Plumbers' Welfare Fund
Local 130, U. A.

Plan Document &
Summary Plan Description

June 1, 2020

TABLE OF CONTENTS

INTRODUCTION

The Trustees of Plumbers' Welfare Fund, Local 130 U.A. are pleased to furnish you with this new combination Plan Document and Summary Plan Description ("Plan/SPD") that explains the benefits available under the Welfare Fund, summarizes the eligibility rules for participation in the Fund, and presents your rights as a Participant. You should take time to read this new Plan/SPD so that you are up to date on the benefits available to you under the Plan. Please note that coverage under the Plan is in no way a guarantee of continued employment with your Employer. This Plan/SPD describes the benefits available to Employees and their eligible Dependents and replaces the prior plan document summary plan description for the Plan. A separate plan document and summary plan description describe the benefits available to retirees.

Immediately following this brief introduction, this Plan/SPD sets out a Schedule of Benefits which will give you a quick reference to the health and welfare benefits provided to you and your eligible Dependents. In most cases, terms that are capitalized are defined either in the Definitions section of this Plan/SPD or in the applicable section where such terms are used.

The Trustees - one-half of whom represent Union plumbing contractors and one-half of whom represent Plumbers', Local 130, U.A. - believe that your Plan provides you and your eligible family members with one of the best and most comprehensive health and welfare plans in the construction industry. It is intended that this Plan/SPD be written so that you can understand how you and your family members become eligible for benefit coverage, how you remain eligible for benefit coverage, and what health and welfare benefits are available to you and your eligible family members. Do not hesitate to contact the Fund Office if you ever have any questions concerning your eligibility for coverage or the benefits to which you are entitled. The personnel in the Fund Office are there to help you.

Sincerely,

The Board of Trustees

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PLUMBERS' WELFARE FUND, LOCAL 130, U. A.

June 1, 2020

Administrative Offices
Third Floor
Stephen M. Bailey Auditorium
1340 West Washington Boulevard
Chicago, Illinois 60607
312-226-5000
FAX 312-226-7285
Website: plumberslu130ua.org

Hours:
7:30 a.m. to 4:30 p.m. Monday through Friday
7:30 a.m. to 7:00 p.m. (2nd Tuesday of each month)
7:30 a.m. to 8:00 p.m. (4th Thursday of each month)

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PLUMBERS' WELFARE FUND, LOCAL 130, U. A.
SCHEDULE OF BENEFITS

PARTICIPANT DEATH, ACCIDENT AND DISABILITY BENEFITS	
PLAN COVERAGE	**BENEFIT AMOUNT**
Death Benefit	$100,000.00 to designated beneficiary of eligible Participant. If there is no designated beneficiary, the death benefit will be paid to the surviving spouse, descendants, or estate of decedent. Death benefit subject to possible off-set of $2,000.00 to be applied to funeral expenses. Divorce revokes designation of spouse as beneficiary.
Accidental Dismemberment Benefit Payable for loss of (1) both hands or both feet, (2) loss of sight of both eyes, (3) loss of 1 hand and 1 foot, (4) loss of 1 hand and sight of 1 eye, and (5) loss of 1 foot and sight of 1 eye.	$20,000.00 Principal Sum.
Payable for loss of (1) 1 hand or 1 foot, or (2) loss of sight of 1 eye.	$10,000.00 Principal Sum.
Weekly Sickness or Accident Benefit Payable from first day of accident or eighth day of Sickness	$400.00 per week (reduced by applicable taxes); Maximum 52 weeks.
Military Service Benefit Payable if a Participant is required to leave covered employment to serve in the Armed Forces or Reserves for a period of 30 days or more	$300 per week (reduced by applicable taxes); Maximum 52 weeks.
PARTICIPANT AND DEPENDENT MEDICAL COVERAGE COST SHARING	
Calendar Year Deductible	$200 for single coverage and $600 for family coverage. **Benefits noted by an asterisk (*) are not subject to the calendar year deductible.** Dental benefits are subject to a separate deductible.
Copayments	$150 copayment for each emergency room visit. This amount does not count toward your deductible but does count against your Out of Pocket Maximum.
Calendar Year Out of Pocket Maximum	$1,500 for individual coverage and $3,000 for coverage other than self-only coverage (e.g., family coverage). **Out-of-network benefits do not count toward the out of pocket maximum.**

PLAN COVERAGE	BENEFIT AMOUNT
Limitations on Benefits	The Plan only recognizes medical services and supplies that are Reasonable and Customary Charges. Note: All out-of-network claims must be submitted to the Fund Office for pre-certification. Failure to pre-certify out-of-network claims (other than for emergency room care) will result in denial of the claim.
MEDICAL BENEFITS WHEN HOSPITALIZED	
Room and Board* Room and board in an intensive care unit, semi-private or private room including Mental Health and Substance Abuse benefits).	The Plan covers 100% of the Reasonable and Customary Room and Board charges of a PPO Hospital or Facility. The Plan will pay 70% of the Reasonable and Customary Fees or Charges for covered Room and Board expenses provided by a non-network provider.
Inpatient Hospitalization Services Necessary services and supplies not included in the Hospital Room and Board charge plus medical charges of a radiologist, oncologist, hematologist, neonatologist, anesthesiologist, and pathologist incurred during the period of room and board.	After the Deductible is applied, the Plan covers 100% of the first $2,000.00 plus 90% of all amounts exceeding $2,000 in a PPO Hospital or Facility. The Plan will pay 70% of the Reasonable and Customary Fees or Charges for covered expenses provided by a non-network provider.
Pre-admission Hospital Testing* Pre-admission hospital testing consists of required tests performed prior to hospitalization.	Paid in full if the tests are included on the Plan's schedule of such tests in section 5.6, and the tests are accepted by the Hospital instead of its own inpatient tests.
Attending Physician/Medical Consultants	After the Deductible is applied, the Plan covers 100% of the first $2,000.00 plus 90% of all amounts exceeding $2,000 from a PPO Provider. The Plan will pay 70% of the Reasonable and Customary Fees or Charges for covered expenses provided by a non-network provider. For Medical Consultants, a maximum of three (3) consultations per period of covered hospitalization.
Residential Treatment Center Confinements (including Mental Health and Substance Abuse benefits)	After the Deductible is applied, the Plan covers 100% of the first $2,000.00 plus 90% of all amounts exceeding $2,000 in an in-network eligible Residential Treatment Center. The Plan will pay 70% of the Reasonable and Customary Fees or Charges for covered expenses provided by a non-network provider.
Blood Transfusions*	Paid in full, even if the transfusion is not received in a Hospital.

PLAN COVERAGE	BENEFIT AMOUNT
Anesthesia	After the Deductible is applied, the Plan covers 100% of first $2,000.00, plus 90% of a PPO Facility or a PPO Provider exceeding $2,000.00. The Plan will pay 70% of the Reasonable and Customary Fees or Charges for covered expenses provided by a non-network provider.
Emergency Room Care Emergency Services for an Emergency Medical Condition provided in a Hospital emergency room.	You pay a $150.00 copayment and the Plan pays 80% of the Reasonable and Customary Fees or Charges in excess of $1,000 for Emergency Medical Services received in both a PPO Hospital and non-network Hospital.
SURGICAL BENEFITS (SUBJECT TO DEDUCTIBLE)	
Primary Surgeon's Charges	The Plan covers 100% of the Reasonable and Customary Charge in the Chicago area established by the prevailing surgical fee schedule utilized by the Fund. The Plan will pay 70% of the Reasonable and Customary Fees or Charges for covered expenses provided by a non-network provider.
Assistant Surgeon's Charges	The Plan pays Assistant Surgeon charges up to 20% of the Reasonable and Customary Charge of the PPO Surgeon's charges. The Plan pays 70% of the 20% of the Reasonable and Customary Charge of the non-network Primary Surgeon's charges. Paid only for procedures for which the use of an Assistant Surgeon is Medically Necessary.
Second or Third Surgical Opinion	The Plan covers 100% of the Reasonable and Customary Charge of a PPO Surgeon for non-emergency surgery. The Plan will pay 70% of the Reasonable and Customary Fees or Charges for covered expenses provided by a non-network provider.
Skin Removal following Gastric Bypass	The Plan covers panniculectomy surgery to remove excess skin following significant weight loss for a Participant who has reached a BMI of 30 or less and maintained a stable weight for at least six months. The Fund also covers panniculectomy surgery due to a functional impairment or infection. The Plan pays as an inpatient hospitalization and will cover 100% of the charges for the first $2,000.00 plus 90% of all amounts exceeding $2,000.00 in a PPO Hospital or Facility. The Plan pays 70% of the Reasonable and Customary Fees or Charges for covered expenses provided by a non-network provider.

PLAN COVERAGE	BENEFIT AMOUNT
Organ Transplants	The Plan does not cover organ transplants unless a Trustees' pre-certification of coverage is obtained before the surgery (except for non-experimental emergency procedures). See the explanation section on Organ Transplants. If pre-certification is obtained, applicable Plan benefits are provided for Hospital, medical, surgical, prescription drugs, rehabilitation, and other relevant medical services received within five (5) days before and twelve (12) months following the transplant surgery.
MATERNITY BENEFITS **Note: Payable only if mother is an Employee or spouse of an Employee**	
Hospital and Obstetrical	After the Deductible is applied, the Plan covers 100% of Room and Board and 100% of the first $2,000.00 plus 90% of all other amounts exceeding $2,000 in a PPO Hospital or Facility (excluding the Room and Board charges). The Plan will pay 70% of the Reasonable and Customary Fees or Charges for covered expenses provided by a non-network provider. The charges include the inpatient services provided by a certified nurse midwife who is licensed to practice by the state.
Pre-natal and Post-natal Care Includes inpatient lab work and ultrasounds and related Doctor visits.	After the Deductible is applied, the Plan covers 100% of first $1,000.00, plus 80% of the Reasonable and Customary Charges or Fees of an in-network provider exceeding $1,000.00. The Plan will pay 70% of the Reasonable and Customary Fees or Charges for covered expenses provided by a non-network provider.
Hospital Nursery Care*	After the Deductible is applied, the Plan covers 100% of the first $2,000.00 plus 90% of all amounts exceeding $2,000.00 in a PPO Hospital or Facility. The Plan will pay 70% of the Reasonable and Customary Fees or Charges for covered expenses provided by a non-network provider. Certain benefits may be paid at 100% under the well-baby benefit.
Newborn Baby Care*	The Plan covers 100% of covered services from a PPO Hospital or Facility. The Plan will pay 70% of the Reasonable and Customary Fees or Charges for covered expenses provided by a non-network provider.

OUTPATIENT BENEFITS	
PLAN COVERAGE	**BENEFIT AMOUNT**
Outpatient Major Medical Care (including Mental Health and Substance Abuse benefits) Includes office visits (including telehealth visits), imaging, and other diagnostic tests not otherwise covered elsewhere under the Plan.	After the Deductible is applied, the Plan covers 100% of the first $1,000 and 80% of the Reasonable and Customary Charges of a PPO provider exceeding the first $1,000. The Plan pays 100% of any PPO Physician or Surgeon fee related to the outpatient surgery. The Plan will pay 70% of the Reasonable and Customary Fees or Charges for covered expenses provided by a non-network provider.
Home Health Care	After the Deductible is applied, the Plan covers 100% of the first $1,000.00, plus 80% of the Reasonable and Customary Charges or Fees of a PPO Provider exceeding $1,000.00 for a maximum of 365 days less the number of days the patient was in a Hospital for the same sickness or injury. The Plan will pay 70% of the Reasonable and Customary Charges or Fees of a non-network provider.
Preventive Services and Wellness Services*	100% of the Reasonable and Customary Charges or Fees of a PPO provider (or 70% of the Reasonable and Customary Charges or Fees of a non-PPO provider) for preventive health services, Wellness Medical Benefits and 100% of the cost for routine immunizations and vaccinations in accordance with the requirements of the Patient Protection and Affordable Care Act ("PPACA") and its implementing guidance.
Infertility Treatment Benefits* Medically Necessary services and procedures for assisted reproductive technologies rendered in connection with the treatment of Infertility.	The Plan will pay 80% of the Reasonable and Customary Charges or Fees of a PPO provider (or 70% of the Reasonable and Customary Charges or Fees of a non-PPO provider) for assisted reproductive technologies for no more than two attempts to achieve conception The Plan limits treatments to $20,000 per lifetime to the extent such services are not considered to be essential health benefits under PPACA.
Durable Medical Equipment and Prosthetic Devices	The Plan pays for 100% of the first $1,000.00 plus 80% of the Reasonable and Customary Charges or Fees of a PPO provider exceeding $1,000.00, but if the cost of any equipment or device exceeds $1,500.00, the acquisition must be approved in advance by the Trustees (or the Plan's Medical Advisor). The Plan will pay 70% of the Reasonable and Customary Charges or Fees of a non-network provider.

PLAN COVERAGE	BENEFIT AMOUNT
Anesthesia (including dental services)	After the Deductible is applied, the Plan covers 100% of the first $1,000.00, plus 80% of a PPO Facility or a PPO Provider exceeding $1,000.00. The Plan will pay 70% of the Reasonable and Customary Fees or Charges for covered expenses provided by a non-network provider (except out-of-network dental anesthesia, which is covered at 80% after the first $1,000.00).
PLUMBERS WELFARE FUND, LOCAL 130 WELLNESS AND VISION CENTER BENEFITS	
Wellness Center Benefits	The Plan pays 100% of Wellness Center Benefits.
Vision Center Benefits	The Plan pays up to $40 or a general eye examination, $40 for contact lens fitting and follow-up exam and $350 for prescription glasses, frames, and lenses. Additional incentives may apply if you use the Plumbers' Vision Center. Please contact the Fund Office.
Motion Center Benefits	The Plan covers a musculoskeletal screening that can help you identify, address, and improve movement dysfunctions.
PRESCRIPTION DRUGS*	
100% of Reasonable and Customary cost for up to a 34 day retail supply less the applicable co-payments as follows: • $10.00 - for covered generic drugs, • $20.00 - for covered brand name drugs on Express Scripts' formulary, and • $40.00 - for covered brand name drugs not on Express Scripts' formulary. 100% for Express Scripts' Prescription Drug Mail Order Program (3 month supply), less the applicable co-payments as follows: • $ 0.00 - for covered generic drugs, • $10.00 - for covered brand name drugs on Express Scripts' formulary, and • $20.00 - for covered brand name drugs not on Express Scripts' formulary. For prescribed specialty and self-administered injectable drugs (except insulin), 100% of Reasonable and Customary cost less the applicable $20.00 co-payment but only if the drug is acquired from Accredo. There is no coverage for specialty and self-administered drugs that are not acquired from Accredo. Unless otherwise determined by the Trustees to be Medically Necessary, erectile dysfunction medication will be limited to six (6) pills per month.	

DENTAL BENEFITS

The Plan covers up to $4,000.00 per calendar year for dental care unless the participant is under age 19. Participants under age 19 are not subject to the $4,000 annual limit. The dental benefit is subject to a $50.00 per person deductible (except for services provided under Coverage A), with a maximum deductible of $150.00 per family unit. After the deductible is met, the Plan pays up to 100% of the reasonable cost of routine dental oral examinations and 80% of other covered dental services, up to the maximum benefit level of the Plan.

Dental sealants for participants under age 19 are covered at 80% of the reasonable and customary charges. The Plan also pays a separate orthodontic benefit covering 80% of charges up to a maximum lifetime limit of $4,500.00. This is in addition to the annual benefit amount.

The above annual and lifetime dollar limits do not apply to individuals under the age of 19.

EYE CARE*

PLAN COVERAGE	BENEFIT AMOUNT
Eye Examinations	Up to $40.00 per examination by an ophthalmologist or licensed optometrist. Limit one examination in any 12 month period. The above dollar limits do not apply to individuals under the age of 19.
Eyeglasses/Contact Lenses	Up to $350.00 for prescribed corrective eyeglasses and frames and prescribed corrective contact lenses in any 12 month period. Up to $40.00 for a contact fitting. The above dollar limits do not apply to individuals under the age of 19.
Eye Examination and Eye Glasses or Lenses Following Eye Surgery or Traumatic Injury	The Plan's eye care benefits are provided for each medically prescribed lens change during the six months following eye surgery or a traumatic injury. The Plan's PPO Provider is EyeMed. Call 1-866-723-0514 to locate a provider near you.
Lasik or Photo Refractive Keratectomy (PRK) Surgery	Up to $1,000 for Lasik or Photo Refractive Keratectomy (PRK) surgery treatment on both eyes in a lifetime.

HEARING CARE*

Hearing Examinations	Up to $125.00 with a limit of one examination in any 12 month period (except for individuals under age 19 who suffer from degenerative hearing loss). The above limit does not apply to inpatient hearing tests performed on a newborn.
Hearing Aids	Up to $1,500.00 with a limit of one hearing aid instrument in any 60 month period. (Unless Bilateral Hearing aids are determined to be Medically Necessary by the Fund's Medical Advisor, in which case the benefit is $3,000.00.) The above limit does not apply to bone anchored hearing aids.

PLAN COVERAGE	BENEFIT AMOUNT
Hearing Aid Instruments for Individuals Under Age 19	Up to $50.00 for a new molded earpiece, once in each 12 month period, and up to $1,500.00 for a newly prescribed hearing aid instrument once in each 36 month period, or $1,450.00 if an individual received a new molded earpiece within 12 months. The above limits do not apply to bone anchored hearing aids.
HOSPICE CARE*	
The Plan pays 80% of the Reasonable and Customary Charges for inpatient and outpatient covered expenses provided by a PPO Provider up to 180 days per three year period. The Plan will pay 70% of the Reasonable and Customary Fees or Charges for inpatient and outpatient covered expenses provided by a non-network provider.	
EMPLOYEE ASSISTANCE BENEFITS	
Employees who participate in the Plan are eligible to receive certain consultation and referral services provided through the Plan's Employee Assistance Program offered through ERS. For more information, contact the Fund Office or ERS directly at 1-800-292-2780.	
HEALTH REIMBURSEMENT ARRANGEMENT ("HRA")	
Under the HRA you will be able to receive reimbursement for your out-of-pocket medical expenses that you were required to pay due to the deductibles, co-payments, and other dollar limits imposed by the Plan. Participants will accumulate one credit for each hour worked in Covered Employment. The value of the HRA credit may be adjusted from time to time. Contact the Fund Office for the latest credit value. See Article XI of this Plan/SPD for additional details.	

I. MAXIMIZING YOUR PLAN BENEFITS

In order to minimize the costs of providing health benefits under the Plan, the Plan encourages you to take the following steps to maximize your Plan benefits:

- Whenever possible, utilize Hospitals and Physicians who participate in the Blue Cross/Blue Shield Hospital and Physician PPO Network. The discounted charges available through Blue Cross/Blue Shield Affiliated Hospitals and Physicians reduce both your out-of-pocket obligations, if any, and the Fund's costs as well. **If you obtain medical services from a non-PPO medical provider or hospital the Plan will recognize only 70% of the Reasonable and Customary Charges or Fees charged by that provider in circumstances where a PPO provider is available, excepting emergency situations approved by the Trustees. You will be responsible for the remaining 30%, plus amounts over the Reasonable and Customary Charges.**
- If you or any of your Dependents anticipate hospitalization, contact the Fund's Utilization Review Provider, Hines and Associates, at 1-800-944-9401 to receive assistance with your care and treatment plan.
- When Prescription Drug needs arise, fill your prescriptions at Express Scripts Affiliated Pharmacies. Using an Express Scripts Affiliated Pharmacy will reduce your out-of-pocket costs and result in additional savings to the Fund. Call Express Scripts' Mail Order Hotline at 1-800-451-6245 for additional assistance.

- Use providers participating in the EyeMed Discount Eye Care Program (1-866-723-0514). This Program permits you to choose a wide variety of eyeglasses and frames that are paid in full under the Plan's vision benefit.

II. ELIGIBILITY FOR PARTICIPATION

To be eligible for Plan benefits you must qualify as a Participant as described below. As a Participant you and your eligible Dependents are entitled to receive health and welfare benefits as described in this Plan/SPD.

2.1 Eligibility-Present Participants

If you are now a Participant, you will remain one until you fail to meet the minimum requirements described in the "Termination of Eligibility" section below.

2.2 Initial Eligibility-New Employees

If you are working in Covered Employment, you will become a Participant on the first day of the month after you accumulate 300 hours worked in Covered Employment. Upon reaching 300 hours worked, you will be an eligible Participant for the remainder of that Benefit Quarter and the next Benefit Quarter. For example, Sam begins Covered Employment in January 2020 and reaches 300 hours in February 2020. Sam's coverage under the Plan will begin on March 1, 2020, and he will have coverage through August 2020 (the remainder of the current Benefit Quarter and the next Benefit Quarter).

The following chart illustrates your coverage under the Plan after meeting the terms of initial eligibility.

IF YOU MEET THE 300 HOURS REQUIREMENT AND BEGIN COVERAGE ON:	YOU WILL HAVE COVERAGE THROUGH:
December 1, January 1, or February 1	May 31
March 1, April 1, or May 1	August 31
June 1, July 1, or August 1	November 30
September 1, October 1, or November 1	February 28 (or February 29 during a leap year)

If you are a permanent full-time employee of an Affiliated Employer, you become a Participant on the first day of the month following the date you complete 30 days of employment, not including time worked as a temporary employee or a probationary employee (probation limited to 90 days), or as otherwise set forth in the applicable participation agreement.

2.3 Effective Date of Coverage

Your effective date of coverage will be the first day of the month after you satisfy the initial eligibility requirements of this Plan. The effective date of coverage for a Dependent(s) will be the

date you become eligible or the date your Dependent first meets the terms of eligibility for Dependent coverage under the Plan, whichever is later.

2.4 Continued Eligibility

After becoming initially eligible, you may continue to be eligible as long as you work for a Contributing Contractor(s) and the Contributing Contractor(s) contributes on your behalf for at least 250 hours in the Contribution Quarter corresponding to the applicable Benefit Quarter.

The following chart illustrates how your **Continued Eligibility** is determined under the Contribution Quarter/Benefit Quarter system:

CONTRIBUTION QUARTERS	BENEFIT QUARTERS
WORK PERFORMED DURING . . .	**DETERMINES ELIGIBILITY FOR . . .**
January, February, March	June, July, August
April, May, June	September, October, November
July, August, September	December, January, February
October, November, December	March, April, May

2.5 Hours Bank

Hours worked in excess of the number of hours required for initial and continued eligibility in the Plan will be credited toward an "Hours Bank." Each Participant will have his own Hours Bank which may be used to continue eligibility in the Plan if a Participant does not have enough hours at a later date. Hours Bank hours credited for each Contribution Quarter are automatically used if necessary to continue eligibility. The maximum number of hours that may be credited to a Participant's Hours Bank is 1,000 hours. All accumulated hours in a Participant's Hours Bank will be terminated immediately if the Participant begins employment with an employer who does not participate in the Fund or another U.A. welfare fund.

2.6 Eligibility Due to Disability

For purposes of applying the eligibility rules, if you are a journeyman, technical engineer, instrument man, rodman or apprentice and must stop working for a Contributing Contractor because of a Disability, as defined in Article XXII, you will still be considered in Covered Employment by a Contributing Contractor and will be credited 40 hours per week up to a maximum of six months for any one period of Disability. This rule does not apply if you are receiving a pension from the Plumbers' Pension Fund, Local 130, U.A, or the Pension Fund-Technical Division, Local 130, U.A. This rule is intended to help establish or maintain eligibility while you are unable to work because of sickness or disability. It is important to note that this rule applies only if the sickness or disability caused you to stop working for a Contributing Contractor. In addition, if you are hospitalized on the date your eligibility terminates, Hospital coverage continues until the end of your period of hospitalization. Excess hours earned while on disability shall be credited toward your Hours Bank.

