacy is incorrect or that the pharmacy otherwise charged too much, or if you believe a non-WellPoint pharmacy reimbursement was paid incorrectly, you may then

submit a written claim requesting reimbursement of any amounts you believe were overcharged to the **claim administrator**:

Benefit Consultants, Inc. (BCI)
13515 Barrett Parkway Dr., Ste. 265
Ballwin, MO 63021.

For Disability Extension of Coverage

In order to request to continue your coverage due to a disability, you should obtain a claim form from the Fund Office, complete your portion, have your doctor submit a physician's certification of disability and send it to:

Benefit Consultants, Inc.
13515 Barrett Parkway Drive, Ste. 265
Ballwin, Missouri 63021

For Short-Term Disability Income Benefits

You must submit a completed claim form and a physician's certification of your disability to the Fund within 90 days following commencement of your Disability. If it is not possible for you to submit a claim form and physician's certification within that period, benefits will be payable only if your claim is approved by two trustees, one management and one union. Claim forms may be obtained from the Fund office or from the Fund's **claim administrator**: Benefit Consultants, Inc., 13515 Barrett Parkway Drive, Suite 265, Ballwin, Missouri 63021; telephone: 800-434-4620. The claim administrator may require additional information beyond the claim form and physician's certification of Disability and may require that you undergo an independent medical examination at the Fund's expense.

Disability benefits will be paid to you weekly and will be mailed to your home address. It is important that you keep both the Fund office and the claim administrator informed of changes in your address.

CLAIM PROCESSING

The Plan will act on your claim, through the **claim administrator** within 30 days from the date the claim is received. If additional information is needed or if special circumstances beyond control of the Plan require more processing time, the Plan may extend the processing time for up to 15 additional days. Requests for short-term disability income benefits or disability coverage extensions will be acted upon within 45 days and this time may be extended up to two additional 30-day periods.

Death benefit claims will be decided within 90 days from receipt of the claim, unless additional information is needed or special circumstances require an extension, in which case the time for processing may be extended up to an additional 90 days.

If the Plan requires an extension of time to process a claim, the claimant will be notified in writing prior to the expiration of the initial 30-day (or 45-day) period. The notice will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, additional information (if any) needed to resolve those issues and the date by which the **claim administrator** expects to render a final decision. If the **claim administrator** requests additional information, the claimant will have at least 45 days to supply that information and this time will stop the running of the time period the Plan has to reach its decision on the claim until such information is received. Failure to supply requested information within the given time limit will lead to a denial of the claim.

The Plan may seek independent medical advice in ruling on any claim and may require such other evidence from the claimant as the Plan may reasonably need to decide the claim. The Plan, at its expense, may require a physical examination of a claimant by a **physician** the Plan selects.

Claim Denial

If the **claim administrator** determines that a person who submits a claim is not entitled to benefits under this Plan or is entitled to a lesser benefit than the amount claimed, then the claimant will be furnished a written statement of the reason or reasons for denial including reference to the Plan provisions on which the denial or reduction is based, a description of any additional material or information necessary for the claimant to establish his right to benefits, and an explanation of why such material or information is necessary. Medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination will be identified without regard to whether the advice was relied upon in making the benefit determination. This written notice will also contain an explanation of the appeal procedure that the claimant can follow to have his claim for benefits reviewed

and a statement that the claimant may bring a civil action under ERISA if the decision of the Trustees is not favorable. The statement will be written in a manner calculated to be understood by the claimant.

CLAIM APPEAL PROCEDURES AND RIGHTS

Appeal Procedure

Time Limit for Filing an Appeal. An appeal must be filed in writing with the **claim administrator** and signed by the party appealing or by his authorized representative, within 180 days of the receipt by the claimant of the denial notice which the appeal concerns.

Appeal Procedures. A claimant who receives an adverse benefit determination, or his duly authorized representative, has the right to appeal the decision to the Trustees by submitting a written statement setting forth issues or comments along with any supporting documents related to his appeal. The written statement must be signed by the claimant or his representative and filed with the **claim administrator** within 180 days of the receipt by the claimant of the denial notice. Send to:

Board of Trustees
Plumbers & Fitters Local No. 101 Health & Welfare Fund
c/o Benefit Consultants, Inc.
13515 Barrett Parkway Drive, Suite 265,
Ballwin, Missouri 63021

Upon request and free of charge, the claimant or his representative may review or obtain copies of documents pertinent to the appeal which are in possession of the Plan, including any internal guideline, protocol or other criteria on which the original benefit determination was based.