2.7 Military Service

The Plan also provides extended eligibility to Covered Employees who are required to leave Covered Employment to serve in the Armed Forces or Reserves of the United States. Coverage continues during the period beginning on the day you leave Covered Employment to serve and ending 90 days from the date of your release from active duty or, in the case of a reservist, your return to inactive duty status. The maximum period of coverage is five (5) years from the date you left employment in Covered Employment, thereafter you will be offered COBRA coverage for up to 24 months. The standard election and payment deadlines under COBRA apply. An employee of a Contributing Contractor immediately before his entry into active service in the Armed Forces or Reserves who returns to Covered Employment within 90 days after he is discharged, released or returned to inactive status is considered employed for 40 hours a week during the period of his military duty subject to the limitations set forth above. If you do not return to Covered Employment for a Contributing Contractor, this rule does not apply; however, if your failure to return within 90 days is the result of being hospitalized or convalescing from an Illness or Injury incurred or aggravated during your performance of military service, you will become immediately eligible upon returning to work in Covered Employment. Your eligibility for subsequent Benefit Quarters will be determined under the Plan's Eligibility Rules.

In order to exercise your continued coverage options above, you must notify the Fund Office when you are called to active service and provide copies of your discharge papers within the time periods provided under the Uniformed Services Employment and Reemployment Rights Act ("USERRA") as described in the following chart.

LENGTH OF MILITARY SERVICE	REEMPLOYMENT/REINSTATEMENT DEADLINE
Less than 31 days	1 day after discharge (allowing 8 hours for travel)
31 through 180 days	14 days after discharge
More than 180 days	90 days after discharge

2.8 Special Enrollment Opportunities

Generally, Employees and Dependents are automatically covered without a requirement that they enroll in the Plan. However, in order to ensure that you and your Dependents obtain timely Plan coverage, you should notify the Plan of any case in which you wish to add a Dependent through a birth, marriage, adoption or placement for adoption.

If you acquire a new Dependent because of marriage, birth, adoption, or placement of a child for adoption, you may enroll yourself and your Dependent(s), provided you enroll within 30 days of the marriage, birth, adoption, or placement for adoption.

2.9 Family and Medical Leave Act (FMLA)

Under certain circumstances, you may be able to take up to 12 weeks of unpaid leave from your employment under FMLA during any 12-month period due to:

1. The birth of a child or placement of a child with you for adoption or foster care;

2. The care of a seriously ill spouse, parent or child;
3. Your serious Illness; or
4. A qualifying exigency arising out of the fact that a family member is in the military on active duty.

FMLA also allows a qualifying person to take up to 26 weeks of unpaid leave during a 12-month period to care for a service member who is recovering from a serious illness or injury sustained in the line of duty.

During your leave, you will maintain all the coverage offered through the Fund for up to a maximum of 12 weeks. You will remain eligible until the end of the leave, provided your Employer properly grants the leave under the federal law and you or your Employer makes the required notification and payment to the Fund. Contact your Employer for more information regarding such a leave and whether you are eligible. Your Employer will decide your eligibility for FMLA leave.

If you and your Employer have a dispute regarding your eligibility and coverage under the FMLA, the Fund will not have any direct role in resolving the dispute and your benefits may be suspended while the dispute is being resolved.

If your coverage terminates, you will then be eligible to purchase COBRA continuation coverage as described in this Plan/SPD. Contact the Fund Office for additional information about your coverage during FMLA leave or continuing your coverage under COBRA.

2.10 Reciprocal Agreements with Other Welfare Funds

The Plumbers' Welfare Fund Local 130, U.A. has reciprocal agreements with other welfare funds throughout the country sponsored by local unions affiliated with the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada. The reciprocal agreements require the transfer to this Fund of employer contributions made in another jurisdiction for Local 130 members working on travel cards. In this way, your eligibility can continue if you are working in Covered Employment under another local union jurisdiction. You must sign an agreement with the other welfare fund authorizing the transfer of contributions to this Fund. The Fund does not have reciprocal agreements with all local union jurisdictions. To learn about the jurisdictions covered by reciprocal agreements, please contact the Fund Office.

No Participant is entitled to benefits both under this Plan and a reciprocal plan at the same time and no Participant under a reciprocal plan is entitled to earn any eligibility or be considered in Covered Employment under the Plan during a period of time that contributions are transmitted from the Fund to the reciprocal plan. A Participant whose contributions are transmitted to the Fund by the trustees of a reciprocal plan is given credit for the hours of employment for which contributions were made, and the hours are regarded as hours in Covered Employment by a Contributing Contractor for purposes of receiving Accidental Death and Dismemberment Benefits under this Plan.

2.11 Coverage of Employees of Affiliated Employers

A full time employee of an Affiliated Employer is eligible to participate (to the extent of the benefits provided to that class of Participants under this Plan) upon the first day of the month

following the start of employment or as otherwise set forth in the applicable participation agreement. For purposes of this section, a full-time employee is one who customarily works 30 hours per week or more. The eligibility of a Participant under this paragraph terminates upon the earliest to occur of the following:

- The date his or her employment terminates; or
- The first day of the month following the month the employee ceases to be a full-time employee or ceases to be on authorized leave of absence because of sickness or disability.

2.12 Coverage of Non-Bargaining Unit Employees

A Contributing Contractor operating in the form of a corporation or limited liability company duly organized under the law of any state may request the Trustees to authorize the eligibility of its Non-Bargaining Unit Employees for participation in this Fund. Eligibility of a Contractor's Non-Bargaining Unit employees may be permitted at the sole and exclusive discretion of the Trustees and any decision to deny coverage is final and binding upon the Contractor and its Non-Bargaining Unit Employees. If the Trustees approve a Contractor's request, the Contractor will execute a written participation agreement with the Fund as a precondition of the eligibility for participation of its Non-Bargaining Unit Employees.

The terms and conditions of the participation agreement regarding Non-Bargaining Employees are established by the Trustees and may be modified from time to time at the Trustees' sole discretion. The participation agreement is incorporated herein by reference. Non-Bargaining Unit Employees are not entitled to Death Benefits, Accidental Dismemberment Benefits, or Weekly Sickness or Accident Benefits, and any other benefits determined to be excluded by the Trustees. A Non-Bargaining Unit Employee of a corporate Contractor is eligible to participate hereunder no sooner than the first day of the month following the month in which the Non-Bargaining Unit Employee is enrolled for coverage with the Fund by his or her employer, or, if later, the first day of the month following the month in which the Trustees' approve the Contractor's request to extend eligibility to its Non-Bargaining Unit Employees. A separate Schedule of Benefits may apply as approved by the Board of Trustees.

2.13 Participation of Newly Organized Plumbers of a Newly Organized Contributing Contractor

In the event a Contractor which employs licensed journeymen and/or apprentice plumbers (referred to for purposes of this section as Plumber(s)) is organized to become a Contributing Contractor (New Contributing Contractor), each Plumber employed by the New Contributing Contractor will be eligible for participation immediately following the New Contributing Contractor signing a collective bargaining agreement with the Union to become a Contributing Contractor.

2.14 Participation of Newly Organized Journeymen and Apprentices

Newly organized journeymen and apprentices (Newly Organized Journeymen) organized as part of the Union's organizational efforts will be eligible for participation immediately upon their first day of Covered Employment.

2.15 Accelerated Eligibility for Individuals Working as Union Salts

In the event an individual who worked pursuant to a written agreement with the Union to assist in efforts to organize a plumbing contractor that is not already a party to a collective bargaining agreement with the Union becomes employed by a Contributing Contractor (such individual shall be referred to for purposes of this section as a "Union Salt"), such individual may be eligible to receive credit for work while working for the non-union contractor pursuant to this section, and such work shall be deemed to be Covered Employment as outlined below.

Hours of work performed as a plumber for a non-union contractor while acting as a Union Salt may be used toward the requirement of completing 500 hours of work in Covered Employment in two consecutive Contribution Quarters necessary to become eligible as a Participant under the Welfare Fund. A Union Salt must provide the Fund with sufficient documentation to prove the hours of work with the non-union contractor that were performed while a Union Salt. However, a Union Salt shall not become eligible as a Participant in the Fund before the Union Salt becomes employed by a Contributing Contractor.

Upon becoming employed by a Contributing Contractor, a Union Salt who has 500 hours of work in Covered Employment through work as a Union Salt will become eligible for coverage on the first day of the month after he is employed with a Contributing Contractor and will continue to be eligible throughout the quarter in which his initial eligibility begins. He will be eligible for coverage in the subsequent quarter if he worked at least 250 hours as a Union Salt in the quarter prior to becoming employed by a Contributing Contractor. In the event the Union Salt fails to qualify for continued quarterly eligibility for the subsequent quarter under the preceding sentence, the Union Salt will receive coverage for the first month of the subsequent quarter under the monthly eligibility terms of the next paragraph and will maintain continued eligibility under those provisions. In all other cases Continuing Eligibility for Union Salts obtaining regular quarterly eligibility will be determined under the Continuing Eligibility provisions of the Plan.

In the event a Union Salt does not have 500 hours of work in Covered Employment through work as a Union Salt at the end of the Contribution Quarter immediately preceding his commencement of Covered Employment, he will obtain eligibility on the first day of the month following his commencement of work in Covered Employment for a Contributing Contractor. Eligibility will continue for subsequent months provided contributions are received for the Union Salt for at least 100 or more hours of work in Covered Employment in the immediately preceding month. For example, if a Union Salt commences work in Covered Employment on March 15, he is provided eligibility on April 1 for the month of April, his eligibility for the month of May will require that contributions are received for 100 or more hours of work in Covered Employment for the April work month. If contributions are not received for the Union Salt for at least 100 or more hours of work in Covered Employment in a work month, his eligibility will terminate on the first of the work month following the work month for which 100 or more hours were not received.

In order to maintain eligibility if contributions for 100 or more hours of Work for Covered Employment are not received for a work month, the Union Salt may make a self-payment at the Fund's self-payment rate for the difference between the hours contributed for the work month and 100 hours. Self-payment under these terms will be permitted for any subsequent work month in the Contribution Quarter in which the shortage initially occurred and for any work month in the next Contribution Quarter. For example, if a Union Salt begins coverage as of April 1 and fails to work 100 hours in the July work month, he will be eligible to make self-payments for the months

of July through September (the Contribution Quarter in which the hours shortage occurred) and the months of October through December (the next Contribution Quarter). His coverage will terminate at the end of December if contributions for less than 100 hours of work in December are received. If the Union Salt's eligibility terminates under this provision, he may only regain eligibility by satisfying the Initial Eligibility requirements of this Plan, he loses any balance accumulated in his Hours Bank and he is not eligible for any other form of self-pay toward any plan eligibility requirement.

Any hours of work performed as a plumber for a non-union contractor while acting as a Union Salt in excess of 500 hours and any contributions for work in Covered Employment received for more than 100 hours in a month will be placed in the Union Salt's Hours Bank. The Union Salt will not be permitted to utilize the Hours Bank until he has accumulated 500 hours in his Hours Bank at the end of a Contribution Quarter or obtained regular quarterly Initial Eligibility. Upon accumulation of 500 hours in his Hours Bank at the end of a Contribution Quarter, the Union Salt will obtain regular quarterly eligibility on the first day of the next Benefit Quarter. For example, if the Union Salt has 500 hours in his Hours Bank on September 30, the end of the July, August, September Contribution Quarter, he will have regular quarterly eligibility beginning on October 1 for the October, November, December Benefit Quarter. Continuing Eligibility for subsequent Benefit Quarters will be determined under the Continuing Eligibility provisions of the Plan.

A Union Salt who is entitled to coverage pursuant to this section shall not be eligible pursuant to the terms applicable to a Newly Organized Plumber of a Newly Organized Contributing Contractor or a Newly Organized Journeyman.

Prior to obtaining regular quarterly eligibility, the Union Salt is entitled only to certain benefits. Coverage for a Union Salt prior to obtaining regular quarterly eligibility does not include Death Benefits, Accidental Dismemberment Benefits, Weekly Sickness or Accident Benefits, Retiree Self-Pay benefits, or the Military Service Benefit. These excluded benefits will be provided on the first day of the Benefit Quarter for which the Union Salt is entitled to regular quarterly eligibility after satisfying the requirement of having 500 hours in his Hours Bank at the end of the immediately preceding Contribution Quarter.

2.16 Fraud Regarding Eligibility Rules

It is a fraudulent act to provide false information and documentation to establish eligibility of a person who is not eligible for Plan benefits. In the event that a claim is filed on behalf of a formerly eligible person and you receive an explanation of benefits indicating that that person was covered, you must notify the Fund Office that the individual is no longer eligible. Acts of fraud will be grounds for termination of eligibility for you and your entire family. The Fund Office also may notify the Contributing Employer of the fraud, and it may be grounds for discipline up to and including termination of employment. You will be held responsible for any claims paid on behalf of an ineligible person.

2.17 Your Duties and Responsibilities

As a Participant in the Plan, you, or if you for any reason are unable to do so, one of your Dependents, have the following duties and responsibilities to keep the Trustees, through the Fund Office, informed without undue delay of the following:

1. Any change in your address or telephone number.
2. The birth or death of a Dependent, and the Dependent's name and date of the event.
3. Your divorce or legal separation from your spouse.
4. Detailed information about any accident or event caused by the act of a third party which results in a claim for benefits by you or an eligible Dependent.
5. Detailed information if you or an eligible Dependent incurs a work related injury which may be comparable under any Workers' Compensation Act or similar Act.

Your failure to promptly notify the Fund Office within thirty (30) days of any of the above events may result in a delay or denial of Plan benefits. Through your cooperation the Plan will continue to provide you and your eligible family members with uninterrupted health and welfare benefits.

III. TERMINATION OF ELIGIBILITY

3.1 Termination of Participant Eligibility

Eligibility for Plan benefits terminates pursuant to the following rules:

If you are an eligible Participant, your eligibility will terminate following the last day of the month in which the first of the following events occur:

1. You fail to meet the requirements for continuing eligibility as described above or in your participation agreement, including a failure to make any self-payments of contributions in a timely manner;
2. You or your Dependent commits an act of fraud or a material misrepresentation with respect to the Plan;
3. The Participant class under which you are eligible is terminated;
4. The Plan terminates, or
5. The Trustees determine that you have engaged in Prohibited Employment (see Definitions section).

   IMPORTANT NOTE: If you apply for and are approved to receive a pension from the Plumbers' Pension Fund, Local 130, U.A., or the Pension Fund - Technical Engineering Division, Local 130, U.A., and any pension fund that has merged into the Plumbers' Pension Fund, Local 130, U.A., you will not thereafter receive credit for hours worked in Covered Employment even though the pension fund permits retirees to work in Covered Employment for a limited number of hours.

6. If you are a full-time employee of an Affiliated Employer (other than a member of the Union working full time for the Union which is deemed work in Covered Employment) you will lose eligibility under the following rules (and any rules set forth in the applicable participation agreement):

   (a) At the end of the month in which your employment terminates, or you cease to be a full time employee or cease to be on authorized leave because of sickness or

disability. Any Hours Bank earned prior to employment with the Affiliated Employer will be frozen until the Employee's Retirement.

(b) The first day of the month following the month the Trustees determine that you have engaged in Prohibited Employment (see Definitions section).

EXAMPLE 1: Ms. Brown starts work with the Plumbers' Welfare Fund (an Affiliated Employer) as a probationary employee on January 15, 2020. On February 15, 2020, Ms. Brown is retained as a full-time employee. She will be eligible for Plan benefits on March 1, 2020, the first day of the month following her employment as a permanent full-time employee. Ms. Brown terminates her employment on November 30, 2020. She will not be eligible for benefits after that date.

EXAMPLE 2: Plumber Smith works full time in Covered Employment for XYZ Plumbing Company for 15 years. He then starts work with the Plumbers' Apprentice Fund, Local 130 as an instructor on January 28, 2020, and becomes eligible for benefits by reason of working for an Affiliated Employer. At that time Plumber Smith was also eligible for benefits by reason of his work in Covered Employment. When Plumber Smith retires as an Apprentice instructor, he will receive credit for the hours he worked in Covered Employment with XYZ Plumbing Company in the 18 months prior to going to work for the Apprentice Fund. By reason of this rule, Plumber Smith will remain eligible for Plan benefits for 12 months following his retirement.

EXAMPLE 3: Assume that in Example 2 Plumber Smith had been working in the plumbing trade, but not in Covered Employment, prior to going to work for the Plumbers' Apprentice Fund. Upon his retirement as an instructor he would not have any credit for hours worked in Covered Employment and his eligibility for Plan benefits would terminate upon his retirement.

Note: If a Participant is hospitalized on the date eligibility terminates under the Plan, coverage under the Plan's Hospital and Surgical benefits continues until the end of the period of hospitalization, subject to the Plan's limitations on the benefits payable.

3.2 Self-Payment of Contributions

If the combination of Contractor contributions for the Contribution Quarter and a Participant's Hours Bank balance is insufficient to continue coverage in the corresponding Benefit Quarter, you may be able to make a self-payment of contributions to continue coverage. To be eligible to make self-payments, you must be available for work in Covered Employment in the plumbing industry with a Contractor who participates in the Fund, or temporarily or permanently disabled.

Self-payments are equal to 250 times the hourly rate in effect for Contributing Contractors, reduced by contribution amounts determined to be attributable to the HRA and for the Retiree Plan, and further reduced by a 25% rate discount provided by the Fund.

Self-payments will be reduced by any hours worked in the corresponding Contribution Quarter and the available Hours Bank balance. Thereafter, all self-payments will be paid monthly based on the above calculation. Self-payments must be received at the Fund Office within ten days of receipt of a termination notice that is sent out by the Fund Office at least ten days prior to the termination of coverage.

You may continue eligibility by means of self-payments for up to four consecutive Benefit Quarters (i.e., 12 months). However, if a Contributing Contractor(s) made contributions to the Plan on your behalf for at least 250 hours for the Contribution Quarter which immediately precedes the

termination of the 12-month self-payment period, you may continue your eligibility for a fifth consecutive Benefits Quarter. The fifth Benefit Quarter eligible for self-payment will begin immediately following the end of the original four consecutive Benefit Quarters self-payment period. This extension of the self-payment period is explained in the following example:

EXAMPLE: If your four consecutive Benefit Quarters self-payment period runs from September 1, 2020 through August 31, 2021, but the Fund received contributions on your behalf for at least 250 hours worked from July 1, 2021 – September 30, 2021 (i.e., the Contribution Quarter immediately preceding the end of the self-payment period), you will be eligible to continue your Active Plan eligibility through self-payments for the fifth Benefit Quarter of September 1, 2021 – November 30, 2021.

Participants eligible due to self-payments will be eligible for all benefits under the Plan. Continued eligibility under the HRA benefit is limited to the existing balance in the HRA account at the time you began making self-payments and no new amounts will be added to your HRA while making self-payments.

Participants who have exhausted their Plan eligibility through self-payments may be able to continue Plan coverage by electing COBRA continuation coverage.

3.3 Reinstatement of Participants

Once eligibility terminates, you regain eligibility on the first day of the month if you have been employed by a Contributing Contractor(s) and the Contributing Contractor(s) has made contributions to the Fund on your behalf for at least 300 hours worked.

3.4 Termination of Dependent Coverage

Coverage for your eligible Dependents terminates on the last day of the month in which the first of the following events occur:

1. Your coverage terminates;
2. Your Dependent fails to meet the eligibility requirements of the Plan for Dependent coverage (e.g., reaches age 26);
3. Your Dependent commits an act of fraud or a material misrepresentation with respect to the Plan; or
4. The Plan terminates.

However, in the event of your death while an eligible Participant, your surviving spouse and eligible Dependents will remain eligible for Plan benefits with no self-pay contributions (except for applicable cost-sharing obligations such as copayments, deductibles and coinsurance) until any of the following occurs: (a) the surviving spouse remarries, (b) the surviving spouse becomes eligible for health insurance coverage through his or her employer, or (c) the Dependent(s) attains age 26.

3.5 Rescission of Coverage

The Plan may rescind your coverage for fraud, intentional misrepresentation of a material fact, or material omission after the Plan provides you with 30 days advance written notice of that rescission

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

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

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

IV. DEATH, ACCIDENTAL DISMEMBERMENT, WEEKLY ACCIDENT AND MILITARY BENEFITS

4.1 Death Benefit

Death Benefit protection is provided to eligible Employees in the amount shown in the Schedule of Benefits. Upon your death, the Death Benefit is paid to your designated beneficiary. If you die without a designated beneficiary or if no designated beneficiary survives you, the Death Benefit is paid to your surviving spouse, otherwise, to your living descendants, per stirpes (i.e., in equal shares) to your children and the children of your deceased child, or to your estate if you have no living descendants. For example, if you fail to designate a beneficiary and at your death you were survived by two children and two grandchildren (the children of your deceased child), your two children would each receive one-third of your Death Benefit and the remaining one-third of your Death Benefit would be divided between your two grandchildren (the children of your deceased child). Divorce revokes the designation of a spouse as beneficiary. The Trustees have authority to pay or reimburse your funeral or burial expenses up to $2,000 from the Death Benefit amount payable. The Trustees, in their sole discretion, may pay the funeral or burial expenses to a third party not otherwise reimbursed by the deceased Participant's estate or the Participant's beneficiary entitled to the death benefit.

It is important that you execute a beneficiary designation when you become eligible for benefits. Beneficiary forms are available at the Fund Office. A valid designation of beneficiary form should be signed and dated by you and filed with the Fund Office. If you decide at any time to change your beneficiary, you may request a new beneficiary form from the Fund Office.

4.2 Accidental Dismemberment Benefit

If a Participant suffers a loss listed in the Schedule of Benefits as the result of accidental bodily injury, the Plan will pay the benefit amount specified in the Schedule of Benefits.

No more than the principal sum requiring the largest payment will be paid for all losses suffered by a Participant due to any one accident. No accidental dismemberment benefit is paid unless the Participant survives the loss or dismemberment by 30 days. No benefit is paid for accidents occurring as a result of a worker's compensation or similar injury.

4.3 Weekly Accident or Sickness Benefit

The Weekly Accident or Sickness Benefit is paid at the rate stated in the Schedule of Benefits if you are unable to work in Covered Employment due to an accident or sickness requiring the regular care of a Physician or Surgeon, but only if 21 days before the accident or the onset of the sickness you were working in Covered Employment or were looking for such work during a period declared by the Trustees to be a period of high unemployment.

Your benefits begin with the first day of a disability caused by an accident or the 8th day of a disability caused by sickness, and may continue for a maximum of 52 weeks for any one disability. If benefits are paid for 26 weeks, additional benefits are paid only after a finding of continued disability by the Trustees' Medical Advisor. The Trustees must review your case and may approve continued payments. If you are an eligible Participant by reason of being an employee of an Affiliated Employer, you are entitled to Weekly Sickness or Accident Benefits under the same rules for a maximum of 52 weeks less the number of weeks of sick pay provided by your employer's sick pay policy.

Benefits are not payable for job related accidents covered under any Workers' Compensation Law, Occupational Disease Law, Employer Liability Law or other similar law. A Participant will not receive Weekly Sickness or Accident Benefits for any month after he has applied for and been approved to receive any pension benefit under the provisions of the Plumbers' Pension Fund, Local 130, U.A., and the Pension Fund - Technical Engineering Division, Local 130, U.A., AFL-CIO, or another applicable pension plan as a result of employment with an Affiliated Employer.

4.4 Continuation Coverage Under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")

If you are in active service for up to 31 days, your coverage during that leave will be continued as long as you make the required self-contributions. If you are in active service for more than 31 days, you may continue coverage for you and your Dependents for up to 24 months under the USERRA. Self-payments for this coverage include the share of the payments as well as any retroactive payments that were made by a Contributing Contractor, Affiliated Employer, or other Contributing Employer.

Your coverage will continue to the earliest of the following:

- The date your former Employer no longer provides coverage to any Employee;
- The date you or your eligible Dependents do not make the required self-payments;
- The date you lose your rights under USERRA, such as for a dishonorable discharge;
- The date you reinstate your eligibility for coverage under the Plan; or

- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA.

Continuation coverage under USERRA will be administered in the same manner as COBRA continuation coverage (including the COBRA election period rules), except that coverage may only be continued for up to 24 months under USERRA, and only the Employee may elect continuation coverage under USERRA for himself or herself, and his or her eligible Dependents. Premiums for continuation coverage under USERRA will be the same amount as premium payments for COBRA continuation coverage.

You need to notify the Fund Office in writing when you enter the military, unless you are prevented from doing so because of military necessity. For more information about continuing coverage under USERRA, contact the Fund Office. The Fund Office will coordinate your USERRA and other military benefits under the Plan.

Once you are discharged from such service, you may be eligible to apply for reemployment with your former Employer in accordance with the provisions of USERRA; this includes your right to elect reinstatement in any coverage currently provided by your Employer.

V. MEDICAL AND HOSPITAL BENEFITS

5.1 Deductible

An individual and family deductible is required for inpatient and outpatient benefits (referred to as "Covered Medical Expenses"), except as otherwise noted in the Schedule of Benefits.

1. Outpatient major medical benefits;
2. Inpatient Hospital benefits (excluding preadmission hospital tests); and
3. Surgical benefits (excluding the cost of approved second or third surgical opinions).

To satisfy the individual deductible, each Participant must pay the first $200 of Covered Medical Expenses incurred during the calendar year before any benefits will be paid by the Plan. For the family deductible, each family member (you, your spouse and any of your eligible Dependents), must meet their own individual deductible until the total amount of the family deductible applicable to Covered Medical Expenses paid by all family members for the calendar year meets the overall family deductible of $600. The deductible counts toward your Out-of-Pocket Maximum (discussed below).

The deductible amount is satisfied by payment of expenses otherwise covered and payable by the Plan. Your payment of medical charges or expenses not covered and payable under the Plan does not satisfy the deductible obligation. No amounts are paid by the Plan for Covered Medical Expenses applied in satisfaction of the deductible.

If you are hospitalized during a period that includes portions of two calendar years and related expenses incurred during the hospitalization are applied to satisfy the deductible, the amounts applied in satisfaction of the deductible for the first calendar year will also be applied to satisfy the deductible requirement for the following calendar year.

The following examples explain how the deductible works.

EXAMPLE 1. A Participant incurs expenses for cosmetic surgery, pays $200 of the charges billed and submits the balance of the bill to Fund for payment. Has the deductible been satisfied?

No. The deductible must be satisfied out of expenses that are covered and payable under the Plan. Since the Plan does not cover cosmetic surgery (except for reconstructive surgery following a mastectomy and panniculectomy surgery to remove excess skin for individuals who have had significant weight loss), expenses incurred for cosmetic surgery (except as specified above) do not count towards satisfaction of the deductible.

EXAMPLE 2. A Participant and his spouse have each met their individual $200 deductibles for the calendar year. One of their two covered children has also met his $200 deductible for the calendar year. Has the family deductible been satisfied?

Yes. Once the $600 family deductible is met by aggregating all of the family members' Covered Expenses, the individual deductible for each family member is considered satisfied even though the fourth family member has not met their $200 individual deductible.

5.2 Copayments

1. Emergency Room Visits. You will also be charged a $150.00 copayment for each emergency room visit. The $150.00 emergency room copayment counts towards your Out-of-Pocket Maximum.
2. Application to Deductible and Out-of-Pocket Expenses. Notwithstanding any provision of this Plan to the contrary, the emergency room copayment shall not be considered in determining whether a Participant has satisfied the Deductible under this Article V.
3. Copayments for prescription drug and dental benefits are described in the Schedule of Benefits.

5.3 Out of Pocket Maximum

The Plan limits the out-of-pocket expenses a Participant must pay for most (not all) conditions per individual and family, per calendar year. This is known as an Out-of-Pocket Maximum. When an individual or family reaches the Out-of-Pocket Maximum in a calendar year, the Plan will pay 100% of most of such person's or family's covered expenses incurred during the rest of the calendar year. The amount for the Out-of-Pocket Maximum is $1,500 for individual coverage and $3,000 for coverage other than self-only coverage (e.g., family coverage).

Expenses not eligible under the Plan or expenses in excess of any maximum of the Plan do not apply to, and are not affected by, the individual or non-individual Out-of-Pocket Maximums. Additionally, amounts you pay related to self-pay contributions, balance billing amounts for non-network providers and other out-of-network cost-sharing expenses do not count toward the Out-of-Pocket Maximum (even if you have already met your Out-of-Pocket Maximum for the year).

5.4 Coinsurance

Coinsurance is the percentage of covered expenses you must pay for after you meet your deductible. Generally, until you meet the Plan's Out-of-Pocket Maximum, the Plan does not pay covered expenses at 100%. Please refer to the Schedule of Benefits for the applicable Coinsurance rates. Also, it is important that you keep in mind that all out-of-network providers (those not in the

PPO network) are subject to Reasonable and Customary Charge limitations. This means that the maximum allowable amount for certain non-network services is based on the definition of a Reasonable and Customary Charge in the Plan. Normally, the Plan's payment will be a percentage of the billed amount (see the Schedule of Benefits). However, in any case where the out-of-network provider's charge exceeds the Reasonable and Customary Charge, the excess amount is not eligible under the Plan, and the provider is free to balance bill the patient.

On the other hand, if you see an in-network provider for covered services or treatment, the maximum allowable amount is based on a contracted fee schedule. Therefore, any amount of the in-network provider's bill over the Reasonable and Customary Charge is not subject to balance billing. As a result, using an in-network provider saves money for the Plan and for you personally.

5.5 Use of Preferred Providers for Medical Benefits

The Fund has an agreement with Blue Cross/Blue Shield of Illinois, a Preferred Provider Organization, for discounts in a network of over 200 hospitals.

Another benefit of the Blue Cross/Blue Shield network is the Physician network which includes over 24,500 Physicians in Illinois and the border areas of the surrounding states. These doctors have agreed to charge the PPO scheduled allowance for services and will bill you only for copayments, deductibles, or non-covered expenses. In order to receive maximum benefits, check with your doctor to find out whether or not he or she is a Blue Cross/Blue Shield PPO Physician.

To locate a BC/BS network provider, call 1-800-810-BLUE (2583) or log on to its website at www.bcbsil.com. You can also check with the Fund Office.

All PPO doctors and all hospitals will submit claims directly to Blue Cross/Blue Shield and should not expect from you payment in full up front. Often doctors and Hospitals that do not follow these procedures do so because a member has not shown their Blue Cross/Blue Shield ID card. Be sure to show your card in order to avoid a delay in claim processing. If any PPO doctors or Hospitals advise differently, please notify the Fund Office.

You are not required to use Physicians or Surgeons that are affiliated with the Blue Cross/Blue Shield PPO and you have complete freedom of choice in making your health care decisions. However, if you elect to use a non-PPO medical provider or facility when a PPO provider or facility is available (e.g., a PPO Facility that is available due to its geographic distance from where you reside or are located, or one that is available in terms of the facility's capacity or specialty/type of service needed, etc.), the Plan will cover only 70% of the Reasonable and Customary Charges of covered medical services and charges by out-of-network doctors, Hospitals, and other providers, and you will be responsible for the balance of the total charges. An exception is made for emergency services approved by the Trustees. However, if you utilize Physicians or Surgeons within the PPO network, both you and the Fund will realize substantial savings. For example:

- The first dollar coverage by the Plan for inpatient Hospital services (other than room and board) in a PPO Hospital is $2,000, and after that amount is paid the Plan covers 90% of the remaining charges for inpatient Hospital services. If Hospital special services totaled $6,000.00, the Plan would pay $5,600.00 (100% of $2,000.00 and 90% of $4,000.00) and you would be responsible to pay the balance of $400.00.

- If in the above example you chose a non-PPO Hospital when a PPO affiliated Hospital was available the Plan would pay 70% of the charges for Hospital special services, or $4,200 and you would be responsible for the balance of $1,800.00.

In order to receive the PPO discount, your Blue Cross/Blue Shield identification card must be presented to the PPO provider. If you do not presently have an identification card one can be obtained from the Fund Office upon request. The card identifies you as a Participant of this Plan and indicates your eligibility for reduced charges from Physicians, Hospitals and facilities affiliated with Blue Cross/Blue Shield. The card should be presented whenever you or an eligible Dependent receives services from a preferred provider Physician, Hospital or ancillary medical service organization.

In determining the Reasonable and Customary Charge or Fee under any benefit offered under the Plan, the Trustees may rely upon the Medical Advisor retained by the Trustees, any recognized published schedule of prevailing surgical charges or fees, or any schedule utilized by Health Care Service Corporation a/k/a Blue Cross/Blue Shield of Illinois.

5.6 Inpatient Hospital Benefit

If you are confined in a Hospital and under the care of a Physician or Surgeon for a non-occupational injury or sickness, the Fund pays the Reasonable and Customary Charges or Fees for Hospital room and board and medical services (see Schedule of Benefits).

1. **Room and Board.** The Plan will pay for Hospital charges covering room and board of a Participant for any sickness or injury as set forth in the Schedule of Benefits. This includes private, semi-private and intensive care unit rooms. If a Participant is readmitted to a Hospital within 30 or fewer days of his or her discharge, the readmission is presumed to treat the same sickness or injury as the prior admission unless the facts clearly establish otherwise. Readmissions occurring after 30 days will be treated as a new sickness or injury.

2. **Pre-admission Hospital Testing.** If you undergo any of the following tests in preparation for a Hospital admission, you will be paid or reimbursed the full, Reasonable and Customary Charges for the tests, if the tests are accepted by the Hospital in place of the same tests performed after Hospital admission:

   (a) Blood Chemical Test
   (b) Blood Count
   (c) Blood Type Screening
   (d) Chest X-Ray
   (e) Clotting Profile
   (f) Electrocardiogram
   (g) Sickle Cell Preparation
   (h) Urinalysis
   (i) Venereal Disease Test

   By having the tests performed before a Hospital admission, the cost is not charged against your deductible and will be charged as set forth in the Schedule of Benefits.

3. **Physician Services**

   (a) **Attending Physician.** If you are hospitalized for a non-occupational injury or sickness, the Plan covers treatment by a licensed Physician as set forth in the

Schedule of Benefits. This benefit excludes Inpatient Hospitalization Services set forth in the Schedule of Benefits.

(b) **Consulting Physician or Surgeon.** If you are hospitalized and your attending Physician or Surgeon engages another Physician or Surgeon for a consultation on the diagnosis or treatment of your medical condition, the Plan pays for the services of the medical or surgical consultant as shown in the Schedule of Benefits. The Plan allows for coverage of a Surgical Assistant up to 16% of the cost of the Surgeon's charge.

4. **Hospital Nursery Care.** Hospital charges for the nursery care of a Participant's newborn child or children are provided as set forth in the Schedule of Benefits.

5. **Emergency Room Care.** Hospital charges for Emergency Services provided in a Hospital emergency room to treat an Emergency Medical Condition. A $150.00 copayment will be charged for each emergency room visit. The $150.00 emergency room copayment counts towards your Out-of-Pocket Maximum.

5.7 Hospital Maternity Benefits

Hospital Maternity Benefits are provided only for the pregnancy of an eligible Employee or the spouse of an eligible Employee carrying the Employee Participant's child. If an eligible Participant or the Participant's spouse is confined in a Hospital due to pregnancy, the maternity services are paid under the Plan's Hospital Benefits and the Plan's Surgical Benefit Schedule. Covered charges include inpatient services provided by a certified nurse midwife who is licensed to practice by the state.

Under a federal law known as the Newborns' and Mothers' Health Protection Act of 1996 ("Newborns' Act"), the Plan may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Newborns' Act generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, under the Newborns' Act, the Plan may not require a provider to obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

No benefits are paid under this Plan for or by reason of an elective abortion, but if an abortion is required where the life of the mother would be endangered, according to the expertise and determination of the overseeing medical professional, if the fetus were carried to term, or where medical complications have arisen from an abortion, a Participant is reimbursed for charges for required Hospital and medical services in accordance with the provisions of this Plan.

5.8 Residential Treatment Center Confinements

The Plan provides benefits for medical care, services, or supplies incurred during a Residential Treatment Center confinement as set forth in the Schedule of Benefits. See section 5.16 regarding covered Residential Treatment Center services for Mental Health Conditions and Substance Abuse.

5.9 How to Maximize Your Benefits Through Case Management

To monitor both the quality and necessity of Hospital care, Hines and Associates provides utilization review and case management services to any Participant anticipating a hospitalization. Under this program, Hines and Associates experts will consult with your Hospital or Physician on the necessity of Hospital admissions and surgical procedures (including outpatient surgery), the availability of alternate courses of treatment, and the appropriate length of Hospital stay. The utilization review program is designed to ensure that you receive the proper and necessary care required to treat your sickness or disability.

Please note that this program does not limit or eliminate any Plan benefits.

The Trustees need your cooperation to make this program a success. You are requested to call Hines and Associates' toll free number, 1-800-944-9401, before any non-emergency Hospital admission. If an emergency admission is required you, or your representative, should call within 48 hours of the Hospital admission. **For non-emergency out-of-network services, you are required to contact Hines and Associates before you receive the services in order to pre-certify that the services are Medically Necessary.**

When you contact Hines and Associates, the representative will ask you to respond to questions about your proposed hospitalization, and other requested treatments, and the name of your attending Physician. All information provided will be held in strictest confidence and will be used only for purposes of administering the utilization review program.

In addition, you may voluntarily seek assistance from one of the Fund's case management specialists for guidance on issues arising during the course of extensive and long term medical treatment. For example, the case management specialist can provide advice on alternate types and sources of medical care including alternate sources of care in the event benefits under the Plan are exhausted.

The Trustees have authorized Hines and Associates to review medical necessity prior to or at the time of treatment as needed and make appropriate recommendations to the Fund as well as review of large claims. The decision of Hines and Associates is not binding on a Participant but such decisions may be relied upon by the Fund to make a determination as to the Medical Necessity regarding a Participant's claim. The decision of the Fund as to Medical Necessity will be communicated in writing to the Participant or the Participant's attending Physician or Health Care Provider. Any appeals of a decision of Medical Necessity should be made pursuant to the Plan's internal appeal procedures set forth in section 16.7.

5.10 Surgical Benefits

If you have an operation performed by a licensed Physician or Surgeon, the Plan will pay the Reasonable and Customary Charge for the surgery under the Fund's Schedule of Benefits by utilizing the published prevailing surgical charges or fees, or any schedule utilized by Blue Cross Blue Shield of Illinois at the discretion of the Board.

1. **Assistant Surgeon Charges.** For assistant Surgeon charges, the Plan pays up to 20% of the Plan's established Reasonable and Customary Charge for the surgery. The assistant Surgical Benefit is paid only if the assistant Surgeon is Medically Necessary for the surgery. If you anticipate having surgery requiring an assistant Surgeon, contact the Fund

Office to determine whether assistant surgical charges are payable for that procedure. Surgical assistant charges are not covered by the Plan.

2. **Second Surgical Opinions.** If you are scheduled for a non-emergency surgical operation and desire a second opinion from a licensed Physician or Surgeon confirming the Medical Necessity of the operation, the Plan will pay the Reasonable and Customary Cost of the second surgical opinion as set forth in the Schedule of Benefits. If the second opinion does not confirm the Medical Necessity for the surgery recommended by your Physician or Surgeon, the Plan will pay the Reasonable and Customary cost of a third opinion from a Physician or Surgeon as set forth in the Schedule of Benefits.

5.11 Coverage for Approved Clinical Trials

The Plan does not cover Experimental or Investigative treatment, procedures or medications. However, if you participate in an "approved clinical trial", the Plan will cover routine patient costs for items and services furnished in connection with the trial, provided that such items otherwise would be covered under the Plan. "Routine patient costs" for this purpose include items and services typically provided under the Plan for a covered individual not enrolled in a clinical trial. In other words, the Plan will not deny coverage or impose additional conditions on coverage merely because you receive these items or services as part of a trial. Also, the Plan will not discriminate against you for participating in a clinical trial. This means, for example, that the Plan will not deny coverage for side effects that you develop as a result of participation in the trial. However, there is still no coverage for: (1) the experimental or investigational item or service itself, (2) items and services not included in the direct clinical management of the patient, but provided in connection with data collection and analysis, or (3) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

An "approved clinical trial" is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in connection with the prevention, detection, or treatment of cancer or another life-threatening disease or condition that is (i) federally funded or approved, (ii) conducted under an investigational new drug application reviewed by the Food and Drug Administration, or (iii) a drug trial that is exempt from having such an investigational new drug application.

5.12 Organ Transplants/Tissue and Pectus Excavatum Precertification Procedures

The Plan will pay the Reasonable and Customary Charges or Fees, as determined from time to time by the Trustees, for organ/tissue donor transplants and pectus excavatum services incurred by a Covered Person that are not experimental. Many organ/tissue transplants and treatments for pectus excavatum are not covered under the Plan. To ensure you have coverage for these procedures, you must be pre-certified by the Trustees prior to the transplant. If you have a non-emergency transplant procedure without being pre-certified, the Plan will not pay anything towards the cost incurred, directly or indirectly, for such procedure. Pre-certification is not necessary for an emergency transplant. Contact the Fund Office immediately if you are recommended or scheduled for any type of transplant surgery.

Donor expenses incurred in connection with an organ/tissue transplant procedure include the cost of securing an organ from a cadaver or tissue bank, the Surgeon's charges for removal of an organ, the charges for obtaining cells through bone marrow harvest or apheresis, the Hospital's charge

for storage or transportation of the organ/tissue, and, in the case of a live organ/tissue donor, any hospitalization charges attributable to the donation of the organ/tissue.

Subject to Trustee approval, eligible transplant services must be received within 5 days before or 12 months following pre-certification. Approved transplant surgical procedures are paid as set forth in the Schedule of Benefits.

Additional Limitations on Organ/Tissue Transplants

If the Trustees pre-certify and approve payment for an organ/tissue transplant listed below, total benefits provided to a Participant under this Plan include all eligible hospitalization, treatment, services or supplies otherwise payable under the Plan that are:

1. incurred as a result of a Participant undergoing an approved organ/tissue transplant; and
2. incurred during a period beginning 5 days prior to the date the transplant surgery takes place and ending 12 months after such date.

5.13 Outpatient Major Medical Benefits

When you have a non-occupational Illness or Injury not requiring hospitalization, the Plan pays the Reasonable and Customary Charges for Medically Necessary medical care, services, or supplies as set forth in the Schedule of Benefits. However, the following limits and exclusions apply to outpatient medical services:

- Medical care, services, or supplies covered under another provision of the Plan;
- Dental care or services, except for dental care required as a result of a direct injurious blow to the mouth or dental care required due to non-dental medical treatment, for example, dental work required in connection with an organ transplant or cancer treatment;
- Purchase or rental of durable medical aids, appliances, or equipment in excess of $1,500.00 will not be covered unless pre-certified by the Trustees (or the Plan's Medical Advisor), and the decision of the Trustees is final and binding, including the decision on whether to rent or purchase an item;
- Home Health Care charges after a Participant has received 365 days of Home Health Care Services minus the number of days of Inpatient Hospital Benefits for the same sickness or injury. The 365 day period resets if the Participant is readmitted to a Hospital following 30 days of Home Health Care Services;
- Medical care, services or supplies that are not provided or prescribed by or under the supervision of a Physician or Surgeon or any other Health Care Provider not acting within the scope of that provider's license or certification under applicable State law;
- Charges exceeding $2,000.00 during a calendar year for chiropractic care not deemed to be an Essential Health Benefit; or
- Binocular therapy after a maximum of 12 sessions.

5.14 Preventive Services Benefit

This Plan provides coverage for certain Preventive Services as required by PPACA as well as additional Wellness Benefits. Coverage for Preventive Services as required by PPACA is provided

on an in-network basis only, with no cost-sharing (for example, no deductibles, coinsurance, or copayments), for the following services:

- Services described in the United States Preventive Services Task Force ("USPSTF") A and B recommendations,
- Services described in guidelines issued by the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control ("CDC"), and
- Health Resources and Services Administration ("HRSA") guidelines including the American Academy of Pediatrics *Bright Futures* guidelines and HRSA guidelines relating to services for women

PPO-Provider preventive services that are identified by the Plan as part of PPACA guidelines will be covered with no cost-sharing by the Participant or Dependent. This means that the service will be covered at 100% of the Plan's allowable charge, with no coinsurance, copayment, or deductible.

If preventive services are received from a non-network provider, they will not be eligible for coverage under this Preventive Services benefit unless there is no provider in the Plan's network who can provide the particular service.

In some cases, federal guidelines are unclear about which preventive benefits must be covered under PPACA. In that case, the Trustees will determine whether a particular benefit is covered under this Preventive Services benefit.

1. Preventive Services Benefit Overview

    (a) **Physical Examination covered after deductible with the standard coinsurance:** Except as noted below (relating to children through age 21 and well woman visits), the Plan will cover the expense related to a routine physical examination by a Physician after you meet the annual deductible with the standard coinsurance. This benefit is limited to one examination per year for each Participant and each Dependent.

    (b) **Preventive Services Covered with No Cost-Sharing:** The following benefits are available under the Fund's Preventive Services benefit with no cost-sharing. In certain circumstances, as determined by the Fund, the preventive benefit is only payable with an appropriate diagnosis.

    (c) **Non-preventive Services are not covered without Cost-Sharing:** The Plan will impose cost-sharing for treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service.

    (d) **Preventive Services for Dependents:** All covered Participants and Dependents are eligible to obtain, without cost sharing, all required in-network preventive services applicable to them (e.g., for their age group). This includes PPACA-required pregnancy-related preventive services and well woman visits, which must be provided to Dependent children (up to age 26) where an attending Health Care Provider determines that the services are age and developmentally appropriate.

2. Covered Preventive Services for Adults

    (a) Abdominal Aortic Aneurysm one-time screening for men ages 65-75 who have ever smoked.

(b) Unhealthy alcohol use screening and counseling: screening and behavioral counseling interventions to reduce unhealthy alcohol use by adults ages 18 and older, including pregnant women, in primary care settings.

(c) Low-dose aspirin to prevent cardiovascular disease and colorectal cancer when prescribed by a health care provider, in adults ages 50 to 59 years who have a 10% or greater 10-year cardiovascular disease ("CVD") risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years. A prescription must be submitted in accordance with Plan rules.

(d) Blood Pressure screening for all adults age 18 and older. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a Physician visit. Cholesterol screening (Lipid Disorders Screening) for men aged 35 and older and women aged 45 and older; men aged 20 to 35 if they are at increased risk for coronary heart disease; and women aged 20 to 45 if they are at increased risk for coronary heart disease.

(e) Colorectal Cancer screening using stool-based methods (such as fecal occult blood testing), sigmoidoscopy, or colonoscopy, in adults beginning at age 50 and continuing until age 75. The test methodology must be medically appropriate for the patient. The Plan will not impose cost sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure. The Plan will not impose cost sharing with respect to the following services when these services are provided in connection with a screening colonoscopy and the attending provider determines the service is medically appropriate: bowel preparation medications, anesthesia services, a pre-procedure specialist consultation, or a pathology exam on a polyp biopsy.

(f) Depression screening for adults.

(g) Type 2 Diabetes screening for asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.

(h) Diet counseling for adults at higher risk for chronic disease.

(i) HIV screening for all adolescents and adults ages 15 to 65 and for younger and older individuals at increased risk.

(j) Obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss for adults with a body mass index of 30 kg/m2 or higher.

(k) Sexually Transmitted Infection ("STI") prevention counseling for adults at higher risk.

(l) Tobacco Use screening for all adults and cessation interventions for tobacco users. For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for: (i) four tobacco cessation counseling sessions of at least ten minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and (ii) all FDA-approved tobacco cessation medications (including

both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

(m) Syphilis screening for all adults at increased risk of infection.

(n) Counseling for young adults to age 24 who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.

(o) Exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.

(p) Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls. Over-the-counter supplements are covered only with a prescription.

(q) Screening for hepatitis C virus ("HCV") infection in persons at high risk for infection and a one-time screening for HCV infection in adults born between 1945 and 1965.

(r) Annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack/year smoking history and currently smoke or have quit within the past 15 years.

(s) Screening for hepatitis B virus infection in adults at high risk for infection.

(t) Low-to-moderate-dose statin for the prevention of cardiovascular disease ("CVD") events and mortality in adults ages 40-75 years with one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking), and a calculated 10-year risk of a cardiovascular event of 10% or greater, when identified as meeting these factors by their treating physician.