All appeals will be decided by the Trustees. The appeal determination will be based on all the evidence related to the claim, including evidence and statements submitted by the claimant, even if such information was not considered in the original benefit determination. In considering the appeal, the Trustees will give no deference to the initial adverse benefit determination.

If the initial adverse benefit determination was based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigative, or not medically necessary or appropriate, the Trustees shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual.

The Trustees will decide the appeal no later than the date of the regular Trustees meeting that immediately follows the plan's receipt of the appeal, unless the appeal is received within 30 days preceding the date of such meeting. In such case, a decision will be made no later than the date of the second meeting following the plan's receipt of the appeal. If special circumstances require a further extension of time for processing, a decision will be made not later than the third meeting following the plan's receipt of the appeal. If such an extension of time for review is required because of special circumstances, the **claim administrator** will notify the claimant in writing of the extension, describing the special circumstances and the date as of which the appeal will be decided, prior to the commencement of the extension.

Appeal Decision

The **claim administrator** will notify the participant or claimant in writing of the appeal decision as soon as possible but not later than five days following the date the decision is made. The notification will include the specific reason(s) for the decision and specific reference(s) to the pertinent Plan provisions on which the decision is based.

The Trustees have the discretionary authority to rule on all appeals and their decisions shall be final and binding on all parties, including but not limited to employers, unions, **participants, retirees, dependents** and beneficiaries and their service providers. Benefits will be paid only if the Trustees decide in their discretion that the applicant is entitled to them.

The Trustees shall have discretion to interpret all documents and other matters pertaining to the appeal, to determine eligibility for benefits, and to exercise such authority as set forth in this Summary Plan Description.

Limitation on Court Actions

If the appeal is denied, the claimant has the right to bring a civil suit under ERISA Section 502(a). However, no legal action may be brought to recover on this plan prior to exhaustion of the claims appeals process described above. No such action may be brought after two years from the date the final appeal decision is issued.

COMPLETE NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Plumbers and Fitters Local No. 101 Health and Welfare Fund (the Fund or the Plan) has a duty under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to outline its legal obligations regarding your private medical information. In general, the Plan is required by this law to maintain the privacy of your health information. The Plan must also provide you with a notice of its legal duties and current privacy practices.

The Plan has the legal obligation to abide by the terms of this notice, but retains the right to change those terms when necessary. Any changes may be effective for any current health information about you and any information that may be obtained in the future. Such changes will be appropriately reflected in this Notice of Privacy Practices. The most recent version of our full notice will always be available to you through our office.

Standard Use and Disclosure of Your Medical Information

The Plan is permitted by law to use or disclose your protected health information (PHI) to provide payment of health benefits and to conduct necessary healthcare operations, which includes outsourcing of claim administration services to Benefit Consultants, Inc. (BCI). There are other purposes for which the Plan or BCI may use or disclose your PHI, but these are the primary instances. Federal law permits the Plan to conduct these activities without express written consent from you. The following are some examples of what these uses and disclosures may entail:

Payment. The Plan, acting on its own or through BCI, may be required to use or disclose your medical information in order to facilitate payment for medical services you receive. This may include, but is not limited to the following actions:

- **Determining your eligibility for plan benefits** – For example, the Plan or BCI may use information obtained from your employer to determine whether you have met the plan's requirements for active eligibility.
- **Determining and fulfilling benefit obligations** – For example, the Plan or BCI may review your healthcare claims to determine if specific services or treatments that you received are covered by the plan.
- **Providing payment for treatment and services** – For example, the Plan or BCI may send your doctor a payment with an explanation of how the amount paid was determined.