(u) Screening for latent tuberculosis infection in populations at increased risk.

(v) Effective March 18, 2020, COVID-19 testing whether performed by a PPO provider or non-network provider subject to medical appropriateness. No cost-sharing (i.e., deductible, coinsurance or copayment) will be applied or required. Coverage for testing includes any related Physician office visit (including in-person office visits, telehealth visits, urgent care clinic visits, or Emergency Room visits) related to the provision of COVID-19 testing. Precertification is not required but any such testing and related services must be Medically Necessary and consistent with guidance from the Centers for Disease Control And Prevention (CDC). This coverage will remain in effect until otherwise directed by the U.S. Department of Health and Human Services (HHS).

3. Covered Preventive Services for Women, Including Pregnant Women

(a) Well woman office visits for women beginning in adolescence and continuing across the lifespan, for the delivery of required preventive services.

(b) Anemia screening on a routine basis for pregnant women.

(c) Bacteriuria urinary tract or other infection screening for pregnant women. Screening for asymptomatic bacteriuria with urine culture for pregnant women is payable at 12 to 16 weeks' gestation or at the first prenatal visit, if later.

(d) Low-dose aspirin after 12 weeks of gestation for women who are at high risk for preeclampsia. A prescription must be submitted in accordance with plan rules.

(e) Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a physician visit.

(f) BRCA counseling about genetic testing for women at higher risk. Women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 or BRCA 2 genes will receive referral for counseling. The Plan will cover BRCA 1 or 2 genetic tests without cost sharing, if appropriate as determined by the woman's health care provider, including for a woman who has previously been diagnosed with cancer, as long as she is not currently symptomatic or receiving active treatment for breast, ovarian, tubal or peritoneal cancer.

(g) Breast cancer screening mammography for women with or without clinical breast examination and with or without diagnosis, every 1 to 2 years for women aged 40 and older.

(h) Breast Cancer Chemoprevention counseling for women at higher risk. The Plan will pay for counseling by physicians with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention, to discuss the risks and benefits of chemoprevention. The Plan will also pay for risk-reducing medications (such as tamoxifene or raloxifene) for women at increased risk for breast cancer and at low risk for adverse medication effects.

(i) Comprehensive lactation support and counseling by a trained provider during pregnancy and for the duration of breastfeeding, and costs for renting breastfeeding equipment. The Plan may pay for purchase of lactation equipment instead of rental, if deemed appropriate by the plan administrator.

(j) Cervical Cancer screening for women ages 21 to 29 with Pap smear every three years; for women ages 30-65, screening with Pap smear alone every three years, or screening with Pap smear and human papillomavirus testing every five years.

(k) Chlamydia Infection screening for all sexually active non-pregnant young women aged 24 and younger, and for older non-pregnant women who are at increased risk, as part of a well woman visit. For all pregnant women aged 24 and younger, and for older pregnant women at increased risk, Chlamydia infection screening is covered as part of the prenatal visit.

(l) FDA-approved contraceptives methods, sterilization procedures, and patient education and counseling for women of reproductive capacity. FDA-approved contraceptive methods, include barrier methods, hormonal methods, and implanted devices, as well as patient education and counseling, as prescribed by a health care provider. The plan may cover a generic drug without cost sharing and charge cost sharing for an equivalent branded drug. The plan will accommodate any individual for whom the generic would be medically inappropriate, as determined by the individual's health care provider. Services related to follow-up and management of side effects, counseling for continued adherence, and device removal are also covered without cost sharing.

(m) Folic Acid supplements for women are planning or capable of pregnancy, containing 0.4 to 0.8 mg of folic acid. Over-the-counter supplements are covered only if the woman obtains a prescription.

(n) Gonorrhea screening for sexually active women age 24 and younger and in older woman who are at increased risk for infection, provided as part of a well woman visit. The Plan will pay for the most cost-effective test methodology only.

(o) Counseling for sexually transmitted infections, once per year as part of a well woman visit.

(p) Counseling and screening for HIV, once per year as part of a well woman visit, and for pregnant women, including those who present in labor who are untested and whose HIV status is not known.

(q) Hepatitis B screening for pregnant women at their first prenatal visit.

(r) Osteoporosis screening for women. Women aged 65 and older will be eligible for routine screening for osteoporosis. Postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool will be eligible for screening. The Plan will pay for the most cost-effective test methodology only.

(s) Rh Incompatibility screening for all pregnant women during their first visit for pregnancy related care, and follow-up testing for all unsensitized Rh (D) negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D) negative.

(t) Screening for gestational diabetes in asymptomatic pregnant women between 24 and 28 weeks' gestation and at the first prenatal visit for pregnant women identified to be at risk for diabetes.

(u) Tobacco Use screening and interventions for all women, as part of a well woman visit, and expanded counseling for pregnant tobacco users.

(v) Syphilis screening for all pregnant women or other women at increased risk, as part of a well woman visit.

(w) Screening and counseling for interpersonal and domestic violence, as part of a well woman visit.

(x) Depression screening for pregnant and postpartum women.

(y) Counseling interventions for pregnant and postpartum women at increased risk of perinatal depression.

4. Covered Preventive Services for Children

(a) Well baby and well child visits from ages newborn through 21 years as recommended for pediatric preventive health care by "Bright Futures/American Academy of Pediatrics." Visits will include the following age-appropriate screenings and assessments:

i) Developmental screening for children under age three, and surveillance throughout childhood

ii) Behavioral assessments for children of all ages

iii) Medical history

iv) Blood pressure screening

v) Depression screening for adolescents ages 11 and older

vi) Vision screening at least once in all children 3 to 5 years to detect amblyopia or its risk factors

vii) Hearing screening

viii) Height, Weight and Body Mass Index measurements for children

ix) Autism screening for children at 18 and 24 months

x) Alcohol and Drug Use assessments for adolescents

xi) Critical congenital heart defect screening in newborns

xii) Hematocrit or Hemoglobin screening for children

xiii) Lead screening for children at risk of exposure

xiv) Tuberculin testing for children at higher risk of tuberculosis

xv) Dyslipidemia screening for children at higher risk of lipid disorders

xvi) Sexually Transmitted Infection (STI) screening and counseling for sexually active adolescents

xvii) Cervical Dysplasia screening at age 21

xviii) Oral Health risk assessment

(b) Newborn screening tests recommended by the Advisory Committee on Heritable Disorders in Newborns and Children (such as hypothyroidism screening for newborns and sickle cell screening for newborns).

(c) Prophylactic ocular topical medication for all newborns for the prevention of gonorrhea.

(d) Oral fluoride supplementation at currently recommended doses (based on local water supplies) to preschool children older than 6 months of age whose primary water source is deficient in fluoride. Over-the-counter supplements are covered only with a prescription.

(e) Obesity screening for children aged six years and older, and counseling or referral to comprehensive, intensive behavioral interventions to promote improvement in weight status.

(f) HIV screening for adolescents ages 15 and older and for younger adolescents at increased risk of infection.

(g) Counseling for children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.

(h) Interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.

(i) Screening for hepatitis B virus infection in adolescents at high risk for infection.

(j) Application of fluoride varnish to the primary teeth of all infants and children through to age 5 starting at the age of primary tooth eruption, in primary care practices.

(k) Syphilis screening for adolescents who are at increased risk for infection.

(l) For adolescents, screening and counseling for interpersonal and domestic violence.

5. Immunizations

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

(a) Immunization vaccines for adults--doses, recommended ages, and recommended populations must be satisfied:

i) Diphtheria/tetanus/pertussis

ii) Measles/mumps/rubella (MMR)

iii) Influenza

iv) Human papillomavirus (HPV)

v) Pneumococcal (polysaccharide)

vi) Zoster

vii) Hepatitis A

viii) Hepatitis B

ix) Meningococcal

x) Varicella

(b) Immunization vaccines for children from birth to age 18—doses, recommended ages, and recommended populations must be satisfied:

i) Hepatitis B

ii) Rotavirus

iii) Diphtheria, Tetanus, Pertussis

iv) Haemophilus influenzae type b

v) Pneumococcal

vi) Inactivated Poliovirus

vii) Influenza

viii) Measles, Mumps, Rubella

ix) Varicella

x) Hepatitis A

xi) Meningococcal

xii) Human papillomavirus (HPV)

6. Office Visit Coverage

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

(a) If a Preventive Service is billed separately from an office visit, then the Plan will impose cost-sharing with respect to the office visit.

(b) If the Preventive Service is not billed separately from the office visit, and the primary purpose of the office visit is the delivery of such Preventive Service, then the Plan will pay 100 percent for the office visit.

(c) If the Preventive Service is not billed separately from the office visit, and the primary purpose of the office visit is not the delivery of such Preventive Service, then the Plan will impose cost-sharing with respect to the office visit.

(d) For example, if a person has a cholesterol screening test during an office visit, and the doctor bills for the office visit and separately for the lab work associated with the cholesterol screening test, the Plan will charge a coinsurance amount for the office visit but not for the lab work. If a person sees a doctor to discuss recurring abdominal pain and has a blood pressure screening during that visit, the Plan will charge a coinsurance amount for the office visit because the blood pressure check was not the primary purpose of the office visit.

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

7. Wellness Medical Benefits

Wellness Medical Benefits not otherwise covered under the Plan's Preventive Services Benefit include the following examinations, tests, and procedures to the extent such examinations, tests and procedures are not covered as Preventive Services as described above.

(a) Males over 18 Years of Age

i) Routine Physical Examinations (including medical history and rectal exam)

ii) Complete Blood Count and Differential Count

iii) Urinalysis

iv) Complete Blood Chemistry (SMA-20)

v) Stool Analysis for Blood Hemoccult

Additional Covered Items for Males over 39 Years of Age

i) Electrocardiogram

ii) PSA Test (payable once every 2 years, Annually if Age 50 or Older)

iii) Chest X-Ray

(b) Females over 18 Years of Age

i) Routine Physical Examination (including Medical History and rectal Exam.)

ii) Complete Blood Count and Differential Count

iii) Urinalysis

iv) Complete Blood Chemistry (SMA-20)

v) Stool Analysis for Blood Hemoccult

vi) Pelvic Exam and Pap Smear

vii) TSH (Thyroid Test), payable once every three years

Additional Covered Items for Females over 39 Years of Age

i) Electrocardiogram

ii) Chest X-Ray

iii) Mammogram (payable once every 2 years, annually if age 50 or older)

(c) Children under 18 Years of Age

i) Routine Medical Exam (including Medical History)

ii) Complete Blood Count and Differential Count

iii) Urinalysis

iv) Complete Blood Chemistry

v) In-Hospital Pediatrician Exams for Newborn Children

(d) Covered Individuals Age 60 or Over (Or Within Risk Groups Determined by the Medical Advisor)

i) Pneumovax vaccination

8. Preventive Services Coverage Limitations and Exclusions

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

(b) Services covered under the Preventive Services benefit are not also payable under other portions of the Plan.

(c) The Plan will use reasonable medical management techniques to control costs of the Preventive Services benefit. The Plan will establish treatment, setting, frequency, and medical management standards for specific Preventive Services, which must be satisfied in order to obtain payment under the Preventive Services benefit.

(d) Immunizations are not covered, even if recommended by the CDC, if the recommendation is based on the fact that some other risk factor is present (e.g., on the basis of occupational, lifestyle, or other indications). Travel immunizations, e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus) are not covered.

(e) Examinations, screenings, tests, items or services are not covered when they are investigational or experimental, as determined by the Plan.

(f) Examinations, screenings, tests, items, or services are not covered when they are provided for the following purposes:

i) When required for education, sports, camp, travel, insurance, marriage, adoption, or other non-medical purposes;

ii) When related to judicial or administrative proceedings;

iii) When related to medical research or trials; or

iv) When required to maintain employment or a license of any kind.

(g) Drugs, medicines, vitamins, and/or supplements, whether available through a prescription or over-the-counter, are not covered under the Preventive Services benefit, except as stated above.

(h) Services related to a man's reproductive capacity, such as vasectomies and condoms.

5.15 Infertility Treatment

The Plan provides coverage for Infertility treatments up to $20,000 per lifetime for injectable drug Infertility treatments determined by the Trustees to be non-Essential Health Benefits. The Plan covers Medically Necessary services and procedures for assisted reproductive technologies rendered in connection with the treatment of Infertility. Such treatments include artificial insemination, gamete intrafallopian fertilization, zygote intrafallopian transfer, in vitro

fertilization, intracytoplasmic sperm injection, low tubal ovum transfer, and uterine embryo lavage. Orally administered or injectable fertility medications are also covered.

The coverage of Medically Necessary services and procedures for assisted reproductive technologies as set forth in the Schedule of Benefits is for no more than two attempts to achieve conception during a lifetime. Coverage for treatments that include oocyte retrievals will be provided only when a successful pregnancy has not been attained or sustained through reasonable, less costly medically appropriate Infertility treatments; however, the requirement will be waived if the applicable Participant has a medical condition that renders such treatment ineffective.

Coverage will not be provided for the following:

- Expenses for a reversal of voluntary sterilization; however, in the event a voluntary sterilization is successfully reversed, benefits will be provided if the diagnosis meets the definition of Infertility.
- Services or supplies rendered to a surrogate or in connection with the use of a surrogate.
- Medical and non-medical expenses of an oocyte or sperm donor; however, the medical expenses of the Participant or the Participant's spouse will be covered.
- Selected termination of an embryo in cases where the mother's life is not in danger.
- Cryo-preservation or storage of sperm, eggs or embryos, so long as a cryo-preserved substance is utilized as part of the procedures for storing the embryos. The Plan will pay up to $50.00 per month for up to three years of eligible cryo-preservation for the storage of embryos.
- Infertility treatments which are determined to be experimental or investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetrics and Gynecology.
- Infertility treatment rendered to a person other than the Participant or Participant's spouse.

In addition to the above provisions, in vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, and intracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetrics and Gynecology guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in vitro fertilization.

5.16 Mental Health and Substance Abuse Benefits

The Plan provides benefits for the diagnosis, treatment and cure of Mental Health Conditions and Substance Abuse. Eligible charges are those covered services deemed Medically Necessary by the Plan and shall be provided in parity with the Plan's medical and surgical benefits. The payment of covered services for Mental Health benefits and Substance Abuse benefits will be paid in accordance with the provisions of the Plan and are subject to all limits and conditions applicable to medical benefits.

Covered Benefits Include:

- Inpatient Services: Inpatient Hospitalization (including confinement in a rehabilitation center) for Mental Health and Substance Abuse services.
- Outpatient Services: Outpatient services that are not consistent with the treatment protocols for your condition will be subject to Medical Necessity review. All services

must be provided by a licensed professional working within the scope of their license including, psychologists, psychiatrists, licensed clinical social worker (LCSW), registered nurse clinical specialists (RN CNS), and licensed clinical professional counselors (LCPC).

- Combined Services: Comprised of partial inpatient hospitalization combined with outpatient treatments.

5.17 Home Health Care

The Plan covers Qualified Home Health Care Services (see Definitions section) as an outpatient benefit, as prescribed by a Physician for continued care immediately following a Hospital (including a Skilled Nursing Facility) confinement. The maximum number of days of Home Health Care Services is 365 for any sickness or injury, less the number of days of hospitalization. The 365 day period resets if the Participant is readmitted to a Hospital following 30 days of Home Health Care Services.

5.18 Required Pre-Certification of Out-Of-Network Providers

All out-of-network claims (except for emergency room care) must be submitted to the Fund Office for pre-certification as to the Medical Necessity of the claim which will be reviewed by either the Fund's Medical Advisor or the Fund's Utilization Review Provider, Hines & Associates. Absent unusual circumstances or the need for additional information, an initial determination from the Fund Office will be made within 15 days of receipt of your claim. Out-of-network claims (other than those for emergency room care) that are not submitted to the Fund Office for pre-certification will be denied.

5.19 Gender Dysphoria

Treatment of Gender Dysphoria will be considered a covered expense for Medically Necessary Services, subject to any conditions and limitations set forth in this Plan. For purposes of this section 5.19, Gender Dysphoria is defined as a disorder characterized by the diagnostic criteria classified in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

In order to be a covered expense, the Participant must undergo an evaluation by a Qualified Mental Health Professional ("QMHP") experienced in the evaluation and treatment of patients with a variety of mental health issues and has the requisite skill and experience in evaluation of patients with Gender Dysphoria and all relevant comorbid mental health conditions, including familiarity in the application of the Diagnostic Statistical Manual of Mental Disorders ("DSM V") or the then current version of the DSM. A practitioner will be considered a QMHP if they are a board certified psychiatrist, psychologist, or an in-network master's level provider with a degree in a clinical behavioral science field from a nationally accredited credentialing board and appropriately licensed in the jurisdiction in which they practice and are qualified to evaluate and treat Participants as noted above. For the treatment of Gender Dysphoria to be considered a Covered Expense, the Participant must satisfy all criteria in the current version of the DSM and have no confounding comorbid mental health conditions, which would be contraindications to treatment, and treatment must have been recommended by a qualified practitioner with appropriate training and credentials acceptable to the Trustees.

Covered expenses may include supportive mental health counseling and treatment of any additional comorbid mental health conditions, appropriate hormonal treatment interventions, orchiectomy, oophorectomy and hysterectomy, or genital reconstructive surgery where those interventions and treatments comply with all other provisions of the Plan. Any limitations on mental health counseling shall be consistent with corresponding limitations on medical/surgical benefits under the Mental Health Parity and Addiction Equity Act ("MHPAEA").

Orchiectomy, oophorectomy/hysterectomy, penectomy, metoidioplasty, penile prothesis, vaginectomy, and genital reconstructive surgery expenses are covered subject to the following conditions:

1. There is well-documented and persistent Gender Dysphoria;
2. The individual is age 18 or over;
3. Two referral letters from QMHPs as described above; one of which must be the Participant's treating mental health professional and second from an additional qualified mental health professional who has performed an appropriate evaluation of the Participant;
4. There must be documented control of any comorbid medical or mental health conditions that would render the Participant incapable of making a fully informed decision or interfere with the diagnosis of Gender Dysphoria and substantially diminish the likelihood of a reasonable treatment outcome;
5. In the absence of a medical contraindication, complete 12 months of continuous hormone therapy appropriate to the member's gender goats and complete 12 months of living in a congruent gender role;
6. Obtain treatment from a practitioner and facility with appropriate experience in the provision of the requested services; and
7. Obtain pre-certification prior to surgical procedure for any out-of-network services.

Hormone therapy is covered under the Prescription Drug Benefit under the following conditions:

1. Completion of evaluations as outlined and have a diagnosis of Gender Dysphoria with no contraindications to treatment;
2. Treatment must be ordered and supervised by a practitioner experienced in the treatment of individuals with Gender Dysphoria;
3. Obtain pre-certification for any out-of-network services prior to beginning therapy; and
4. Age 18 or over.

Covered services for Gender Dysphoria will not include any service considered to be cosmetic or not Medically Necessary, including, but not limited to, hair replacement or removal, voice therapy or lessons, liposuction, rhinoplasty, breast augmentation, lip reduction, lip augmentation, laryngeal or thyroid cartilage shaving or contouring, abdominoplasty, chestwall contouring, body contouring, facial contouring, skin resurfacing, collagen injections and any other cosmetic procedure or service otherwise excluded under the Plan.

Also not covered are the following:

1. Treatment outside the United States
2. Transportation, meals and lodging;

3. Reversal of genital surgery; and
4. Reproduction services, including, but not limited to, sperm preservation in advance of hormone treatment or gender dysphoria surgery, cryopreservation of fertilized embryos, oocyte preservation, surrogate parenting, donor eggs, donor sperm and host uterus, except to the extent covered under Section 5.15 of the Plan.

VI. PRESCRIPTION DRUG BENEFIT

The Plan pays 100%, less the applicable copayment, of the Reasonable and Customary Charge of Prescription Drugs, including injectable drugs, which may be self-administered, prescribed by a Physician to cure or mitigate a sickness or illness. (See Schedule of Benefits.)

Your prescription needs may be met at a significant discount through the Fund's agreement with Express Scripts. Your use of Express Scripts' Affiliated Pharmacies allows you to make a smaller cash payment to receive necessary Prescription Drugs and also reduces the Fund's cost of providing and maintaining your Prescription Drug benefit at the current level of coverage. Out-of-network prescription drugs are not covered. Additionally, the Fund may enter into agreements with Express Scripts and other service providers to implement Prescription Drug programs to reduce the costs of your prescription drug benefits or enhance such benefits based on various health factors.

The Express Scripts' nationwide network provides that you may have a participating pharmacy near you, wherever you may be. In the Chicagoland Area, the Express Scripts' network includes most of the national pharmacy chains, as well as a broad network of independent pharmacies. Ask your pharmacist if he or she participates in the Express Scripts' network. If you would like the name of a participating pharmacy conveniently located in your area, contact the Fund Office, or utilize Express Scripts' toll-free information number, 1-800-451-6245 www.expressscripts.com.

Prescribed specialty drugs and self-administered injectable drugs (except insulin) must be purchased from Accredo to be eligible for coverage by the Plan. Contact the Fund Office if you need to fill a prescription for a self-administered injectable drug, or if Accredo is not able to fill the prescription. Unless determined to be Medically Necessary based on verification from your prescribing Physician, a generic alternative will be prescribed. Unless otherwise determined by the Trustees to be Medically Necessary, erectile dysfunction medication will be limited to six (6) pills per month.

For maintenance type drugs (e.g., heart medication, blood pressure medication, diabetic medication, etc.), you are encouraged to have your prescription filled through Express Scripts' Prescription Drug Mail Order Program. For birth control drugs, you are required to have your prescription filled through Express Scripts' Prescription Drug Mail Order Program. You can receive up to three months of prescribed maintenance drugs and medications. The Mail Order Program operates in the same manner as if the medication was purchased at a retail pharmacy with your Express Scripts' Identification Card, (use your BC/BS ID card), except for the amount of your copayment. Use of this Program will save you money.

VII. DENTAL BENEFITS

The Plan pays the Dental Benefits stated in the Schedule of Benefits. The Dental Benefits under the Plan are subject to an individual Deductible with a maximum Deductible per family unit.

7.1 Dental Claims

The Fund's dental claims are processed by Delta Dental of Illinois. You will save money if you use a Dentist who is part of the Delta Dental network. If your dentist is part of the Delta Dental network, advise your dentist that you are a Participant (or Dependent of a Participant) in the Plumbers' Welfare Fund, Local 130, U.A. You can also contact the Fund Office or go online at www.deltadental.com or call 1-800-323-1743 to learn if your dentist is a member of the Delta Dental network or to find a conveniently located network dentist. If you use a dentist who is out-of-network, you may be balance billed for any unpaid services you receive.

7.2 Dental Benefit Definitions

The following definitions are applicable to your Dental Benefits:

- **Allowable Charge.** The usual, customary, and reasonable fee or charge for the Dental Services rendered and supplies furnished in the area where the Dental Services and supplies are provided.
- **Coverage Year.** The twelve month calendar year -- January through December.
- **Deductible.** The amount of Covered Dental Expenses that a Participant must pay before Dental Benefits are payable. See Schedule of Benefits for the amount of the individual Deductible and for the maximum Deductible for a Family Unit.
  The Deductible applies only once in any calendar year. However, any expense applied against the Deductible in the last three months of a calendar year may also be applied against the Deductible for the next calendar year so that dental claims will not be subjected to a Deductible late in one calendar year and soon again in the next following year.
- **Dental Hygienist.** A person licensed to practice dental hygiene by the governmental authority having jurisdiction over the licensure and practice of dental hygiene and who works under the supervision and direction of a Dentist.
- **Dentist.** A person licensed by the State of Illinois or another State to practice dentistry and dental surgery.
- **Dental Service.** The ordinary and usual professional services rendered by a Dentist.
- **Family Unit.** A Participant and his or her eligible Dependents.
- **Maximum Amount Payable.** The total amount payable for all covered dental services, excluding Pediatric Care, rendered during any one calendar year for any one member of Participant's Family Unit.
- **Treatment Plan.** A written report, showing the recommended treatment of any dental disease, defect, or injury prepared by a Dentist as a result of any examination made by him or her.

7.3 Dental Benefits Descriptions

Coverage A - Routine Oral Examination

This benefit covers 100% of Allowable Charges for a Routine Oral Examination. No Deductible applies to Coverage A. This benefit covers two examinations a year, but at least six months must elapse between examinations.

Routine Oral Examination includes:

- Prophylaxis - may be done by a Dental Hygienist and is not subject to the Maximum Amount Payable;
- Oral examinations;
- X-rays - if professionally indicated (full mouth x-rays once in any 12 months);
- Diagnosis; and
- Topical fluoride applications for Dependent children (once in any 12 months).

Coverage B - Basic Dental Care

If a Participant incurs expenses as a result of a dental disease, defect or injury, benefits are payable for Allowable Charges incurred for the services listed below. Also included is the expense incurred for examination, other than a Routine Oral Examination, if the examination is made in connection with dental disease, defect or injury, or suspected dental disease. This benefit is for the following services and is subject to the annual Deductible:

- Restorative services: amalgam, synthetic porcelain and plastic restorations;
- Periodontics: includes treatment for diseases of the gums;
- Endodontics: includes pulpal therapy and root canal filling;
- Oral surgery: provides for extractions and other oral surgery, including pre- and post-operative care;
- Emergency treatment for the relief of pain;
- Dental examinations required for a dental disease, defect, or injury; and
- Dental sealants for individuals under 16 years of age.

Coverage C - Gold Restorations, Crowns and Prosthetics

If, as a result of loss or removal of teeth due to dental disease, defect, or injury, a Participant incurs expenses for dental prosthetics while coverage is in force, benefits are payable for the Allowable Charges incurred for those appliances listed below. This benefit is for the following Allowable Charges for dental procedures and is subject to the annual Deductible:

- Gold restorations when the teeth cannot be restored with another filling material;
- Crowns and jackets when the teeth cannot be restored with a filling material;
- Prosthetics: provides bridges, partial dentures, complete dentures and space maintainers;
- Denture replacement benefits: if the replacement of a denture is professionally indicated for a Participant or Dependent, benefits are payable for Allowable Charges incurred for a replacement that is not the result of the theft or loss of a previous denture supplied under this Plan. These benefits are payable only after a Participant has been covered for one year. If, however, the initial replacement of an opposing complete denture requires the replacement of the existing complete denture, benefits are payable for the replacement of

that denture. Any charge for denture replacement made less than five years after the prior denture replacement was made under the program are not payable; and
- Dental implants.

Coverage D - Orthodontic Care

This benefit covers 80% of Allowable Charges for necessary orthodontic treatment by a Dentist subject to the lifetime limit contained in the Schedule of Benefits. The Deductible does not apply to Coverage D. The lifetime orthodontic benefit is in addition to the annual maximum benefit applying to other dental benefits. Initial and subsequent installations of orthodontic appliances are covered. Orthodontic care charges are not allowable until orthodontic services are actually rendered. If eligibility terminates during the course of orthodontic treatment, the Plan will continue to pay for orthodontic treatment for the 30 days after loss of eligibility. However, the maximum amount for this extended eligibility period is the average of the previous quarterly payments, or if orthodontic treatments were received for less than three months on the date of termination, the maximum amount is $100.00. The benefits payable after termination are subject to all other Plan provisions governing termination of eligibility.

The above dollar limits do not apply to individuals under the age of 19.

7.4 Limitations and Exclusions on Dental Benefits

Inlays, Crowns, and Jackets

If a tooth can be restored with amalgam, silicate or plastic, but a more expensive type of restoration is selected, the Plan pays only the benefit for the basic restoration. Any unpaid treatment cost is the responsibility of the Participant.

Partial and Complete Dentures

If in the construction of a complete or partial denture "personalized" restorations or "specialized techniques" replace standard procedures, the Plan pays only the benefit for the standard denture. Any unpaid costs are the Participant's responsibility.

Mouth Rehabilitation

If you select a course of Mouth Rehabilitation, the Plan pays only the applicable percentage of the fees for procedures necessary to eliminate oral disease and replace missing teeth. The cost of any other treatment, including costs related to appliances or restorations intended to increase vertical dimension or restore the occlusion, are not covered.

Additional Exclusions

- Services performed for purely cosmetic purposes or to correct congenital conditions;
- Charges for courses of treatment, including prosthetics, undertaken before the person became an eligible Participant or Dependent; or
- Services of anesthetists or anesthesiologist.

VIII. EYE CARE BENEFITS

The Plan pays the cost of an eye exam by a licensed Physician or optometrist and the cost of prescribed glasses or contact lenses up to the maximum amounts shown in the Schedule of Benefits. With the exception of coverage for individuals under age 19, payments are not made for more than one pair of prescribed eye glasses or prescribed contact lenses during any 12 consecutive month period. In addition, the Plan covers the cost of Lasik or Photo Refractive Keratectomy (PRK) surgery for both eyes up to the amount shown in the Schedule of Benefits.

However, if a Participant or Dependent undergoes eye surgery or suffers a traumatic injury causing a change in his or her lens prescription, the Plan benefits are provided for each medically prescribed lens change during the six month period following the date of the surgery or the date of injury. The date of the last medically prescribed lens change before or during the six month period following eye surgery is the starting date for measuring the 12 month waiting period for additional eye care benefits.

The Plan, through an agreement with EyeMed, has made it possible for you to obtain eye exams, and a selection of eye glasses and contact lenses with no out-of-pocket cost if you use an eye care provider within the EyeMed Network. Please call EyeMed toll free at 1-866-723-0514 or visit EyeMed's website at www.eyemed.com for the participating location near you.

At each EyeMed Provider, you may select from several eyeglass styles, which are paid in full under the Fund's Eye Care Benefit. Upgrades and enhancements to the basic frames and lenses are available at an additional discounted charge. To obtain the EyeMed discount you are required only to go to an EyeMed location and identify yourself as a Participant in the Plumbers' Welfare Fund, Local 130, U.A.

Additionally, the Vision Center at the Plumbers' Welfare Fund, Local 130, U.A. Wellness Center provides eye exams, fittings for glasses and contact lenses, and minor adult surgical procedures up to the amounts shown in the Schedule of Benefits.

IX. HEARING CARE

The Plan will pay the cost of a hearing examination by a qualified otologist, otolaryngologist, or audiologist, up to the maximum shown in the Schedule of Benefits. No more than one examination is covered during any 24-month period except for an individual under 19 years of age who has degenerative hearing loss, in which case, one hearing exam every 6-month period is covered. If you obtain a prescribed hearing aid instrument, the Plan pays for the cost of the instrument or instruments up to the maximum amount shown in the Schedule of Benefits.

No more than one hearing aid instrument is covered during any 60-month period; however, the Plan will pay for bilateral hearing aid instruments up to the amount shown in the Schedule of Benefits only if prescribed hearing aid instruments are determined by the Plan's Medical Advisor to be Medically Necessary. For individuals under the age of 19 years, the Plan will pay for a new molded earpiece once in each 12 month period and for a new hearing aid instrument once in each 36 consecutive month period, up to the amount shown in the Schedule of Benefits, but the benefit for the hearing aid instrument is reduced if the molded ear piece is acquired within 12 months of receiving the hearing aid instrument. The limits set forth in the Schedule of Benefits do not apply to bone anchored hearing aids.

X. HOSPICE CARE

The Plan pays Hospice Care charges as shown in the Schedule of Benefits. Hospice care is specialized care for terminally ill patients designed to provide physical and psychological comfort for an individual suffering from a terminal illness and for members of the patient's family.

The covered Hospice Care benefit must be for a Participant who has been diagnosed as "terminally ill" which means being diagnosed with a life expectancy of six months or less. The Hospice Care benefit is payable in addition to the Plan's Hospital and outpatient benefits. The Plan's Prescription Drug benefit, subject to the applicable co-pay, is paid throughout a period of hospice care. Hospice services may be provided as an inpatient benefit at a licensed hospice care facility, Hospital or convalescent facility or as an outpatient at the patient's home under a plan of hospice treatment prepared by a Physician. Covered home hospice or outpatient hospice charges include part-time or intermittent nursing by a registered nurse or licensed practical nurse for up to 8 hours per day or services of a part-time or intermittent home health aide for up to 4 hours per day. This benefit is limited to 180 days per three-year period.

The following charges or services are not covered:

- Services of a caregiver who lives in the Participant's home or is a member of the Participant's family.
- Domestic or housekeeping services unrelated to the patient's care.
- Services providing a protective environment when no skilled service is required including companionship or sitter services.
- Services, which are not directly related to a covered patient's medical condition, for example: estate planning, pastoral counseling or funeral arrangement services, nutritional guidance or food services, or transportation services.
- Any charges or services not covered under the Plan or paid under another benefit of the Plan.

XI. WELLNESS AND VISION CENTER

11.1 Wellness Center Benefits

The Fund provides a Wellness Center, which provides a number of different benefits that are integrated with other benefits offered under the Plan. Certain benefits, as described below (and in the Schedule of Benefits), provided by the Wellness Center will be covered by the Plan with no cost-sharing; meaning that you do not have to pay any deductible, coinsurance, or copayment to receive services. Only Participants in the Plan and the Retiree Medical Plan are eligible to participate in the Wellness Center benefit. Eligibility for Wellness Center benefits terminates when your eligibility for Plan benefits terminates. The Wellness Center provides the following services:

- Annual calendar year physical exams
- Lab work, including blood draws and onsite testing for urinary tract infections, glucose, strep throat, mononucleosis, and flu; all other blood test will be sent to offsite labs
- Physical therapy
- Treatment for sprained or strained muscles
- Urgent care visits
- Routine vaccinations, subject to availability

- Wellness education
- Certain generic prescription drugs, subject to availability

The Wellness Center also offers services through the Cerner Motion Health SM program that aims to prevent, identify and address the musculoskeletal needs of individuals. This comprehensive program offers a musculoskeletal assessment and provides a personalized movement-based treatment approach through reset, retrain and reinforce methods.

11.2 Vision Center

In addition to the eye care benefits offered under the Plan, you may also receive vision care at the Vision Center within the Wellness Center. The Vision Center provides eye exams, fittings for glasses and contact lenses, and minor adult surgical procedures. Vision benefits provided through the Vision Center include a reimbursement up to $100 per eye exam visit subject to a $500 annual family maximum for charges in excess of the EyeMed benefit $350 limit for glasses, frames or contact lenses. The $500 maximum does not apply to individuals under age 19.

XII. HEALTH REIMBURSEMENT ARRANGEMENT ("HRA")

12.1 Reimbursable Expenses Under the HRA

The Plan will reimburse out-of-pocket expenses through a Health Reimbursement Arrangement ("HRA"). Under the HRA, you will be able to receive reimbursement for your out-of-pocket medical expenses that you were required to pay due to the deductibles, copayments, and other dollar limits imposed by the Plan. The HRA can also be used to reimburse you for amounts paid for medical expenses that exceed the Plan's determination of the Reasonable and Customary charge for a procedure or treatment. Examples of expenses that can be reimbursed through the HRA include the following:

- Your deductible;
- Self-contributions or out-of-pocket payments required under the Retiree Plan;
- Payments required to continue Plan coverage under the self-payment program or COBRA;
- Any copayments, including copayments for Prescription Drugs;
- Out-of-pocket costs for benefits as permitted under Section 213 of the Internal Revenue Code (IRC §213), including menstrual products;
- Amounts that exceed any limits for dental, eye care (including Lasik or PRK surgery), or hearing benefits; and
- Amounts charged by a Physician that exceed the Reasonable and Customary charge for the procedure or treatment.

12.2 Accumulating HRA Credits

Participants will accumulate one credit under the HRA for each hour worked in Covered Employment. On a monthly basis, portions of a full hour worked in Covered Employment shall be rounded up to the nearest hour. A Participant does not accumulate credits during any time that the Participant is not actively working in Covered Employment for a Contributing Contractor or an Affiliated Employer or is not eligible for benefits under this Plan. Each credit will be valued as

described in the Schedule of Benefits. The Trustees may adjust the value of the credits from time to time. The value of the credit is $0.65 per hour. Credits will accumulate monthly based on the hours that a contractor or employer reports for a Participant. While a Participant may accumulate credits prior to becoming eligible for benefits under this Plan, a Participant will not be eligible to use or apply HRA credits to any claims or expenses until after becoming enrolled for benefits under this Plan. You may permanently opt out of and waive future reimbursements from the HRA each year. If at any time you believe that your hours were not properly reported, please contact the Fund Office.

Note: Generally, a Participant that is employed by an Affiliated Employer, is a Non-Bargaining Unit Employee, or is eligible for benefits under the Plan pursuant to a participation agreement will accumulate HRA credits based on the terms of their respective participation agreement. Such a Participant does not accumulate credits during any time that the monthly payment for the Participant's coverage is not remitted to the Fund or the Participant is not eligible for benefits under the Plan.

You will receive credits to your HRA if either you or your spouse utilize a health club membership. If you or your spouse has 150 or more health club visits during a calendar year, you or your spouse will receive a $300.00 credit to the HRA. If you or your spouse has 100 to 149 health club visits, you or your spouse will receive a $200.00 credit to the HRA. If you or your spouse has 50 to 99 health club visits you or your spouse will receive a $100.00 credit to the HRA. The number of visits required for the credit is for each individual. Visits by you and your spouse may not be combined to reach the required number to receive an HRA credit. However, both you and your spouse may receive a credit during the calendar year if you each meet one of the visit minimums. Credits to your HRA account will be made upon the Fund Office's receipt of your health club membership invoice and proof of visits.

12.3 Using Your HRA Credits

Participants may apply for reimbursement at the end of each calendar quarter by contacting the Fund Administrator, submitting claims online at employee.eflexgroup.com or by using their HRA debit card as described below. A Participant may be reimbursed up to the lesser of the amount of covered expenses or the amount of credits accumulated by the Participant. In order to receive reimbursement for an expense the charge must have been incurred after the individual was covered by the HRA and while the individual was eligible for benefits under the Plan. Additionally, the claim must be properly substantiated with (1) a receipt or billing statement that includes the date of service or purchase, the name of the person and the amount paid, and (2) copies of the explanations of benefits from any health coverage regarding the expense. Additionally, reimbursement cannot be made for any amount that was paid from another source such as other health coverage. Claims that are not properly substantiated will be rejected by the Fund Office. You should keep copies of all materials submitted with your claim for reimbursement in case your tax records are audited. You will not be entitled to any earnings (such as interest) on the money credited to the HRA, nor will you be subject to losses.

12.4 Using Your HRA Debit Cards

Participants with HRA accounts will be issued debit cards reflecting their HRA account balance. The debit cards will be administered through TASC DirectPay system. The amount available

through your card will reflect the current unused credits to your HRA. You will not receive a card until you have earned initial eligibility under the Plan. Additionally, if you lose eligibility under the Plan, you generally will not be able to access allocations to the HRA made with respect to hours worked after your loss of eligibility until such time as you regain eligibility. Once you lose eligibility, you will not be able to use your debit card but you will be able to submit paper claims for dates of service prior to losing eligibility under the Plan, (however, you can continue to access HRA contributions allocated with respect to hours worked before you lost eligibility buy submitting paper claims).

You may contact the Fund Office at 312-226-5000 or TASC at 800-350-3778 if you have questions about your HRA debit card.

12.5 Terminating or Forfeiting HRA Credits

When a Participant is terminated from Covered Employment or loses eligibility for coverage under the Plan, any remaining credits will be forfeited. No Participant or Dependent is vested in any credits under the HRA and cannot receive cash except in reimbursement of covered medical expenses. A Participant that loses eligibility under the Plan but has elected self-pay health coverage under the Retiree Medical Plan or COBRA continuation coverage will not forfeit accumulated credits and will be eligible to apply accumulated credits to covered medical expenses and payments for self-pay health coverage or COBRA.

If you lose active eligibility and elect COBRA, you will continue to accrue additional credits to your HRA account if you are still in Covered Employment and will have immediate access to those contributions. Your rights, if any, to COBRA under the HRA will be explained in the COBRA Election Notice that is provided following a loss of eligibility.

Upon the death of a Participant, the surviving spouse (or any Dependent if there is no surviving spouse) may apply any remaining accumulated credits of the Participant for covered medical expenses of the surviving spouse or other Dependents of the Participant provided that such surviving spouse or other Dependents are otherwise eligible for benefits under this Plan. Upon the death of a Participant, if no surviving spouse or Dependent is eligible for benefits under this Plan, then any remaining accumulated credits of such Participant shall be forfeited.

XIII. COBRA CONTINUATION COVERAGE

The right to continue group health coverage under this Plan was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). COBRA coverage becomes available to you when you (and your Dependent(s)) would otherwise lose your group health coverage under the Plan due to a COBRA qualifying event. The Plan provides no greater COBRA rights than what COBRA requires—nothing in this document is intended to expand your rights beyond COBRA's requirements.

13.1 What is COBRA Coverage?

COBRA coverage is a continuation of the Plan's group health coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event occurs and any required notice of that event is properly provided to the Plan, COBRA coverage must be offered to each person losing coverage

who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under a Qualified Medical Child Support Order may also be qualified beneficiaries. This is discussed in more detail in the separate paragraphs below). Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

The Plan provides one option for COBRA coverage, which includes your group health coverage under the Plan. However, COBRA coverage does not include Death Benefits, Accidental Dismemberment Benefits, Military Benefits and Accident or Disability benefits. If you (as the Employee) have a newborn child, adopt a child or have a child placed with you for adoption while COBRA coverage is in effect, you may add the child to your coverage. You must notify the Fund Office in writing of the birth or placement in order to have this child added to your coverage. Children born, adopted or placed for adoption as described above, have the same COBRA rights as your Dependents who were covered by the Plan before the event that triggered COBRA coverage.

Upon your election for COBRA continuation coverage, you may continue to accrue additional HRA credits while receiving COBRA continuation coverage at the rate established by the Trustees from time to time. However, the cost of the COBRA continuation coverage shall be appropriately adjusted for the HRA credits.

13.2 What is a Qualifying Event?

If you are a Participant, you will become eligible for COBRA if you lose your coverage under the Plan because either one of the following qualifying events occurs:

- Your hours of employment are reduced, or
- Your employment terminates for any reason other than your gross misconduct.

If you are the spouse of a Participant, you will lose your coverage under the Plan if any of the following qualifying events occurs:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment terminates for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Dependent children of a Participant will lose coverage under the Plan if any of the following qualifying events occurs:

- The parent-Participant dies;
- The parent-Participant's hours of employment are reduced;
- The parent-Participant's employment terminates for any reason other than his or her gross misconduct;
- The parent-Participant becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or

- The child stops being eligible for coverage under the Plan as a "Dependent" child.

13.3 When is COBRA Coverage Available?

The Fund Office will offer COBRA coverage to qualified beneficiaries when the qualifying event is the end of employment, reduction of hours of employment, death of the Participant, commencement of a proceeding in bankruptcy with respect to the Plan, or the Participant becoming entitled to Medicare benefits (under Part A, or Part B, or both).

If you elect self-pay health coverage under the Retiree Medical Plan of the Plumbers' Welfare Fund, Local 130, U.A., you are not eligible for COBRA coverage. If your spouse elects self-pay health coverage, she/he is not eligible for COBRA coverage.

13.4 Notification Obligations

You or your Dependent must inform the Fund Office of your divorce, legal separation, or Dependent child no longer qualifying as a Dependent within 60 days of the qualifying event. If you do not notify the Fund Office within 60 days of such a qualifying event, you and/or your Dependent will lose your right to elect COBRA continuation coverage.

Your Employer will notify the Fund Office of your termination of employment, reduction in hours, death, or entitlement to Medicare coverage. However, because Employers contributing to multiemployer funds may not be aware of these events, the Fund Office will rely on its records for determining when eligibility is lost under these circumstances. To help ensure that you do not suffer a gap in coverage, we urge you or your family to notify the Fund Office of qualifying events as soon as they occur.

When the Fund Office is notified that one of these events has occurred, you and your Dependents will be notified of the right to elect COBRA continuation coverage. Once you receive a COBRA notice, you have 60 days to respond if you wish to elect COBRA continuation coverage. If you do not elect coverage, your Dependents will be given the opportunity to elect coverage independently from you. If your Dependent is a minor or otherwise incapable of electing coverage, the Dependent's parent or legal guardian should contact the Fund Office for more information.

13.5 Period of Coverage

1. Coverage Continues for 18 Months. You may elect to make self-contributions for COBRA continuation coverage for yourself and your Dependents for up to 18 months if coverage ends due to your termination of employment or your reduction in hours.
2. Coverage Continues for 29 Months. If your employment ends due to your termination of employment or reduction in hours, and at that time, or within 60 days of the event, you or one of your Dependents is totally disabled (as determined by Social Security), coverage may continue for an additional 11 months, for a total of 29 months. To continue coverage for an additional 11 months, you must notify the Fund Office of your determination of total disability by the Social Security Administration. The self-payment for the additional 11 months will be 150% of the self-payment for the first 18 months.
3. Coverage Continues for 36 Months. Your Dependents may elect to continue coverage for up to 36 months if coverage ends because:

(a) You die;

(b) You become entitled to health care coverage under Medicare;

(c) You and your spouse divorce or legally separate; or

(d) Your Dependent child is no longer eligible for coverage under the Plan.

4. Second Qualifying Event. If your family experiences another qualifying event while receiving 18 months of COBRA coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any Dependent children receiving continuation coverage if the Participant dies, becomes entitled to Medicare (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

13.6 How Much Does COBRA Cost?

The Fund Office will notify you of the cost of your COBRA continuation coverage when it notifies you of your right to coverage. The cost for COBRA continuation coverage will be determined by the Trustees on a yearly basis.

Your first payment for COBRA continuation coverage must include payments for any months retroactive to the day your and/or your Dependents' coverage under the Plan terminated as well as for the current month. This first payment is due no later than 45 days after the date you or your Dependents return the election form to the Fund Office.

Subsequent payments are due on the first business day of each month for which coverage is provided, with a grace period of 30 days. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you make a payment later than the first day of the month for the period to which it applies, but before the end of the grace period for the coverage, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If payment is not received by the end of the grace period, all benefits will terminate immediately. Once your COBRA continuation coverage is terminated, it cannot be reinstated.

The standard COBRA premium is determined by the Trustees and adjusted from time to time as permitted by federal law. Generally, each qualified beneficiary is required to pay the entire cost of COBRA continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, as discussed below, 150 percent) of the cost to the Plan for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage.

13.7 When COBRA Ends

COBRA coverage may end for any of the following reasons:

1. You or your Dependent becomes covered under another group medical, prescription drug, dental or vision plan.
2. The required contribution is not timely paid.
3. The Fund terminates the Plan.
4. You or your Dependent reaches the end of the 18-month, 29-month or 36-month COBRA coverage period.
5. Your coverage under the Plan ends and you become enrolled in Medicare. However, if your eligible Dependents are entitled to COBRA coverage, their maximum coverage period is 36 months from the initial qualifying event, or
6. Your Dependents become entitled to Medicare.

13.8 Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program ("CHIP"), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

13.9 Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit www.medicare.gov/medicare-and-you.

13.10 If You Have Questions

Questions concerning your COBRA coverage rights should be addressed to the Fund Office. 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).

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace created pursuant to the Affordable Care Act. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment period for another group health plan for which you are eligible, even if that plan generally does not accept late (or mid-year) enrollees. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov or call 800-318-2596 for more information.

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 sent to the Fund Office.

XIV. YOUR RIGHTS UNDER HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Because PPACA prohibits the use of preexisting condition limitations, certificates of creditable coverage are no longer needed. Therefore, the Fund Office will no longer issue certificates of creditable coverage unless you submit a written request for a certificate.

14.1 HIPAA Privacy

HIPAA requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice. The privacy notice will be available from the Fund office.

This Plan and the Plan Sponsor, will not use or further disclose information that is protected by HIPAA ("protected health information" or "PHI"), except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan. The Plan also hires professionals and other companies to assist it in providing health care benefits. The Plan will require all of its business associates to also observe HIPAA's privacy rules.