- **Pre-certifying or pre-authorizing health care services** – For example, the Plan or BCI may consider a request from you or your physician to verify coverage for a specific hospital admission or surgical procedure.
- **Subrogating health claim benefits for which a third party is liable** – For example, the Plan or BCI may exchange information about an accidental injury with your attorney who is pursuing reimbursement from another party.
- **Coordinating benefits with other plans under which you have health coverage** – For example, the Plan or BCI may disclose information about your plan benefits related to a specific claim to another group health plan in which you or a dependent may participate.
- **Obtaining payment under a contract of reinsurance** – For example, if the total amount of your claim(s) exceeds a certain amount the Plan or BCI may disclose the necessary information about your claim(s) to our stop-loss insurance carrier.

Health Care Operations. The Plan or BCI may also use and disclose your medical information in their everyday health care operations. This may include, but is not limited to the following actions:

- **Case management and care coordination** – For example, a case manager may contact home health agencies to determine whether they may be of assistance in providing you with services that you need, or may contact you or a provider regarding treatment alternatives.
- **Conducting quality assessment and improvement activities** – For example, a contracted third party auditor may review your data while performing a claim audit. All third parties who have access to the PHI maintained by the Plan or BCI will be contractually obligated to uphold the Plan’s high privacy standards.
- **Employee training** – For example, the Plan or BCI may need to demonstrate the processing of claims for health benefits for a new employee. Generally, generic data will be used, but in some cases, it may be necessary to train the employee using actual data while under close supervision.
- **Contracting for reinsurance** – For example, your PHI (such as age and sex) may be disclosed to carriers of stop loss insurance to obtain premium quotes.

- **Reporting to Trustees** – For example, the Plan or BCI may disclose information to the Board of Trustees of the Plumbers and Fitters Local No. 101 Health and Welfare Fund, acting as Plan Sponsor, for reviewing and making determinations regarding an appeal or for monitoring benefit claims or analyzing benefit structure and claim experience including those that may or do involve stop-loss insurance.

The Plan's Disclosure of PHI to the Trustees

In the course of business practices, the Plan or BCI may disclose information to Board of Trustees of the Plumbers and Fitters Local No. 101 Health and Welfare Fund, acting as Plan Sponsor, for reviewing and making determinations regarding an appeal or for monitoring benefit claims or analyzing benefit structure and claim experience including those that may or do involve stop-loss insurance. Generally, the Plan or BCI will disclose PHI to the Plan Sponsor only if necessary for Plan operations. With respect to PHI, the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the plan documents or as required by law;
- Ensure that any agents, including subcontractors, to whom it provides PHI received from Health Plan agree to the same restrictions and conditions that apply to Plan Sponsor with respect to such information;
- Not use or disclose PHI for employment-related actions and decisions;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of Plan Sponsor;
- Report to Health Plan's designee any PHI use or disclosure that it becomes aware of which is inconsistent with the uses or disclosures provided for;
- Make PHI available to an individual based on HIPAA access requirements;
- Make PHI available for amendment and incorporate any PHI amendments based on HIPAA amendment requirements;
- Make available the information required to provide an accounting of disclosures;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Health Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Health Plan's compliance with HIPAA;
- Ensure that the adequate separation between the group health plan and the

plan sponsor is established as required by HIPAA (45 CFR 164.504(f)(2)(iii)); and

- If feasible, return or destroy all PHI received from the Health Plan that Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the specified disclosure purpose. If return or destruction is not feasible, Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction infeasible.

The Plan Sponsor agrees to the preceding protections with respect to electronic PHI (ePHI) and also to:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan.
- Ensure "adequate separation" supported by reasonable and appropriate security measures. "Adequate separation" means the Plan Sponsor will use ePHI only for Plan administration activities and not for employment-related actions or for any purpose unrelated to Plan administration. Any employee or fiduciary of the Plan or Plan Sponsor who uses or discloses ePHI in violation of the Plan's security or privacy policies and procedures shall be subject to the Plan's disciplinary procedure.
- Ensure that any agent or subcontractor to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information.
- Report to the Plan Security Officer any Security Incident of which it becomes aware.

Limitation on Staff with Access to PHI

Adequate separation between the Plan, BCI and the Plan Sponsor will be maintained. Therefore, in accordance with HIPAA, only the following employees may be given access to PHI: The Plan Privacy Officer and their designated staff (which includes employees of the Fund and BCI).

The persons described above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If the persons described above do not comply with this Summary Plan Description, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

The Plan designates that its health care components that are covered by the privacy rules include only health benefits and not other plan functions or benefits (such as pension benefits).