You will have certain rights with respect to your PHI, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You will also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice that provides a complete description of your rights under HIPAA's privacy rules. Please contact the Fund Office at Welfare Fund Administrator Plumbers' Welfare Fund, Local 130, U.A., 1340 West Washington Boulevard, 3rd Floor, Chicago, IL 60607, (312) 226-5000 if:

- You need a copy of the privacy notice;
- You have questions about the privacy of your health information; or
- You wish to file a complaint under HIPAA.

14.2 The Plan's Use and Disclosure of Your Protected Health Information

The Plan will use your PHI to the extent and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations. The Plan will use and disclose your PHI as required by law and as permitted by your authorization or the authorization of your beneficiary. With an authorization, the Plan will disclose PHI to the applicable Pension Fund, reciprocal benefit plans and Workers' Compensation insurers for purposes related to administration of those plans.

1. **Definition of Payment.** Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:
    (a) Determination of eligibility, coverage, and cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim);
    (b) Coordination of benefits;
    (c) Adjudication of health benefit claims (including appeals and other payment disputes);
    (d) Subrogation of health benefit claims;
    (e) Establishing employee contributions;
    (f) Risk adjusting amounts due based on enrollee health status and demographic characteristics;
    (g) Billing, collection activities, and related health care data processing;
    (h) Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant (and their authorized representatives') inquiries about payments;
    (i) Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(j) Medical necessity reviews, or reviews of appropriateness of care or justification of charges;

(k) Utilization review, including, preauthorization, concurrent review, and retrospective review;

(l) Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, SSN, payment history, account number, and name and address of the provider and/or health plan); and

(m) Reimbursement to the Plan.

2. **Definition of Health Care Operations.** Health Care Operations include, but are not limited to, the following activities:

(a) Quality assessment;

(b) Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;

(c) Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

(d) Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);

(e) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

(f) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies;

(g) Business management and general administrative activities of the entity, including, but not limited to:

i) management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;

ii) customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers;

iii) resolution of internal grievances; and

iv) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.

3. **The Plan's Disclosure of Protected Health Information to the Board of Trustees.** The Plan is a multiemployer plan under which the Board of Trustees is both the Plan Sponsor and Plan Administrator. When the Board of Trustees is engaged in settlor functions it is acting as Plan Sponsor and will not have access to PHI. When the Board of Trustees is engaged in administrative functions it is acting as Plan Administrator and will have access to PHI to the extent necessary to administer the Plan. The Board of Trustees will maintain adequate separation between its Plan Administrator and Plan Sponsor functions.

   With respect to PHI, the Plan Sponsor agrees to:

   (a) Not use or further disclose the information other than as permitted or required by this Plan/SPD or as required by law;

   (b) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

   (c) Not use or disclose the information for employment-related actions and decisions unless authorized by the individual;

   (d) Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor unless authorized by the individual;

   (e) Report to the Plan any use or disclosure of the information of which it becomes aware that is inconsistent with the uses or disclosures provided for in this Summary Plan Description. Specifically, the Plan Sponsor will report to the Plan any Breach as defined by 45 CFR § 164.402;

   (f) Make PHI available to the individual in accordance with the access requirements of HIPAA;

   (g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

   (h) Make the information available that is required to provide an accounting of disclosures;

   (i) Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of HHS for the purposes of determining compliance by the group health Plan with HIPAA;

   (j) Cooperate with the Plan's efforts to comply with the Breach notification regulations set forth in 45 CFR §§ 164.404, 164.406 and 164.408.

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

4. **Disclosure of Protected Health Information to Plan Employees**. Adequate separation between the Plan and the Plan Sponsor will be maintained.

Therefore, in accordance with HIPAA, only the following employees or classes of employees, as well as the Trustees, will be given access to PHI:

(a) The Fund Administrator,

(b) Fund personnel,

(c) The Field Representative,

(d) All other staff members of the Plan Sponsor to whom the Fund Administrator has delegated responsibility for Plan administration, and

(e) The Trustees.

The persons described above will only have access to and will only use and disclose PHI for Plan administration functions that the Plan sponsor performs for the Plan in accordance with HIPAA's minimum necessary rules. If these persons do not comply with this Plan and its related HIPAA policies, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

14.3 HIPAA Security

The Plan will also comply with the security regulations issued pursuant to the HIPAA, 45 CFR Parts 160, 162 and 164 (the "Security Regulations"). The Board of Trustees shall, in accordance with the Security Regulations:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the PHI that it creates, receives, maintains or transmits on behalf of the Plan.
2. Ensure that "adequate separation" is supported by reasonable and appropriate security measures. "Adequate Separation" means the Board of Trustees will use PHI 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 Fund who uses or discloses PHI in violation of the Plan's security or privacy policies and procedures or this Plan provision shall be subject to the Plan's sanction policy.
3. Ensure that any agent or subcontractor to whom it provides PHI agrees to implement reasonable and appropriate security measures to protect the information.
4. Take appropriate action related to any Security Incident of which it becomes aware.

Unless defined otherwise in this document, all capitalized terms in this provision have the definition given to them by the Security Regulations which are incorporated herein by reference.

XV. PLAN LIMITATIONS AND EXCLUSIONS

15.1 General Limitations

The Plan does not cover any medical care, services, or supplies rendered or supplied to a Participant:

1. In connection with a general health examination except care, services or supplies that are Preventive Services or that are covered under the Plan's Wellness Medical Benefit;

2. Any expense that exceeds the applicable Plan limitation;
3. That are compensable under any Workers Compensation law, Workers' Occupational Disease law, Employer Liability law, or any other similar laws;
4. That are provided or paid for by any governmental agency or under any governmental law or program, except as specifically provided in the Plan;
5. That are rendered or supplied without charge, or for which there would be no charge except for the Plan;
6. That are not Medically Necessary;
7. That are related to surgical assistants;
8. That are related to vasectomy reversals (vasovasostomy) or reversal of a tubal ligation;
9. That are considered experimental or investigational (for purposes of the Plan, experimental or investigational care, services, or supplies include but are not limited to those treatments, procedures, or items determined to be experimental or investigational under Federal Law and Regulations or the Laws and Regulations of the State of Illinois);
10. That are cosmetic in nature, unless the care, services or supplies are Medically Necessary. However, the following services will be covered under limited circumstances: (i) mastectomy patients are covered for reconstructive surgery following the mastectomy as required by the Women's Health and Cancer Rights Act of 1998; and (ii) panniculectomy surgery to remove excess skin for individuals who have had significant weight loss, reached a BMI of 30 or less and have maintained a stable weight for at least six months.
11. That are for personal hygiene, comfort or convenience items;
12. That are abortions, except as otherwise provided under the Plan;
13. For primarily custodial care provided to take care of a Participant who cannot take care of himself and is not primarily rendered or applied to cure any illness or injury;
14. That is extended Hospital care;
15. For organ transplants, unless the Trustees provide advance written approval or the procedure was performed on an emergency basis;
16. For treatment of pectus excavatum, unless the Trustees provide advance written approval;
17. For food or food supplements, vitamins, minerals, appetite suppressants or dietary supplements or formulas, whether or not prescribed by a Physician, but this exclusion does not apply to the following: (a) total parenteral nutrition or enteral nutrition when it is used in circumstances where normal ingestion of food in not possible and the total parenteral nutrition or enteral nutrition in Medically Necessary as the only means to permit the Participant to obtain nutrients necessary to sustain physical health; and (b) infant formulas for the treatment of phenylketonuria (PKU) or other heritable diseases.
18. That are incurred while outside of the geographical boundaries of the United States of America except where the Participant requires medical care while traveling temporarily outside of the United States due to an emergency;

19. That exceed the lesser of the Reasonable and Customary Charge or Fee, or the Plan's benefit for the covered care, service, or supply;
20. For Prescription Drugs filled through on-line or internet pharmacies;
21. For expenses for Infertility treatments, including diagnostic tests and Prescription Drugs, rendered to an individual other than a Participant, except as otherwise provided under the Plan;
22. That is excluded under the terms of any group insurance contract which is a part of this Fund;
23. For retainer fees or similar fees by a Physician or other provider;
24. Medical care, services or supplies that are not provided or prescribed by or under the supervision of a Physician or Surgeon;
25. Hospital expenses not covered under the Plan's basic coverage such as the cost of newspapers, personal comfort items, telephone charges, and similar items provided during hospitalization; and
26. Expenses for gene therapy services and treatment. Any and all expenses related to gene therapy services and treatment, including Zolgensma, a gene therapy treatment, are excluded from coverage under the Plan. Gene therapy typically involves replacing a gene that causes a medical problem with one that does not, adding genes to help the body fight or treat disease, or inactivating genes that cause medical problems. Gene therapy expenses are also excluded from the Plan's prescription drug benefit.
27. Genetic testing, except genetic testing for cystic fibrosis when Medically Necessary.

15.2 Special Limitations

In addition to the limitations previously set forth in this Plan/SPD, the following limitations also apply:

Non-Bargaining Unit Employees

Non-Bargaining Unit Employees are not eligible for Death Benefits, Accidental Dismemberment Benefits, and Weekly Sickness or Accident Benefits.

Newly Organized Journeymen

Benefits for a newly organized journeyman do not include Death Benefits, Accidental Dismemberment, Weekly Sickness or Accident Benefits, Military Service Benefits, or the Retiree Plan until the newly organized journeyman satisfies the Continuing Eligibility requirements for the Benefit Quarter which corresponds to work performed in the Contribution Quarter during which immediate initial eligibility was extended.

Certain Schedule A Agreement Trainees

Benefits for Trainees with "Mc", "Md", or "Me" classifications who are subject to the Schedule A Agreement do not include Retiree Benefits, Death Benefits, Accidental Dismemberment, Weekly Sickness or Accident Benefits, Eye Care, Hearing Care, or Dental Benefit coverage.

XVI. INTERNAL CLAIMS AND APPEAL PROCEDURE

16.1 Introduction

This section describes the procedures followed by the Plan in making internal claim decisions and reviewing appeals of denied claims.

The Plan's internal claims and appeal procedures are designed to provide you with full, fair, and fast claim review and so that Plan provisions are applied consistently with respect to you and other similarly situated participants and dependents. With respect to health benefit claims, the Plan must consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary or appropriate, or is experimental or investigational).

The internal claims process pertains to determinations made by the Fund Administrator (or other claims administrator designated by the Trustees) about whether a request for benefits (known as an initial "claim") is payable. If the Fund Administrator denies your initial claim for benefits (known as an "adverse benefit determination"), you have the right to appeal the denied claim under the Plan's internal appeals process.

For health benefits, you may be able to seek an external review with an Independent Review Organization ("IRO") that conducts reviews of adverse benefit determinations either (i) after the Plan's internal appeals process has been exhausted, or (ii) under limited circumstances before the Plan's internal claims and appeals process have been exhausted.

16.2 Definitions

1. **Days Defined.** For the purpose of the initial claims and appeal processes, "days" refers to calendar days, not business days.
2. **Adverse Benefit Determination.** An adverse benefit determination, for the purpose of the internal claims and appeal process, means:
    (a) A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Plan or a determination that a benefit is not a covered benefit;
    (b) A reduction of a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion, or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not Medically Necessary or appropriate, or experimental or investigational; or

(c) A rescission of coverage, whether or not there is an adverse effect on any particular health or disability (Weekly Sickness or Accident Benefit) benefit. An adverse benefit determination does not include rescissions of coverage with respect to life, death, and accidental death and dismemberment insurance/death benefits.

3. **Health Care Professional.** A health care professional, for the purposes of the claims and appeals provisions, means a Physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

4. **Claim.** A claim is a request for a Plan benefit made by you or your covered Dependent (also referred to as "claimant") or your authorized representative in accordance with the Plan's reasonable claims procedures. See section 16.3 below for the various types of claims under the Plan.

16.3 Types of Claims

1. **Health Benefit Claims.** There are four categories of health claims as described below:

   (a) **Pre-Service Claims** - A Pre-Service Claim is a claim for a benefit that requires approval of the benefit (in whole or in part) before health care is obtained. For example, all out-of-network non-emergent services require pre-certification for Medical Necessity, because pre-certification if required before Plan coverage is provided, out-of-network non-emergent services are considered Pre-Service Claims.

   (b) **Urgent Care Claims** – An Urgent Care Claim is any Pre-Service Claim for health care treatment that (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (ii) in the opinion of the claimant's attending health care provider with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. However, the Plan will not deny benefits for these procedures or services if it is not possible for the claimant to obtain the pre-approval, or the pre-approval process would jeopardize the claimant's life or health.

   (c) **Concurrent Claims** - A Concurrent Claim is a claim that is reconsidered after an initial approval has been made and results in a reduced or terminated benefit. Also, a Concurrent Claim can pertain to a request for an extension of a previously approved treatment or service.

   (d) **Post-Service Claims** - A Post-Service Claim is a request for benefits under the Plan that is not a Pre-Service Claim. Post-Service Claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim or electronic bill submitted for payment after services have been provided are examples of a Post-Service Claim. A claim regarding the rescission of coverage will be considered to be a Post-Service Claim. Most claims covered by the Plan will be considered Post-Service Claims.

2. **Weekly Sickness and Accident Benefit Claims.** A Weekly Sickness and Accident Claim is a request for benefits during a period of disability. Weekly Sickness and Accident Claims are filed after a Participant suffers a disability and benefits are paid if the Fund

Administrator determines that the Participant has suffered a disability as defined by the terms of the Plan.

3. **Death and Accidental Death and Dismemberment Benefit Claims.** A Death and Accidental Death and Dismemberment Benefit Claim is a request by a designated beneficiary for benefit payment following the death of the Participant. A claim for Accidental Death and Dismemberment Benefits may also be filed by a Participant after he or she has provided the Plan with proof of a bodily loss.

16.4 Claim Elements

An initial claim must include the following elements to trigger the Plan's internal claims process:

- Be written or electronically submitted (oral communication is acceptable only for Urgent Care Claims);
- Be received by the Fund Administrator;
- Name a specific individual Participant and his/her Social Security Number;
- Name a specific claimant and his/her date of birth;
- Name a specific medical condition or symptom;
- Provide a description and date of a specific treatment, service or product for which approval or payment is requested (must include an itemized detail of charges);
- Identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and
- When another plan is primary payer, include a copy of the other plan's Explanation of Benefits (EOB) statement along with the submitted claim.

A request is *not* a claim if it is:

- Not made in accordance with the Plan's benefit claims filing procedures described in this section;
- Made by someone other than you, your covered Dependent, or your (or your covered Dependent's) authorized representative;
- Made by a person who will not identify himself or herself (anonymous);
- A casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- A request for prior approval or pre-certification where prior approval or pre-certification is not required by the Plan;
- An eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;
- The presentation of a prescription to a retail pharmacy or mail order pharmacy that the pharmacy denies at the point of sale. After the denial by the pharmacy, you may file a claim with the Plan;
- A request for an eye exam, lenses, frames or contact lenses that is denied at the point of sale from the Plan's contracted in-network vision provider(s). After the denial by the vision service provider, you may file a claim with the Plan.

If you submit a claim that is not complete or lacks required supporting documents, the Fund Administrator will notify you about what information is necessary to complete the claim. This

does not apply to simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim or which relate to proposed or anticipated treatment or services that do not require prior approval.

16.5 Initial Claim Decision Timeframes

1. Claim Filing Deadline

   Claims should be filed within 90 days following the date charges were incurred. Failure to file claims within the time required will not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible and in no event later than twelve (12) months from the date the charges were incurred.

   The time period for making a decision on an initial claim request starts as soon as the claim is received by the Fund Administrator, provided it is filed in accordance with the Plan's reasonable filing procedures, regardless of whether the Plan has all of the information necessary to decide the claim. A claim may be filed by you, your covered Dependent, an authorized representative, or by a network provider. In the event a claim is filed by a provider, the provider will not automatically be considered to be your authorized representative.

2. Health Care Claims – Decision Timeframes

   The Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which notice of an adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

   (a) Pre-Service Claims

   Claims for Pre-Service (that are not for Urgent Care) will be decided no later than 15 days after receipt by the Fund Administrator. You will be notified in writing (or electronically, as applicable) within the initial 15 day period whether the claim was approved or denied (in whole or in part).

   The time for deciding the claim may be extended by up to 15 days due to circumstances beyond the Fund Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written (or electronic, if a applicable) notification before the expiration of the initial 15 day determination period.

   If you improperly file a Pre-Service Claim, the Fund Administrator will notify you in writing (or electronically, as applicable) as soon as possible, but in no event later than 5 days after receiving the claim. The notice will describe the proper procedures

for filing a Pre-Service Claim. Thereafter, you must re-file a claim to begin the Pre-Service Claim determination process.

If a claim cannot be processed due to insufficient information, the Fund Administrator will notify you in writing (or electronically, as applicable) about what specific information is needed before the expiration of the initial 15 day determination period. Thereafter, you will have 45 days following your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision is suspended. The claim decision deadline is suspended until the earlier of 45 days or the date the Fund Administrator receives your response to the request for information. The Fund Administrator then has 15 days to make a decision and notify you in writing (or electronically, as applicable).

(b) Urgent Care Claims

In the case of an Urgent Care Claim, if a health care professional with knowledge of your medical condition determines that a claim constitutes an Urgent Care Claim, the health care professional will be considered by the Plan to be your authorized representative bypassing the need for completion of the Plan's written authorized representative form.

The Fund Administrator will decide claims for Urgent Care as soon as possible, but in no event later than 72 hours after receipt of the claim. The Fund Administrator will orally communicate its decision telephonically to you and your health care professional. The determination will also be confirmed in writing (or electronically, as applicable) no later than three (3) days after the oral notification.

If you improperly file an Urgent Care Claim, the Fund Administrator will notify you and your health care professional as soon as possible, but in no event later than 24 hours after receiving the claim. The written (or electronic, as applicable) notice will describe the proper procedures for filing an Urgent Care Claim. Thereafter, you must re-file a claim to begin the Urgent Care Claim determination process.

If a claim cannot be processed due to insufficient information, the Fund Administrator will provide you [and your health care professional] with a written (or electronic, as applicable) notification about what specific information is needed as soon as possible and no later than 24 hours after receipt of the claim. Thereafter, you will have not less than 48 hours following receipt of the notice to supply the additional information. If you do not provide the information during the period, the claim will be denied (i.e., an adverse benefit determination). Written (or electronic, as applicable) notice of the decision will be provided to you [and your health care professional] no later than 48 hours after the Fund Administrator receives the specific information or the end or the period given for you to provide this information, whichever is earlier.

(c) Concurrent Claims

If a decision is made to reduce or terminate an approved course of treatment, you will be provided with a written (or electronic, as applicable) notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to request an appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated.

A Concurrent Claim that is an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes described above under the Urgent Care Claim section.

A Concurrent Claim that is not an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes applicable to the Pre-Service or Post-Service Claim, as applicable, provisions described above in this section.

If the Concurrent Care Claim is approved you will be notified orally followed by written (or electronic, as applicable) notice provided no later than 3 calendar days after the oral notice.

If the Concurrent Care Claim is denied, in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice.

(d) Post-Service Claims

Claims for Post-Service treatments or services will be decided no later than 30 days after receipt by the appropriate Fund Administrator. You will be notified in writing (or electronically, as applicable) within the 30-day initial determination period if the claim is denied (in whole or in part).

The time for deciding the claim may be extended by 15 days due to circumstances beyond the Fund Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written (or electronic, as applicable) notification before the expiration of the initial 30-day determination period.

If a claim cannot be processed due to insufficient information, the Fund Administrator will notify you in writing (or electronically, as applicable) about what information is needed before the expiration of the initial 30-day determination period. Thereafter, you will have 45 days after your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date the Fund Administrator receives your written response to the request for information. The Fund Administrator then has fifteen (15) days to make a decision and notify you in writing (or electronically, as applicable).

3. Weekly Sickness and Accident Benefit Claims – Decision Timeframes

Claims for Weekly Sickness and Accident benefits will be decided no later than 45 days after receipt by the Fund Administrator. You will be notified in writing (or electronically,

as applicable) within the 45-day initial determination period if the claim is denied (in whole or in part).

The time for deciding the claim may be extended by 30 days due to circumstances beyond the Fund Administrator's control; provided you are given written (or electronic, as applicable) notification before the expiration of the initial 45-day determination period. A decision will be made within 30 days of the date the Fund Administrator notifies you of the delay. The period for making a decision may be delayed an additional 30 days if due to matters beyond the control of the Fund Administrator, provided you are notified of the additional delay, before the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which the Fund Administrator expects to render a decision.

If a claim cannot be processed due to insufficient information, the Fund Administrator will notify you in writing (or electronically, as applicable) about what information is needed before the expiration of the initial 45-day determination period. Thereafter, you will have 45 days after your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision on the claim is suspended The claim decision deadline is suspended until the earlier of 45 days or until the date the Fund Administrator receives your written response to the request for information. The Fund Administrator then has 30 days to make a decision and notify you in writing (or electronically, as applicable).

4. Death and Accidental Death and Dismemberment Benefits – Decision Timeframe

Generally, you will receive written (or electronic, as applicable) notice of a decision on your initial claim within 90 days of receipt of your claim by the Fund Administrator. If additional time or information is required to make a determination on your claim (for reasons beyond the control of the Fund Administrator), you will be notified in writing (or electronically, as applicable) within the initial 90-day determination period. The 90-day period may be extended up to an additional 90 days.

16.6 Initial Determinations of Benefit Claims

1. Notice of Adverse Benefit Determination

If the Fund Administrator denies your initial claim, in whole or in part, you will be given a notice about the denial (known as a "notice of adverse benefit determination"). The notice of adverse benefit determination will be given to you in writing (or electronically, as applicable) within the timeframe required to make a decision on a particular type of claim. The notice of adverse determination will:

(a) Identify the claim involved (and for health benefit claims – include the date of service, health care provider, claim amount if applicable, denial code and its corresponding meaning);

(b) Give the specific reason(s) for the denial (and for health benefit claims - include a statement that the claimant has the right to request the applicable diagnosis and treatment code and their corresponding meanings; however such a request is not

considered to be a request for an internal appeal or external review for health benefit claims);

(c) If the denial is based on a Plan standard that was used in denying the claim, a description of such standard.

(d) Reference the specific Plan provision(s) on which the denial is based;

(e) Describe any additional material or information needed to perfect the claim and an explanation of why such added information is necessary;

(f) With respect to health and Weekly Sickness and Accident benefit claims, the opportunity, upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to an initial claim for benefits;

(g) Provide an explanation of the Plan's internal appeal and external review for health benefit claims processes along with time limits and information about how to initiate an appeal and an external review for health benefit claims;

(h) Contain a statement that you have the right to bring civil action under ERISA section 502(a) following an appeal;

(i) With respect to health and Weekly Sickness and Accident benefit claims, if the denial was based on an internal rule, guideline, protocol, standard, or similar criteria, a statement will be provided that a copy of such rule, guideline, protocol or similar criteria that was relied upon will provided to you free-of-charge upon request;

(j) If the denial of a health care claim or Weekly Sickness and Accident benefit claim was based on Medical Necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided to you free-of-charge upon request;

(k) With respect to Weekly Sickness and Accident benefit claim, a discussion of the Plan's initial claim discussion, including the basis for disagreeing with: (i) any disability determination by the Social Security Administration (SSA); (ii) the views of a treating health care professional or vocational expert evaluating the claimant, to the extent the Plan does not follow such views as presented by the claimant; or (iii) the views of medical professionals or vocational experts whose advice was obtained on behalf of the Plan, regardless of whether or not the advice was relied upon by the Plan in making an adverse benefit determination;

(l) For Urgent Care health benefit claims, the notice will describe the expedited internal appeal and external review processes applicable to Urgent Care Claims. In addition, the required determination may be provided orally and followed with written (or electronic, as applicable) notification; and

(m) With respect to health benefit claims, provide information about the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with the Plan's internal claims and appeal processes as well as with the external review process.

2. Notice of Approval of Pre-Service and Urgent Care Claims

If a Pre-Service claim is approved by the Fund, you will receive written (or electronic, as applicable) notice within 15 days of the Fund Administrator's receipt of the claim. Notice of approval of an Urgent Care Claim will be provided in writing (or electronically, as applicable) to you and your health care professional within the applicable timeframe after the Claims Administrator's receipt of the claim.

(a) Internal Appeal Request Deadline

i) **Health Care Claims.** If an initial health care claim is denied (in whole or in part) and you disagree with the Fund Administrator's decision, you or your authorized representative may request an internal appeal. You have 180 calendar days following receipt of a notice of adverse benefit determination to submit a written request for an internal appeal. The Plan will not accept appeals filed after this 180-day period. Under limited circumstances, explained below in the section on External Review, you may bypass the Plan's internal claims and/or appeal processes and file a request for an external review.

ii) **Weekly Sickness and Accident Claims Benefit.** If an initial Weekly Sickness and Accident Benefit Claim is denied and you disagree with the Fund Administrator's decision, you or your authorized representative may request an internal appeal. You have 180 calendar days following your receipt of an initial notice of adverse benefit determination to submit a written request for an internal appeal. The Plan will not accept appeals filed after this 180-day period.

iii) **Death and Accidental Death and Dismemberment Benefits.** If an initial Death and Accidental Death and Dismemberment benefit claim is denied and you disagree with the Fund Administrator's decision, you or your Authorized Representative (defined below) may request an appeal. You have 60 calendar days following your receipt of an initial notice of adverse benefit determination to submit a written request for an appeal. The Plan will not accept appeal requests filed after this 60-day period.

16.7 Internal Appeals Process

1. Appeal Procedures

To file an internal appeal, you must submit a written statement to the Plan at the following address:

Board of Trustees
Plumbers' Welfare Fund,
Local 130, U. A. c/o Fund Office
1340 West Washington Boulevard, 3rd Floor
Chicago, IL 60607
312-226-5000 (phone)
312-226-7285 (facsimile)

Appeal requests involving Urgent Care Claims may be made orally by calling the Board of Trustees at the telephone number listed above.

Your request for an internal appeal must include the specific reason(s) why you believe the initial claim denial was improper. You may submit any document that you feel is appropriate to the internal appeal determination, as well as submitting any written issues and comments.

As a part of its internal appeals process, the Plan will provide you with:

(a) The opportunity, upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to your initial claim for benefits;

(b) The opportunity to submit to the Plan written comments, documents, records and other information relating to your initial claim for benefits;

(c) With respect to health care claims appeals or Weekly Sickness and Accident benefit appeals, the Plan will automatically provide you with a reasonable opportunity to respond to new information by presenting written evidence and testimony;

(d) A full and fair review by the Plan that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim determination;

(e) With respect to health care claims appeals or Weekly Sickness and Accident benefit claims, the Plan will automatically provide you free-of-charge, with any new or additional evidence or rationale considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied initial claim. The Plan will automatically provide you with any new or additional evidence or rationale as soon as possible once it becomes available to the Plan and sufficiently in advance of the date on which notice of an adverse determination on appeal is scheduled to be provided to you. New or additional evidence or rationale will be provided to you so that you have a reasonable opportunity, sufficiently in advance of the date on which a notice of an adverse benefit determination upon appeal is required to be provided, to respond to the Plan regarding such evidence. If the new or additional evidence or rationale is received by the Plan so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, then the period for providing a notice of a final adverse benefit determination will be delayed (tolled) until you have had a reasonable opportunity to respond. After you respond (or do not respond after having a reasonable opportunity to do so), the Plan (acting in a reasonable and prompt manner) will notify you of its benefit determination upon appeal as soon as it can provide a notice of determination, taking into account any medical exigencies.

(f) A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary or fiduciaries of the Plan who is neither the individual who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(g) With respect to health care claims appeals or Weekly Sickness and Accident benefit claims appeals, continued coverage during the pendency of the appeal process; and

(h) In deciding an appeal of any adverse benefit determination regarding a health benefit claim that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or appropriate, the fiduciary or fiduciaries will:

i) Consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment; and

ii) Is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and

The Plan will provide, upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

2. Appeal Determination Timeframes

(a) Health Care Claim Appeals

i) **Pre-Service Claim Appeals.** A determination will be made and a written (or electronic, as applicable) notice regarding the appeal will be sent to you within 30 days from the date your written request for an appeal is received by the Plan.

ii) **Urgent Care Claim Appeals.** This is an expedited internal appeals process under which a written notice regarding a decision on the approval or denial of the expedited internal appeal will be sent to you (and your health care professional) no later than within 72 hours of the Plan's receipt of your (oral or written) request for appeal. If your situation involves an urgent medical condition, which the timeframe for completing an expedited internal appeal would seriously jeopardize your ability to regain maximum function, and the claim involves a medical judgment or a rescission of coverage, you may seek an expedited external review at the same time that you request an expedited internal appeal (you must seek both).

iii) **Concurrent Claim Appeals.** You may request an internal appeal of a Concurrent Claim by submitting the request orally (for an Urgent Care Claim) or in writing to the Board of Trustees. A determination will be made on the internal appeal and you will be notified as soon as possible before the benefit is reduced or treatment is terminated.

iv) **Post-Service Claim Appeals.** The Plan will make an appeal determination no later than the date of the Board of Trustees' meeting immediately following the Plan's receipt of your written request for an internal appeal, unless the request for an internal appeal review is filed within 30 calendar days preceding the date of such meeting. In such

case, an appeal determination will be made no later than the date of the second meeting following the Plan's receipt of your written request for an appeal. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, an appeal determination will be rendered not later than the third meeting following the Plan's receipt of your written request for review. If such an extension is necessary, the Plan will provide you with a written (or electronic, as applicable) notice of extension describing the special circumstances and date the appeal determination will be made. The Board of Trustees will notify you in writing (or electronically, as applicable) of the benefit determination no later than 5 calendar days after the benefit determination is made.

(b) Weekly Sickness or Accident Benefit Claims

The Plan will make an appeal determination no later than the date of the meeting immediately following the Plan's receipt of your written request for an appeal, unless the request for an appeal review is filed within 30 calendar days preceding the date of such meeting. In such case, an appeal determination will be made no later than the date of the second meeting following the Plan's receipt of your written request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting following the Plan's receipt of your written request for review. If such an extension is necessary the Plan must provide you with a written (or electronic, as applicable) notice of extension describing the special circumstances and date the appeal determination will be made. The Board of Trustees will notify you of the benefit determination no later than five (5) calendar days after the benefit determination is made.

(c) Death and Accidental Death and Dismemberment Benefit Claims

A written (or electronic, as applicable) notice regarding a determination of your appeal will be sent to you within 60 days from the date your written request for an appeal is received by the Plan.

3. Notice of Final Adverse Benefit Determination Upon Appeal

A written (or electronic, as applicable) notice of the appeal determination must be provided to you that includes:

(a) The specific reason(s) for the adverse benefit determination upon appeal, including (i) the denial code (if any) applicable to a health benefit claim and its corresponding meaning, (ii) a description of the Plan's standard (if any) that was used in denying the claim, and (iii) a discussion of the decision;

(b) Reference the specific Plan provision(s) on which the denial is based;

(c) A statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;

(d) A statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;

(e) An explanation of the external review process, along with any time limits and information about how to initiate a request for an external review regarding the denied internal appeal of a health benefit claim;

(f) If the denial of a health care claim or Weekly Sickness and Accident claim was based on an internal rule, guideline, protocol, standard, or similar criterion a statement must be provided that such rule, guideline, protocol or criteria will be provided free of charge, upon request;

(g) If the denial of a health care claim or Weekly Sickness and Accident claims was based on a medical judgement (Medical Necessity, experimental or investigational), a statement must be provided that an explanation regarding the scientific or clinical judgement for the denial will be provided free of charge, upon request;

(h) With respect to Weekly Sickness and Accident claims, a discussion of the Plan's initial claim discussion, including the basis for disagreeing with (i) any disability determination by the Social Security Administration (SSA); (ii) the views of a treating health care professional or vocational expert evaluating the claimant, to the extent the Plan does not follow such views as presented by the claimant; or (iii) the views of medical professionals or vocational experts whose advice was obtained on behalf of the Plan, regardless of whether or not the advice was relied upon by the Plan in making an adverse benefit determination; and

(i) With respect to a health care claim, disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with internal claims and appeals and external review processes.

This concludes the appeal process under this Plan.

16.8 No Assignment of Claims or Appeal Rights

Rights to make claims or appeals may not be assigned to any other party, including a health care provider, and any purported assignment will not make that entity a Participant or beneficiary under this Plan. All benefit payments are paid to Participants and Dependents and are not grantable, transferable, or otherwise assignable in anticipation of payment in whole or in part, by the voluntary or involuntary acts of any Participant, Dependent or beneficiary or by operation of law.

Any benefit payable under the Plan, at the sole discretion of the Trustees, may be paid directly to the individual or institution that provided the covered services. If payments are made to the health care provider individual or institution that provided the covered services, the payment will be considered the same as payment to a Participant, Dependent or beneficiary and the health care provider individual or institution shall have no independent right to payment.

Additionally, any benefit payable for claims incurred by an eligible Dependent named as an alternate recipient under the terms of a Qualified Medical Child Support Order (as defined by Section 609 of ERISA) may be paid directly to the individual or institution that provided the

covered services (except in cases where the Participant or the alternate recipient's custodial parent or legal guardian establishes that they are personally entitled to reimbursement of amounts personally advanced in payment of expenses covered by the Plan).

16.9 Exhaustion of Remedies

You must exhaust all of the claims and appeals procedures of the Plan before you bring any action in court or administrative action for benefits. After you have exhausted all of the procedures in this Article and if you are dissatisfied with the written decision of the Board of Trustees on review, you may institute legal action. If your appeal is denied, no legal action can be brought with respect to a claim under the Plan after one year from the decision on appeal.

16.10 Discretionary Decision Making Authority of the Trustees

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

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

16.11 Authorized Representative

An authorized representative is the person who can act on the behalf of the Participant who is the subject of the claim ("Claimant") to file a claim under the Plan. The Fund requires a written statement from the Claimant that he/she has designated the named individual(s) as the authorized representative along with the representative's name, address and phone number. Where the Claimant is unable to provide a written statement, the Fund requires written proof (e.g. power of attorney for health care purposes, court order of guardian/conservator) that the proposed authorized representative has been authorized to act on the Claimant's behalf. Acting as an authorized representative does not provide the person or entity any independent rights, including the rights of a beneficiary, the right to receive information from the plan or the right to receive information or documents from the plan based upon any alleged failure to timely provide such information or documents.

Once the Claimant names an authorized representative, the Fund must route all future correspondence related to claims and appeals to the authorized representative and not the Claimant.

However, the Fund will make every effort to copy the original Claimant where possible. The Fund must honor the designated authorized representative for one year, or as mandated by a court order, before requiring a new authorization, unless the original Claimant has limited the authorized representation to one claim or a series of claims related to the same illness or accident. The Claimant may revoke a designated authorized representative by submitting a signed statement.

The Fund reserves the right to withhold information from a person who claims to be the authorized representative if there is suspicion about the qualifications of the Claimant claiming to be the authorized representative.

16.12 Elimination of Conflict of Interest

With respect to health care benefits and Weekly Sickness and Accident benefits, to ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators, medical professionals and vocational experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

16.13 Facility of Payment

If the Board of Trustees or its designee determines that you cannot submit a claim or prove that you or your Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the health care professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Board of Trustees, Fund Administrator nor any other designee of the Plan will be required to see to the application of the money so paid.

16.14 External Review of Claims

If your initial claim for health care benefits has been denied (i.e., an adverse benefit determination) in whole or in part, and you are dissatisfied with the outcome of the Plan's internal claims and appeals process described earlier, you may (under certain circumstances) be able to seek external review of your claim by an Independent Review Organization ("IRO"). This process provides an independent review of eligible claims in compliance with PPACA.

1. Claims Eligible for the External Review Process

   Post-Service, Pre-Service, Urgent Care, and Concurrent Care Claims, in any dollar amount, are eligible for external review by an IRO if:

   (a) The adverse benefit determination of the claim involves a medical judgment, including but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, denial related to coverage of routine costs in a clinical trial, or a determination that a treatment is experimental or investigational. The IRO will determine whether a denial involves a medical judgment.

(b) The denial is due to a rescission of coverage (i.e., the retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

2. Claims Not Eligible for the External Review Process

The following types of claims are not eligible for the external review process:

(a) Claims that involve only contractual or legal interpretation without any use of medical judgment.

(b) A determination that you or your dependent are not eligible for coverage under the terms of the Plan.

(c) Claims that are untimely, meaning you did not request review within the four (4) month deadline for requesting external review.

(d) Claims as to which the Plan's internal claims and appeals procedure has not been exhausted (unless a limited exception applies).

(e) Claims that relate to benefits other than health care benefits (such as Weekly Sickness and Accident, Death Benefits, Accidental Death and Dismemberment Benefits, and Dental/Vision benefits that are considered excepted benefits).

(f) Claims that relate to benefits that the Plan provides through insurance. Claims that relate to benefits provided through insurance are subject to the insurance company's external review process, not this process.

In general, you may only seek external review after you receive a "final" adverse benefit determination under the Plan's internal appeals process. A "final" adverse benefit determination means the Plan has continued to deny your initial claim in whole or part and you have exhausted the Plan's internal claims and appeals process.

Under limited circumstances, you may be able to seek external review before the internal claims and appeals process has been completed:

(a) If the Plan waives the requirement that you complete its internal claims and appeals process first.

(b) In an urgent care situation (see "Expedited External Review of an Urgent Care Claim"). Generally, an urgent care situation is one in which your health may be in serious jeopardy or, in the opinion of your health care professional, you may experience pain that cannot be adequately controlled while you wait for a decision on your internal appeal.

(c) If the Plan has not followed its own internal claims and appeals process and the failure was more than a minor error. In this situation, the internal claims and appeal is "deemed exhausted," and you may proceed to external review. If you think that this situation exists, and the Plan disagrees, you may request that the Plan explain in writing why you are not entitled to seek external review at this time.

3. External Review of a Standard (Non-Urgent Care) Claim

Your request for external review of a standard (not Urgent Care) claim must made in writing within 4 months after you receive notice of an adverse benefit determination.

Because the Plan's internal claims and appeals process generally must be exhausted before external review is available, external review of standard claims will ordinarily only be available after you receive a "final" adverse benefit determination following the exhaustion of the Plan's internal claims and appeals process.

To begin the standard external review process, do the following:

Fund Administrator
1340 West Washington Boulevard, 3rd Floor
Chicago, IL 60607
312-226-5000

(a) Preliminary Review of a Standard (Non-Urgent Care) Claim by the Plan

Within 5 business days of the Plan's receipt of your request for external review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:

i) You are/were covered under the Plan at the time the health care item or service is/was requested; or, in the case of a retrospective review, you were covered at the time the health care item or service was provided.

ii) The adverse benefit determination satisfies the above-stated requirements for a claim eligible for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination, or a failure to pay premiums causing a retroactive cancellation of coverage.

iii) You have exhausted the Plan's internal claims and appeals process (or a limited exception allows you to proceed to external review before that process is completed).

iv) Your request is complete, meaning that you have provided all of the information or materials required to process an external review.

Within one business day of completing its preliminary review, the Plan will notify you in writing whether:

i) Your request is complete and eligible for external review.

ii) Your request is complete but not eligible for external review. (In this situation, the notice will explain why external review is not available, and provide contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).)

iii) Your request is incomplete. (In this situation, the notice will describe the information or materials needed to make the request complete. You must provide the necessary information or materials within the 4 month filing period, or, if later, within 48 hours after you receive notification that your request is not complete.)

(b) Review of a Standard (Not Urgent Care) Claim by the IRO

If your request is complete and eligible for external review, the Plan will assign it to an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims, and it rotates assignments among these IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

Once the claim has been assigned to an IRO, the following procedures apply:

i) The IRO will timely notify you in writing that your request is accepted for external review.

ii) The IRO will explain how you may submit additional information regarding your claim if you wish. In general, you must provide additional information within ten (10) business days. The IRO is not required to, but may, accept and consider additional information you submit after the 10 business day deadline.

iii) Within 5 business days after the claim has been assigned to the IRO, the Plan will provide the IRO with the documents and information it considered in making its adverse benefit determination.

iv) If you submit additional information to the IRO related to your claim, the IRO must forward that information to the Plan within one business day. Upon receipt of any such information (or at any other time), the Plan may reconsider its adverse benefit determination regarding the claim that is the subject of the external review. Any reconsideration by the Plan will not delay the external review. If Plan reverses its determination after it has been assigned to an IRO, the Plan will provide written notice of its decision to you and the IRO within one business day. Upon receipt of such notice, the IRO will terminate its external review.

v) The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo, meaning that the IRO is not bound by the Plan's previous internal claims and appeal decisions. However, the IRO must review the Plan's terms to ensure that its decision is not contrary to the terms of the Plan, unless those terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

vi) To the extent additional information or materials are available and appropriate, the assigned IRO may consider the additional information including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

vii) In a standard case, the IRO will provide written notice of its final decision to you and the Plan within 45 days after the IRO receives the request for the external review.

The IRO's decision notice will contain:

i) A general description of the reason(s) for the request for external review, including information sufficient to identify the claim, including the date or dates of service, the health care provider, the claim amount (if applicable), and the reason for the previous denial.

ii) The date that the IRO received the assignment to conduct the external review and the date of the IRO decision.

iii) References to the evidence or documents, including the specific coverage provisions and evidence-based standards, considered in reaching its decision.

iv) A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards relied upon.

v) A statement that the IRO's decision is binding on you and the Plan, except to the extent that other remedies may be available to you or the Plan under applicable state or federal law.

vi) A statement that judicial review may be available to you.

vii) A statement regarding assistance that may be available to you from an applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act. You may contact the Illinois Office of Consumer Health Insurance ("OCHI") Hotline at: 877-850-4740 (available 7-days per week). OCHI operates from the Illinois Department of Insurance.

4. Expedited External Review of an Urgent Care Claim

You may request an expedited external review in the following situations if:

(a) You receive an adverse benefit determination regarding your initial claim that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal.

(b) You receive a "final" adverse benefit determination after exhausting the Plan's internal appeals procedure that (i) involves a medical condition for which the timeframe for completion of an standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or (ii) concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, and you have not yet been discharged from a facility.

To begin a request for expedited external review, do the following:

Fund Administrator
1340 West Washington Boulevard, 3rd Floor
Chicago, IL 60607
312-226-5000

Preliminary Review of an Urgent Care Claim by the Plan

Immediately upon receipt of a request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described above for the standard claim external review process). The Plan will defer to your attending health care professional's determination that a claim constitutes "urgent care." The Plan will immediately notify you (e.g., telephonically, via fax) whether your request for review meets the requirements for expedited review, and if not, it will provide or seek the information described above for the standard claim external review process.

Review of an Urgent Care Claim by the IRO

Upon a determination that a request is complete and eligible for an expedited external review following the preliminary review, the Plan will assign an accredited IRO. The Plan has arranged for at least 3 accredited IROs to provide external review of claims, and rotates assignments among those IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

The Plan will expeditiously provide or transmit to the IRO all necessary documents and information that it considered in making its internal adverse benefit determination.

The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review. In reaching a decision, the IRO must review the claim de novo meaning that it is not bound by any previous decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO decision must not be contrary to the terms of the plan, unless the terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above for the standard claim external review process, as expeditiously as your medical condition or circumstances require, but not more than 72 hours after the IRO receives the request for an expedited external review. If notice of the IRO decision is not provided to you in writing, the IRO must provide written confirmation of the decision to you and the Plan within 48 hours after it is made.

5. What Happens After the IRO Decision is Made?

(a) If the IRO's final external review decision reverses the Plan's internal adverse benefit determination, upon the Plan's receipt of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

(b) If the final external review upholds the Plan's internal adverse benefit determination, the Plan will continue not to provide coverage or payment for the reviewed claim.

(c) If you are dissatisfied with the external review determination, you may seek judicial review to the extent permitted under ERISA Section 502.

XVII. COORDINATION OF BENEFITS

This Article applies to benefits provided under all parts of the Plan except Weekly Sickness or Accident benefits, Death Benefits, Military Benefits and Accidental Dismemberment Benefits.

Definitions

The term "Plan" as used in this Article means any Plan providing benefits or services for or by reason of medical, dental, or vision care or treatment, which benefits or services are provided by:

1. Group blanket insurance coverage, group Blue Cross or Blue Shield, or other group prepayment coverage, coverage under a labor-management trusteed Plan, union welfare plan, employer organization plan, and coverage sponsored by or provided through a school or other educational institution, and
2. Coverage under any Plan solely or largely tax-supported or otherwise provided for, by, or through action of any governmental program or required or provided by any statute or law.

In no event shall the term "Plan" include individual policies issued on a franchise basis nor group remittance subscriber contracts.

The term "Plan" is construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

The term "Local 130 Health and Welfare Plan" as used in this Article means that portion of the Plumbers' Welfare Fund, Local 130, U.A., which provides the benefits that are subject to this Article.

The term "Allowable Expense" as used in this Article means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person with respect to whom a claim is made. When a Plan provides benefits in the form of furnishing services or supplies rather than cash payments, the reasonable cash value of each service or supply furnished shall be deemed to be both an Allowable Expense and a benefit paid.

Effect on Benefits

1. This Article applies to determine the benefits as to a person covered under the Local 130 Health and Welfare Plan for any period of illness or injury compensable under the Local 130 Health and Welfare Plan if, for the Allowable Expenses incurred as to such person during such period, the sum of:

    (a) The benefits that would be payable under the Local 130 Health and Welfare Plan in the absence of this Article, and

    (b) The benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to those contained in this Article would exceed such Allowable Expenses.

2. For any period in which this Article applies, the benefits that would be payable under the Local 130 Health and Welfare Plan in the absence of this Article for the Allowable Expenses incurred as to such person during such period is reduced to the extent necessary so that the sum of the reduced benefits and all the benefits payable for such Allowable Expense under all other Plans, except as provided in Subparagraph (3), do not exceed the total of the Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefor.

3. If (i) another Plan which is involved in Subparagraph (2) of this Paragraph (c) and which contains a provision coordinating its benefits with those of the Health and Welfare Plan would, according to its rules, determine its benefits after the benefits of the Local 130 Health and Welfare Plan have been determined; and (ii) the rules set forth in Subparagraph (4) would require the Local 130 Health and Welfare Plan to determine its benefits before the other Plan, then the benefits of the other Plan will be ignored for the purposes of determining the benefits under Local 130 the Health and Welfare Plan.

4. For the purpose of Subparagraph (3), the rules establishing the order of benefit determination are:

    (a) The benefits of a Plan with no provision for coordination of benefits are determined before the benefits of a Plan which contains such provision.

    (b) The benefits provided under Part A and Part B of Title XVIII of the Social Security Act, as amended, (Medicare) are determined before the benefits provided under any other Plan, to the extent the Social Security Act or other applicable law does not require that Medicare benefits be determined after the benefits provided under any other Plan.

    (c) The benefits of a Plan covering a person as an employee who is neither laid off nor retired are determined before the benefits of a Plan covering a person as a laid off or retired person if both plans utilize this rule in establishing the order of benefit determination.

    (d) The benefits of a Plan that covers the person on whose expense the claim is based other than as a Dependent are determined before the benefits of a Plan which covers the person as a Dependent.

(e) The benefits of a Plan that covers the person on whose expenses claim is based as a Dependent of a person whose day and month of birth is earliest in the calendar year are determined before the benefits of a Plan which covers the person as a Dependent of a person whose day and month of birth is later in the calendar year. However, if the other Plans do not have this day and month rule, then the benefits of a Plan that covers the person on whose expenses claim is based as a Dependent of a male person are determined before the benefits of a Plan that covers the person as a Dependent of a female person; except that in the case of a person for whom claim is made as a Dependent child of divorced or separated parents.

i) When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan that covers the child as a Dependent of the parent with custody of the child are determined before the benefits of a Plan that covers the child as a Dependent of the parent without custody.

ii) When the parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan that covers the child as a Dependent of the parent with custody are determined before the benefits of a Plan that covers that child as a Dependent of the step-parent, and the benefits of a Plan that covers that child as a Dependent of the stepparent are determined before the benefits of a Plan that covers that child as a Dependent of the parent without custody.