Additional Uses and Disclosures

In addition to the general uses and disclosures of your information mentioned above, there may be some more specific and extremely rare situations when it is necessary, and permissible, for the Plan or BCI to use or disclose of your medical information without your permission. Examples include, but are not limited to:

- **As Required by Law** – The Plan or BCI may use or disclose PHI to the extent that such use or disclosure is required by law and complies with and is limited to the relevant requirements of such law. The covered entity also must comply with other requirements, including notifying the individual of such disclosure except as otherwise provided.
- **For Public Health Activities** – Where disclosures are necessary for public health activities, the Plan or BCI may disclose to certain designated agencies, authorities and organizations.
- **About Victims of Abuse, Neglect, or Domestic Violence** – The Plan or BCI may disclose PHI about an individual whom the covered entity reasonably believes to be a victim of abuse, neglect or domestic violence to an appropriate government authority.
- **For Health Oversight Activities** – A health oversight agency may receive PHI for designated oversight activities.
- **For Judicial and Administrative Proceedings** – The Plan or BCI may disclose PHI in the course of any judicial or administrative proceeding; in response to an order of a court or administrative tribunal, provided only that PHI expressly authorized is disclosed; or in response to a subpoena, discovery request or other lawful process if certain specific requirements are met.
- **For Law Enforcement Purposes** – The Privacy Standards prescribe several specific circumstances of appropriate disclosure for law enforcement purposes, including: pursuant to legal process and as otherwise required by law; for identification and location purposes, as long as no more than the specified limited information is released; for identification of a victim of a crime if certain protective requirements are met; about decedents; to report crime on the covered entity’s premises; and to report crime in emergencies. Again, disclosure is appropriate only in the specific situations described in the Privacy Standards and only after the specific requirements are met.

- **About Decedents** – Certain disclosures may be made to coroners, medical examiners and funeral directors related to deceased individuals.
- **For Cadaveric Organ, Eye or Tissue Donation Purposes** – The Plan or BCI may use or disclose PHI to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of cadaveric organs, eyes or tissue for donation and transplantation purposes.
- **For Research Purposes** – Certain limited uses and disclosures of PHI may occur for academic research purposes. Research falling under the auspices of general data analysis is not affected by this requirement.
- **To Avert a Serious Threat to Health or Safety** – The Plan or BCI may disclose limited PHI, consistent with applicable laws and standards of ethical conduct, if the covered entity, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to health or safety. Further, such disclosure must be to a person reasonably able to appropriately act or must be necessary for law enforcement authorities to identify or apprehend an individual.
- **For Specialized Government Functions** – The Privacy Standards recognize the need for special disclosure rules for certain military and veterans’ activities, national security and intelligence activity, protective services for the President and others, medical suitability determinations, correctional institutions and other law enforcement custodial situations and covered entities that are government programs providing public benefits.

Your Rights

The federal law (HIPAA) that protects the privacy of your health information provides you with several individual rights. It is important to recognize that the majority of PHI in the possession of the Plan or BCI is contained in copies of records owned by the covered entity that provided the information. Therefore, to invoke some of the following rights you may need to contact the owner of the records. For more details on the processes to follow in order to invoke these rights, please contact the Plan Privacy Officer.

- You have the right to have a copy of this notice of privacy practices. Additional copies can be obtained by contacting the Plan Privacy Officer.
- You have the right to inspect and copy information in the permanent health care record that the Plan maintains.
- You may also request changes to the information contained in your record, which the Plan may approve or deny.

- You have the right to request that restrictions be placed on the use and disclosure of your health information. Once again, the Plan may approve or deny this request.
- You also have the right to receive a list of the uses and disclosures of your health information made by the Plan. Certain limitations may apply.

You have the right to receive communications from the Plan regarding your health information in a confidential manner.

Complaints

If you believe that your privacy rights have been violated, you may complain to the organization you believe is at fault. You may also complain to the Department of Health and Human Services, though they have advised that initial complaints should be handled internally and they should be contacted only as a last resort. You are protected from retaliation for any and all complaints you make. For additional information on the complaints process or for any questions related to this document, contact the Plan at:

Plumbers and Fitters Local No. 101 Health and Welfare Fund
Attn: Privacy Officer
137 Iowa Avenue
Belleville, IL 62220
Ph. (618) 234-5504

GENERAL PROVISIONS

A. Actions at Law

No legal action may be brought to recover on this Plan prior to the last day after proof of expenses incurred has been filed and the Plan's appeals process has been exhausted. Further, no lawsuit may be brought more than two years from the date the claimant is notified in writing of the Trustees' decision with respect to the appeal or claim.

B. Payment of Benefits

All benefits are payable when the **plan administrator** receives written proof of loss. All benefits will be automatically assigned to the provider, absent proof of payment.

C. Workers' Compensation

This Plan and the benefits provided are not in lieu of and will not affect any requirements for coverage under any workers' compensation law or other similar law.

D. Facility of Payment

If a claimant is a minor or is physically or mentally incapable of giving a valid release for payment, the **plan administrator**, at its option, may make payment to a party who has assumed responsibility for the care of such person. Such payments will be made until claim is made by a guardian. If a claimant dies while benefits remain unpaid, benefits will be paid, at the **plan administrator's** option to:

1. a person or institution on whose charges claim is based; or
2. a surviving relative (spouse, parent or **child**).

Such payment will release the **plan administrator** of all further liability to the extent of payment.

E. Assignment

Benefits payable are automatically paid directly to the provider, unless you submit proof of payment. Any such payment will discharge the **plan administrator** to the extent of payment made. Unless permitted by law, payments may not be attached, or be subject to your debts.

This Plan will also honor any assignment of rights made by **you** or on your behalf or on behalf of your beneficiary as required by Medicaid, that is, a state plan for medical assistance approved under Title XIX of the Social Security Act. In addition, to the extent that Medicaid makes payments which this Plan has a legal liability to make, this Plan will reimburse Medicaid for those payments, but only to the extent it is required to do so by law.

F. Records

The **plan administrator** will keep records for **you** and your **dependents**. Such records will include the following:

1. **You** and **your dependents** by name, age and amount of coverage;
2. Effective date of coverage and date coverage ends;
3. Change of status; and
4. Other related data.

G. Examination

The **plan administrator** has the right to have the claimant examined as often as reasonably necessary while a claim is pending. Medical benefits are payable under this Plan only if they are **medically necessary** for **you** or **your dependent's illness** or **accidental injury**. This Plan reserves the right to make a utilization review to determine whether services are **medically necessary** for **you** or **your dependent's** proper treatment. All such information will be confidential.

H. Notice of Payment Due

If the **plan administrator** cannot locate any person to whom a payment is due, after three (3) months from the date such payment is due, a notice of payment due will be mailed to the last known address of that person. If within three (3) months after that mailing, such person has not made written claim, the **plan administrator** may direct that such payment and all remaining payments otherwise due to such person be canceled. The plan will have no further liability upon such cancellation.

J. Free Choice of Physician

The HMO and PPO physicians and other providers who are members of the plan's managed care networks are qualified medical professionals, however neither the plan nor managed care organization is responsible for damages caused by provider acts or failures to act. Accordingly, **you** and your

dependents will have free choice of any legally qualified physician or surgeon and the physician/patient relationship shall be maintained with any provider chosen.

K. Waiver or Estoppel

No term, condition or provision of the Plan will be deemed to have been waived, and there will be no estoppel against the enforcement of any provision of the Plan, except by written instrument of the party charged with such waiver or estoppel. No such waiver will be deemed a continuing waiver unless specifically stated. Each waiver will operate only as to the specific term or condition waived and will not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

L. Responsibility for Payment of Claims

The Plan will be the sole source of benefits under the Plan, and to the maximum extent permitted by law, the Fund Administrator assumes no liability or responsibility for payment of benefit, and each person covered under the Plan or other person who will claim the right to any payment with respect to benefits under the Plan will be entitled to look only to the Plan for such payment and will not have any right, claim or demand therefore against the Fund Administrator or the Trustees.

M. Construction

Wherever found in this Plan, a masculine pronoun includes the feminine pronoun and vice versa.

N. Headings

Section and paragraph headings appearing throughout this document are provided for the convenience of the reader and should be used for reference only. Such headings are not part of the substantive text and do not modify any provision thereof.

Plumbers and Fitters Local No. 101 Health and Welfare Fund Summary of Material Modifications

July 2009

The Trustees of the Health and Welfare Fund have recently approved the addition of smoking cessation benefits as described below. This notice also includes a reminder about the Plan's mastectomy related benefits, which is required by law. (There have been no mastectomy benefit changes.)

Please keep this notice with your Summary Plan Description for future reference.

Smoking Cessation Benefits

Beginning January 1, 2009, the Plan will pay charges for the following smoking cessation treatment charges for participants and spouses (no dependent children):

- Auriculotherapy, upon prior notice to Benefit Consultants. Covered expenses for auriculotherapy are not subject to the medical calendar year deductible and will be payable at 100% up to the smoking cessation maximum benefit. No benefits will be payable for auriculotherapy if the claim administrator is not notified prior to receiving treatment.
- Prescription and over-the-counter smoking cessation medications, subject to the applicable pharmacy co-payment (the generic co-payment will apply to over-the-counter products).

All benefits for smoking cessation treatment are limited to a maximum of \$250 per calendar year and \$500 lifetime for each eligible individual, which will apply to all smoking cessation charges for auriculotherapy and medications covered under the Plan's prescription drug benefits combined.

Women's Health and Cancer Rights Act—Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

Call Benefit Consultants at 1-800-434-4620 for more information about the information contained in this notice or any of your benefits under the Plan.

SUMMARY MATERIAL MODIFICATION & NOTICE TO PARTICIPANTS IN THE PLUMBERS AND FITTERS LOCAL 101 HEALTH & WELFARE PLAN

April 2009

You are receiving this notice as a participant in the Plumbers and Fitters Local 101 Health & Welfare Plan (“Plan”) concerning recent changes to the plan, including an update to the Plan’s rules for reinstatement of coverage following termination and a notice of your rights under the federal Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA).

REINSTATEMENT OF COVERAGE FOR CLASS 1 (BARGAINING UNIT) EMPLOYEES

The Plan previously required employees whose coverage had terminated, to work at least 300 hours in covered employment in a single calendar quarter within 18 months of your termination date, in order for coverage to be reinstated on the first day of the second following calendar quarter. (For example, if you worked 300 hours in January, February and March, your coverage would be reinstated on July 1).

If your coverage terminates due to lack of hours you may still qualify for reinstatement under the previous rule, however beginning with hours worked on or after January 1, 2009, the Plan offers an alternative means to reinstatement—your coverage will also be reinstated if you meet the requirement for initial eligibility by completing 500 hours of work in covered employment within a 12-month period after the date your coverage terminates. Your eligibility will be determined in the same way as initial eligibility:

- If you become eligible on the first day of a quarter (i.e., January 1, April 1, July 1 or October 1), you will remain eligible for that entire quarter;
- If you become eligible on any other date, you will remain eligible for the remainder of the quarter in which you become eligible as well as for the entire next quarter.

CHILDREN’S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA)

Effective April 1, 2009, CHIPRA provides special enrollment rights in the event of loss of eligibility under Medicare or the Children Health Insurance Program of any of the states and the potential eligibility for premium assistance in those states which have adopted a program compliant with CHIPRA.

1. Enrollment Rights due to loss of eligibility for SCHIP or Medicaid. Eligible participants (which may include dependents of participants) who are not enrolled in the Plan have the right to enroll in the Plan for coverage in the event the eligible participant’s enrollment in a State Children’s Health Insurance Program (under Title XXI of the Social Security Act) (“SCHIP”) or as an enrollee in Medicaid is terminated due to a loss of eligibility (except failure to pay premiums, or fraud).

- a. In the event of the loss of enrollment in either program, an eligible participant (which may include dependents of eligible participants) must request coverage in the Plan within sixty (60) days of the loss of eligibility.
 - b. In that event, the eligible participant shall notify the Plan Administrator in writing (as indicated below) of their interest in enrollment, provide proof of loss of eligibility and provide the necessary information to complete enrollment within 31 days of requesting coverage.
2. Enrollment Rights due to eligibility for premium subsidy under CHIPRA. As of January 1, 2009, most states have implemented some form of premium assistance subsidy program under Medicaid or SCHIP. In the event that a participant in one the states offering premium assistance subsidies becomes eligible for premium assistance through that state's SCHIP or Medicare, that eligible participant shall have sixty (60) days to notify the Plan Administrator in writing (as indicated below) of their interest in enrollment, provide proof of eligibility and provide the necessary information to complete enrollment within 31 days of requesting coverage.

The specific provisions of each state's premium assistance vary and the Plan makes no representations about the rules of eligibility or the benefits provided by each program. The determination for program eligibility is exclusively by the appropriate state.

In the event that an eligible participant requires information about the Plan and/or its benefits to assist the state agency in determining eligibility for premium assistance, the Plan will provide the necessary information upon receipt of a written request for information, which shall be in the form specified by the Plan Administrator, and shall include the specific information requested by the state agency, and contact information for delivery of the information.

Plan Administrator: For further information contact the Fund Office of the Plumbers and Fitters Local 101 Health & Welfare Plan, 137 Iowa Avenue, Belleville, IL 62220, or 618-234-5504.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, contact the Plan Administrator or the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or EBSA's website www.dol.gov/ebsa.

Plumbers and Fitters Local No. 101 Health and Welfare Fund Summary of Material Modifications

The Plumbers and Fitters Local No. 101 plan has been amended by making the following changes to the Plan effective January 1, 2009.

Wellness Care Maximum

The Plan's "wellness care" benefit, as shown in the Schedule of Benefits and under Covered Medical Expenses, is increased to \$300 per calendar year for each covered person up to age 50. Expenses for well-child and HPV immunizations are not included in the maximum benefit.

As of January 1, 2008, expenses for well-child immunizations will be limited to a lifetime maximum benefit of \$750 for each covered person.

Benefits for Hospitalization and/or Anesthesia in Connection with Non-Covered Dental Services

If general anesthesia and/or inpatient or outpatient hospital confinement is medically necessary for children under nine years of age in connection with dental services that are not covered under the medical benefits of the Plan, expenses for such anesthesia and/or hospital expenses are covered. Hospitalization and/or anesthesia for custodial purposes or patient convenience are not covered.

Reminder—No Coverage for Non-Network Surgery Centers

The Trustees would like to clarify that charges for services and supplies provided by a non-network outpatient surgery center or rendered by a non-network provider in a non-network outpatient surgery center are excluded from coverage by the Plan.

If you have any questions about any of the Plan changes described in this notice or any of your eligibility and benefits under the Plan, please contact the Fund Office at 618-234-5504 or Benefit Consultants at 1-800-434-4620.

Plumbers and Fitters Local No. 101 Health and Welfare Fund

Summary of Material Modifications

May 2008

The following is a summary of recent changes to the Plan as well as a required notice reminding you about the Plan's mastectomy benefits.

Calendar Year Maximum Infertility Benefit

The Plan's calendar year maximum benefit for infertility treatment has been increased to \$5,000 (the lifetime maximum will remain at \$10,000).

Fertility Drugs

Fertility drugs will no longer be excluded under the Plan's prescription drug card program. Charges for covered drugs will not be subject to the medical benefit calendar year or lifetime infertility treatment limits.

Coordination of Medical and Dental Benefits Under the Plan

Effective June 1, 2008, if the Plan covers a dental service under both its medical benefits and its dental benefits, the following will apply.

If the dentist or oral surgeon who provides the services participates in the Plan's HMO or PPO network and the service is covered under the Plan's medical benefits, the expense will be paid under the Plan's medical benefits only. If the dentist or oral surgeon does not participate in the Plan's HMO or PPO network and the service is covered under the dental benefit provision, the expense will be paid under the Plan's dental benefits only.

Claims Procedures for Death Benefits or Disability Extension of Benefits

In order to receive death benefits, you must notify Benefit Consultants and provide a copy of the death certificate. Payment will be made directly to you or your designated beneficiary.

For extension of benefits due to disability, you must contact Benefit Consultants for a claim form, which should be completed and returned to Benefit Consultants with proof of disability.

Mastectomy Benefits Reminder

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Benefit Consultants at the number shown below for more information.

Plumbers and Fitters Local No. 101 Health and Welfare Fund

Summary of Material Modifications

December 2007

The Trustees of the Health and Welfare Fund have approved the following Plan changes. Please keep this document with your Summary Plan Description (SPD) for future reference.

- A. Subsidized Continuation Coverage for Disabled Participants (on page 29 of your SPD) has been amended effective January 1, 2006 to clarify the use of banked hours for continued eligibility while a participant is disabled:

Disabled Participants

If **you** are totally disabled, your coverage and that of your **eligible dependents** may be continued as provided below. "Total Disability" for purposes of this continuation of coverage section means the inability due to **illness** or **injury** to perform the duties of your job.

Coverage may only be continued under this provision for eligible persons who are not covered under another group health plan or entitled to Medicare. If such other coverage terminates due to your spouse's termination of employment or retirement during the maximum coverage periods described below, your coverage and that of **your dependents** may be reinstated with no **preexisting condition** limitations.

The duration of time **you** may continue coverage under this provision and the amount **you** will be required to pay, are determined by the number of hours of **covered employment you** have attained.

- If **you** have less than 10,000 hours, **you** may continue coverage under this Plan for yourself and **your dependents** for a period of 29 months. Any banked hours **you** have will be used to provide continued coverage (see "Hour Bank" on pages 10-11). If **you** have no banked hours or if your banked hours become exhausted, **you** may continue coverage for yourself and **your dependents** for the remainder of the 29-month period by paying the Plan's full COBRA rate.
- If **you** have at least 10,000 hours, but less than 20,000 hours, **you** may continue coverage under this Plan for yourself and **your dependents** for a period of 29 months. Any banked hours **you** have will be used to provide continued coverage (see "Hour Bank" on pages 10-11). If **you** have no banked hours or if your banked hours become exhausted, **you** may continue coverage under this Plan for yourself and **your dependents** for the remainder of the 29-month period by paying a monthly premium equal to one-half of the Plan's COBRA rate.
- If **you** have 20,000 or more hours, coverage for **you** and your **eligible dependents** will be continued at no cost to **you** for 29 months. At the expiration of this 29-month period, any banked hours **you** have will be used to provide continued coverage for **your dependents** (see "Hour Bank" on pages 10-11). If you have no banked hours or if your banked hours become exhausted, **your dependents** may continue coverage by paying a monthly premium equal to one-half of the Plan's COBRA rate during the next 36 months and the full COBRA rate thereafter.

- B.** Continuation coverage for surviving dependents of deceased participants (SPD pages 30-31) has been amended effective January 1, 2008. The new subsection reads as follows:

Survivors of Deceased Participants

Surviving eligible **dependents** of deceased active participants may be entitled to continue their coverage under the Plan beyond the 36-month COBRA Continuation Coverage period by paying the full monthly COBRA premium rate. In order to be eligible for continued coverage under this provision, the following qualifications must be met:

- a. The surviving **dependents** are not covered under another group health plan or entitled to Medicare. If such other coverage terminates due to termination of employment or retirement, coverage may be reinstated with no **preexisting condition limitations**.
- b. The deceased participant must have attained 20,000 or more hours in **covered employment**. Surviving **dependents** of participants with less than 20,000 hours will be entitled to 36 months of Continuation Coverage at the full COBRA rate as provided above.

Coverage under this provision will terminate upon remarriage of the surviving spouse. If the surviving spouse remarries within the first 36 months of Continuation Coverage, however, coverage may be continued for the remainder of the 36-month period allowed under COBRA by paying its full monthly premium rates.

- C.** Effective January 1, 2007, the Plan has removed the hospitalization requirement for coverage of pharmaceuticals and their administration in connection with organ transplants. The first full paragraph on page 53 of your SPD has been revised to read:

Organ Transplant Expenses include: pre-transplant testing and consultation; all services and supplies required for the transplant procedure; postoperative care in the **hospital** (inpatient or outpatient); extended care in a facility or at home; pharmaceuticals and their administration, including but not limited to high-dose chemotherapy and anti-rejection drugs; **durable medical equipment**; and, to the extent specified above, donor expenses.

If you have any questions about any of the Plan changes described in this notice or any of your eligibility and benefits under the Plan, please contact the Fund Office at 618-234-5504 or Benefit Consultants at 1-800-434-4620.