Notwithstanding (i) and (ii) above, if there is a court decree that otherwise establishes financial responsibility for the medical and dental or other health care expenses with respect to the child, the benefits of a Plan that covers the child as a Dependent of the parent with financial responsibility are determined before the benefits of any other Plan that covers the child as a Dependent child.

(f) If a person whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another plan, the following shall be the order of benefit determination:

iii) First, the benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent);

iv) Second, the benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(g) As to Plans as to which rules (a), (b), (c), (d), (e) and (f) do not establish an order of benefit determination, the benefits of a Plan that has covered the person on whose expenses claim is based for the longer period of time are determined before the benefits of a Plan that has covered such person the shorter period of time.

5. The Trustees are not required to determine the existence of any Plan, or the amount of benefits payable under any Plan except the Local 130 Health and Welfare Plan, and the payment of benefits under the Local 130 Health and Welfare Plan are affected by the benefits that would be payable under any and all other Plans only to the extent that the Trustees have or are furnished with information relative to the other Plans.

6. When this Article operates to reduce the total amount of benefits otherwise payable to a person covered under the Local 130 Health and Welfare Plan during any period of illness or injury compensable under the Local 130 Health and Welfare Plan, each benefit that would be payable in the absence of this Article is reduced either proportionately or in any other equitable manner as the Trustees of the Local 130 Health and Welfare Plan determine, and the reduced amount is charged against any applicable benefit limit of the Local 130 Health and Welfare Plan.

For the purposes of determining the applicability of and implementing the terms of this Article of the Local 130 Health and Welfare Plan or any provision of similar purpose of any other Plan, the Trustees may, without the consent of or notice to any person, release to or obtain, from any insurance company or other organization or person, any information concerning any person, that the Trustees deem necessary for this purpose. Any person claiming benefits under the Local 130 Health and Welfare Plan must furnish to the Trustees necessary information to implement this provision.

Facility of Payment.

Whenever payments that should have been made under the Local 130 Health and Welfare Plan in accordance with this Article are made under any other Plan, the Trustees have the right, exercisable alone and in their sole discretion, to pay over to organizations making the other payments any amounts determined to be warranted in order to satisfy the intent of this Article, and the amounts paid are deemed to be benefits paid under the Local 130 Health and Welfare Plan and, to the extent of the payments, the Trustees are fully discharged from liability under the Local 130 Health and Welfare Plan.

Right of Recovery.

Whenever payments have been made by the Trustees for Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Article, the Trustees have the right to recover the payments, to the extent of the excess, from among one or more of the following, as the Trustees determine: any persons to or for or with respect to whom such payments were made, any insurance company, or any other organization.

Special Rule Where Both Spouses are Participants.

Solely in situations where two Plan Participants are married, the Plan's Reasonable and Customary Charges or Fees for surgical, in-hospital doctor, dental, eye care, and hearing care charges are double the amount otherwise payable in situations where only one spouse is an eligible Participant. The Reasonable and Customary Charges or Fees for all other hospital and medical expenses are not adjusted.

XVIII. THE PLAN'S RIGHT OF SUBROGATION AND RIGHT OF REIMBURSEMENT

In the event the Fund pays or is obligated to pay benefits on behalf of a Participant, his estate, his Dependents, or his Dependent's estate, for illness, accident, sickness, work-related injury, or

injury, regardless of how such injury occurred and the Participant or Dependents have the right to recover the amounts of such benefits from any other person, corporation, insurance carrier or governmental agency, including uninsured or underinsured insurance cover-age, or any other first-party contract or claim, the Trustees of the Funds and the Fund shall be subrogated to all of the Participant's or Dependents' right of recovery against such person, corporation, insurance, carrier, governmental agency or uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim and shall have a right of reimbursement from the Participant or Dependent to the full extent of payments made by the Fund and for the cost of collection of these amounts, including attorney's fees. The Fund has a right to be reimbursed from any settlement, judgment, insurance proceeds, no-fault automobile insurance payments, or other recovery for any and all benefits paid in connection with such injury, illness, accident, or sickness up to the amount of recovery. The full amount of benefits paid shall include any PPO Charge or other payment to a medical discount provider paid with respect to the involved benefits which shall be considered part of the amount of benefits paid. For subrogation purposes, any medical claims related to a Participant's or beneficiary's injury, which are treated at the Wellness Center, shall be charged the allowable Blue Cross Blue Shield rates for any services rendered.

A Participant, his estate, his Dependents, or his Dependent's estate must immediately inform the Fund in writing of any legal action or any recovery that arises subsequent to the payment of benefits by the Fund. A Participant, his estate, his Dependents, or his Dependent's estate must cooperate fully with the Fund in connection with the exercise of its rights under this provision and must do nothing to prejudice such rights of reimbursement and repayment.

The Trustees and the Fund shall have a first equitable lien and constructive trust upon any recovery by agreement in the amount of all benefits paid up to the amount of recovery, regardless of how the recovery is allocated or structured and this equitable lien by agreement shall be enforceable as part of an action to enforce plan terms under ERISA Section 502(a)(3), including injunctive action to ensure that these amounts are preserved and not disbursed. The Trustees' and the Fund's equitable lien by agreement imposes a constructive trust upon the assets received as a result of a recovery by the Participant or Dependents, as opposed to the general assets of the Participant or Dependents, and enforcement of the equitable lien by agreement does not require that any of these particular assets received be "traced" to a specific account or other destination after they are received by the Participant or Dependents. The Trustees' and the Fund's equitable lien by agreement is from the first dollar received and its enforcement does not require that the Participant or Dependents be "made-whole" or that the entire debt be paid to the Participant or Dependents prior to the lien's payment. The Trustees' and the Fund's equitable lien by agreement is also not reduced by the legal fees incurred by the Participant or Dependents in recovering the amounts or by any state law doctrine, such as the "Common Fund" doctrine, which would purport to impose such a reduction. In the event the Participant or Dependent dissipates the recovery received related to the injury, accident, or sickness prior to reimbursing the Fund, the Fund shall have the right to file an action in law against the Participant or Dependent seeking monetary damages from the Participant or Dependent's general assets. The Fund shall also have the right to offset or withhold any future benefits that the Participant, Dependent, or estate may be entitled to receive until the Fund has been reimbursed.

The Participant or Dependents or the Participant acting on behalf of a minor Dependent shall execute and deliver such documents and papers, including but not limited to an assignment of the claim against the other party or parties, assignment to the minor child or any parental claim to

recover medical expenses of the minor child, and/or a Subrogation or Reimbursement Agreement to the Fund, as the Trustees may require. The Fund may withhold benefits until such Subrogation or Reimbursement Agreement is signed. The Participant or Dependents shall do whatever else is necessary to secure the rights of the Trustees and the Fund including allowing the intervention by the Trustees or the Fund or the joinder of the Trustees or the Fund in any claim or action against the responsible party or parties or any uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim.

If the Participant or Dependents do not attempt a recovery of the benefits paid by the Fund or for which the Fund may be obligated, the Trustees or the Fund shall, if in the Fund's best interest and at the Trustees' sole discretion, be entitled to institute legal action or claim against the responsible party or parties, against any uninsured or underinsured insurance coverage, or against any other first-party or third-party contract or claim in the name of the Fund or Trustees in order that the Fund may recover all benefit amounts paid to the Participant or Dependents or paid on their behalf, together with the costs of collection, including attorney's fees.

In the event of any recovery by judgment or settlement against the responsible party or parties or by payment by an uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim, payment of the lien from the proceeds of the recovery shall take place in the following fashion. Initially, the reasonable costs of collection of the equitable lien by agreement, including the Fund's attorney's fees, shall be distributed to the Fund. Next, the amount of benefits paid from the Fund to and on behalf of the Participant or Dependents, to the full extent of benefits paid or due as a result of the occurrence causing the injury or illness, shall be distributed to the Fund. The remainder or balance of any recovery shall then be paid to the Participant or Dependents and their attorneys if applicable.

In the event of any failure or refusal by the Participant or Dependents to execute any document requested by the Trustees or the Fund or to take other action requested by the Trustees or the Fund to protect the interests of the Trustees or the Fund, the Trustees may withhold payment of benefits from the Fund or deduct the amount of any payments from amounts otherwise payable by the Fund for future claims of the Participant or Dependents. After making claim for benefits from the Fund, the Participant or Dependents shall take no action which might or could prejudice the rights of the Trustees or the Fund.

In the event the Participant or Dependents recover any amount by settlement or judgment from or against another party or by payment from any uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim, the Fund will request repayment of the amount of its equitable lien for the full amount of benefits paid by the Fund. If the Participant and/or Dependents refuses or fails to repay such amount, then in that event, the Fund shall be entitled to recover such amounts from Participants and/or Dependents by instituting legal action against the Participant and/or Dependents and/or by deducing such amounts as may be due on future claims submitted by the participant and dependents. Once a settlement or judgment is reached on the claim additional bills cannot be submitted with respect to the same injury.

The Participant or Dependents shall be required to pay their own legal fees and costs and indemnify the Fund for any legal fees paid by the Fund pursuant to the enforcement of the Plan. The Trustees shall pay no legal costs or fees from the Fund without receiving a recovery and then only, in their sole discretion, within the terms of this provision. In the event that an attorney is hired by or on behalf of the Participant or his Dependents and the Fund is given notice and an opportunity to

pursue its own subrogation recovery, the Fund shall not be required to hire such attorney. If the attorney representing the eligible individual nevertheless wishes to proceed, and creates a common fund from which the Trustees can recover pursuant to their equitable lien by agreement for subrogation and reimbursement, the Trustees, on behalf of the Fund and at their sole discretion, may agree to reduce its recovery to include the attorney's legal fees. This reduction shall also include any prorated portion of the cost of recovery. If the attorney agrees to proceed, he will be considered to have waived the Common Fund doctrine.

These provisions shall apply to any case in which the Fund or Trustees have not been repaid the full amount of benefits made for and on behalf of a Participant or Dependent, together with cost of collection, as of the date of this provision, and any subrogation and reimbursement claim or lien presented by the Fund or Trustees, where the Fund or Trustees have not been repaid the full amount of benefits made for and on behalf of a Participant or Dependent, together with cost of collection, as of the date of these provisions, shall be construed to involve an equitable lien by agreement under these provisions.

(If you want more information about Subrogation, contact the Fund Office.)

XIX. IMPORTANT INFORMATION ABOUT THE PLAN

19.1 Name and Type of Plan

This Plan is known as the Plumbers' Welfare Fund, Local 130, U.A. This Plan provides health and welfare benefits for expenses arising from hospitalization, surgery, medical treatment, prescription drug, vision or dental care. This Plan also provides benefits for disability, death, Wellness Center, AD&D and health reimbursement account benefits.

19.2 Plan Sponsor and Administrator

The Board of Trustees is the Plan Sponsor, Plan Administrator and the name fiduciary of the Plan. The Board of Trustees is responsible for the Plan's operation. The Board of Trustees consists of six employer and six Local Union 130 U.A. representatives. If you wish to contact the Board of Trustees, you may use the address and phone number below:

Plumbers' Welfare Fund, Local 130, U. A.
Administrative Offices
Third Floor
Stephen M. Bailey Auditorium
1340 West Washington Boulevard
Chicago, Illinois 60607
Phone: (312) 226-5000

As of June 1, 2020, the Trustees of this Fund are:

UNION TRUSTEES	EMPLOYER TRUSTEES
James F. Coyne, Co-Chairman 1340 W. Washington Boulevard Chicago, IL 60607 Kenneth Turnquist 1340 W. Washington Boulevard Chicago, IL 60607 John Hosty 1340 W. Washington Boulevard Chicago, IL 60607 James Mansfield 1340 W. Washington Boulevard Chicago, IL 60607 Bart Holzhauser 1340 W. Washington Boulevard Chicago, IL 60607 Michael Shea, 1340 W. Washington Boulevard Chicago, IL 60607 Joe Mondia, Alternate Trustee 1340 W. Washington Boulevard Chicago, IL 60607	David Ariano, Co-Chairman Ravinia Plumbing 575 Bond Street Lincolnshire, IL 60069 James Bruckner Chas. F. Bruckner and Son, Inc. Plumbing 503 West 26th Street Chicago, IL 60616 James O'Sullivan O'Sullivan Plumbing, Inc. 9726 194th Place Mokena, IL 60448 Brian Burns C. W. Burns Co., Inc. 1536 Brook Dr. # E Downers Grove, IL 60515 John Bali Another Plumbing Company, LLC 13753 Mckanna Rd Minooka, Illinois 60447, US Michael Falk Falk PLI Engineering & Surveying, Inc. 6370 Ameriplex Drive #100 Portage, IN 46368 S.J. Peters, Alternate Trustee Plumbing Contractors Assn. of Greater Chicago 603 Rogers Street, Suite 2 Downers Grove, IL 60515

19.3 Plan Vendor Contact Information

See the following contact information about the Plan's various vendors:

MEDICAL BENEFITS		
Blue Cross Blue Shield of Illinois	www.bcbsil.com	1-800-571-1043
DENTAL BENEFITS		
Delta Dental of Illinois	www.deltadentalil.com	1-800-323-1743

VISION BENEFITS		
EyeMed	www.eyemedvisioncare.com	1-866-723-0514
PRESCRIPTION DRUG BENEFITS		
Express Scripts	www.express-scripts.com	1-800-451-6245
Accredo	www.accredo.com	1-877-222-7336
UTILIZATION REVIEW		
Hines & Associates	www.hinesassoc.com	1-800-944-9401
EMPLOYEE ASSISTANCE PROGRAM		
ERS	www.ers-usa.org	1-800-292-2780

19.4 Identification Numbers

The number assigned to this Fund by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501. The Employer Identification number assigned to the Board of Trustees by the Internal Revenue Service is 36-2141153.

19.5 Agent for Service of Legal Process

The Fund Administrator is the Fund's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon the Fund Administrator at the address shown in "Plan Sponsor and Plan Administrator" above. However, documents may also be served upon the Trustees individually at their respective addresses.

19.6 Collective Bargaining Agreements

The Fund is established and maintained under the terms of collective bargaining agreements between the Union and the Kankakee & Iroquois Counties Plumbing & Piping Contractors Association, the West Suburban Association of Plumbing Contractors, and the Plumbing Contractors Association of Greater Chicago, respectively. These agreements set forth the conditions under which participating Contractors are required to contribute to the Fund.

Upon written request to the Fund Office, Participants and beneficiaries may obtain information as to the address of a particular Contractor and whether that Contractor is required to pay contributions to the Fund.

19.7 Plan Year

The Plan Year begins on June 1 and ends on May 31. The fiscal year of this Plan for purposes of its financial records is also based on the Plan Year.

19.8 Source of Contributions and Benefits

All contributions, except COBRA self-pay contributions, to the Fund are made by Employers under their collective bargaining agreements with Local 130, U.A., or participation agreements with the Fund. Such agreements require contributions to the Plan at a fixed rate per hour worked. Benefits are provided from the Fund's assets which are accumulated under the provisions of the Trust Agreement and held in a trust fund for the purpose of providing group health and welfare benefits to covered Participants and their Dependents and defraying reasonable administrative expenses.

19.9 Plan Investments

The Fund's assets and reserves are held in custody by a financial institution selected by the Board of Trustees.

19.10 Workers' Compensation Not Affected

The Plan is not in lieu of and does not affect any requirement for coverage of Workers' Compensation insurance.

19.11 The Plan is Tax Exempt

The Plan is classified by the Internal Revenue Service as a 501(c)(9) Trust. This means that the Employers' contributions to the Trust are tax deductible and are not included as part of your income. Also, in most cases, the benefit paid on your behalf is not taxable as personal income. Also, investment earnings on Plan assets are excluded as taxable income of the Trust since they are specifically set aside for the purpose of providing benefits to Participants.

19.12 Right of Trustees to Amend Trust and Plan

The Trustees expressly reserve the right to amend this Plan/SPD at any time in order to add to or modify the terms of the Plan or to change benefits. No Participant, former Participant, retired Participant or Dependent is vested in health and welfare benefits under this Plan. If the Trustees amend or terminate the Plan, they will notify you in writing of any material changes that are made to your coverage.

19.13 Application for Benefits

If you become disabled or sick, contact the Fund Office as soon as possible for a benefit application form. If possible, contact the Fund Office before you enter the Hospital or receive treatment by a Physician. You must make application for benefits within one year from the date medical services are rendered. Generally, except for amounts paid directly to Providers, only the Participant is paid

or reimbursed for medical expenses incurred by him and his eligible Dependents. For that reason, all claim forms must be signed by the Participant.

19.14 Payment of Benefits

Death Benefits are paid to your surviving designated beneficiary or as otherwise provided in the Plan. All other benefits in the Plan are payable to the Participant, to the Hospital, or other eligible providers of covered services. No benefits are payable from the Plan to or for the benefit of any individual who intentionally and unjustifiably causes the death of a Participant as determined by the Trustees. The Trustees may, without the consent of any beneficiary, pay any benefit accrued under this Plan for medical benefits to the provider of the medical or hospital service or to reimburse the person or persons who paid the provider of the hospital or medical service but the reimbursement will not exceed the benefit accrued for the medical or hospital services. Any determination under this paragraph must be made by the Trustees, and is final and binding on all persons.

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

1. Your surviving designated beneficiary;
2. Your spouse;
3. Your Dependent children, including legally adopted children;
4. Your parents;
5. Your brothers and sisters; or
6. Any person the Trustees determine is entitled to payment.

The Fund may rely upon an affidavit or other written statement to determine benefit payments, unless it receives written notice of a valid claim before payment is made. The affidavit will release the Fund from further liability. Any payment made by the Fund in good faith will fully discharge it to the extent of such payment.

If benefit payments are payable to an infant, or to a person under legal disability, or to a person not adjudicated incompetent but, by reason of mental or physical disability, in the opinion of the Trustees, is unable to properly administer the benefit payments, then the payments may be paid out by the Trustees for the benefit of the infant or person, in any of the following ways as they think best; and the Trustees have no duty or obligation to see that the funds paid are used or applied for their intended purpose or purposes:

1. directly to the infant or disabled person;
2. to the legally appointed guardian or conservator of the infant or disabled person;
3. to any spouse, parent, descendant, brother or sister of the infant or disabled person for welfare, support and maintenance;
4. by the Trustees using the payments directly for the support, maintenance, and welfare of any the infant or disabled person.

19.15 Right of Trustees to Resolve Disputes and to Interpret Plan

The Trustees have the power to adopt rules and regulations for the administration of the Trust and Plan and to interpret and construe the provisions of the Trust and Plan and any rules and regulations adopted by the Trustees. All questions or controversies of any character arising between any parties or persons in connection with administration or operation of the Trust Fund including benefit claims made by any Participant, Dependent, beneficiary, or any other person; questions concerning the construction, interpretation, or application of the language of the Plan, the Trust, rules and regulations adopted by the Trustees, or any other writing, decision, or instrument; or any other act involving the operation or administration of the Trust Fund will be submitted to the Trustees for decision.

The Trustees have the power and authority to take any and all actions required to resolve all questions and controversies; including the power to make factual findings; to fix omissions in the Trust, the Plan, any rules and regulations promulgated by the Trustees or any benefit communications; to resolve Plan ambiguities; and to construe the terms of the Trust and the Plan and any rules and regulations promulgated under the Trust and Plan. All decisions, determinations, and findings of the Trustees are binding upon all persons dealing with the Trust Fund or claiming any benefit thereunder.

19.16 Limitation on Legal Action Against the Plan

Any legal action by a Participant or Dependent (or their representatives, agents, heirs, or assigns) to enforce a right to benefits under this Trust or the Plan must be commenced within one year of the date the Participant or Dependent completes the internal administrative appeal of the benefit denial. For purposes of this section, a Participant or Dependent is considered to complete his administrative appeal of a benefit denial when one of the two occurs below, whichever one occurs first:

- The expiration of 180 days after the date a Participant or Dependent received notice of the initial denial or partial denial of his claim; or
- The date the Participant or Dependent receives notice that his appeal of the initial denial or partial denial of his claim has been denied by the Fund or the Independent Review Organization.

For purposes of this section, a Participant or Dependent is considered to receive notice on the date the notice is mailed, postage prepaid, to the person at the address shown on the Fund's records.

19.17 Incentive Program

In the event you secure a refund of more than $25.00 to the Trust Fund of an overcharge on a bill from a Hospital, doctor, or other provider for treatment provided to the Participant or Dependent, you shall receive twenty-five percent (25%) of the total amount of the refund but no more than $500.00 per year.

19.18 Interests in the Trust Fund

No Participant or any other person has any right, title, interest in or to the Trust Funds, or any part thereof; however, any Participant who is covered by a group insurance contract, or his beneficiary,

is entitled to benefits in the amount and subject to the terms and conditions of the group insurance contract. No Participant or any other person has any right, title, or interest in, or the option to receive, any part of the Contractors' contributions. No Participant or any other person has the right to assign his benefits or receive a cash consideration in lieu of his benefits.

19.19 No Employment Contract

Nothing in this Plan or the Trust may be construed to constitute an employment contract between any Contractor and Employee.

19.20 Notification by Participants and Dependents

You and your Dependent(s), if applicable, are required to inform the Fund Office of any change in the employment status or family status (including but not limited to divorce, legal separation, or a child Dependent ceasing to meet the definition of a Dependent) that may affect your eligibility or your Dependent's eligibility, if applicable, to continue to participate in and receive benefits under the Plan. An individual receiving benefits as a result of electing COBRA continuation coverage is required to inform the Fund Office of any change of employment, change of family status, or Medicare eligibility that may affect the eligibility of such individual to continue to receive benefits under this Plan. Such notification must be made within thirty (30) days from the date of the event affecting your or your Dependent's participation or the receipt of Plan benefits, or as otherwise permitted by law.

19.21 Qualified Medical Child Support Order

This Plan recognizes and will provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice. A QMCSO is an official court order or an order issued by a state agency authorized to issue child support orders under state law that provides benefits for a Dependent child or children in the event of a divorce or other family law action.

Upon receipt of a medical support order, the Fund Office will promptly notify you and the person affected by the medical support order, of the receipt of such order and the Plan's procedures for determining whether the order is a QMCSO. The Fund Office will then determine whether the order is a QMCSO pursuant to the Plan's procedures and notify you and each affected person of the determination. You have the right to request from the Fund Office a copy of the Plan's QMSCO procedures free of charge.

19.22 Important Notices of Specific Rights Under the Law

Women's Health and Cancer Rights Act of 1998 Notice

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. But WHCRA does NOT require health plans or issuers to pay for mastectomies. If a group health plan chooses to cover mastectomies, then the plan is generally subject to WHCRA requirements. To the extent WHCRA applies to a particular Welfare Benefit Program, coverage will be provided for: (1) all stages of reconstruction of the breast on which the mastectomy has been performed; (2)

surgery and reconstruction of the other breast to produce a symmetrical appearance and (3) prostheses and treatment of physical complications of mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Plan. Please consult the Schedule of Benefits for specific deductible and coinsurance information related to mastectomy benefits. For further information, contact the Fund Administrator.

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 protects Americans against discrimination based on their genetic information when it comes to health insurance and employment.

Mental Health Parity Addiction and Equity Act of 2008

The Mental Health Parity Addiction and Equity Act of 2008 requires that plans providing both medical/surgical benefits and mental health benefits may not impose more restrictive financial requirements (such as deductibles and copayments) and treatment limitations (such as limits on days of coverage, prior approval requirements, etc.) on mental health benefits than are imposed on medical/surgical benefits.

HIPAA Privacy Notice

You have been furnished under separate cover a Notice of Privacy Practices describing the practices the Plan will follow with regard to your "protected health information." If you would like to receive another copy, please contact the Fund Administrator.

Patient Protection Notice

The Plan generally allows the designation of a primary care provider with respect to medical benefits. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Fund Office.

For children, you may designate a pediatrician as the primary care provider.

The Plan does not require you to obtain prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Fund Office.

XX. STATEMENT OF ERISA RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants are entitled to:

- Examine, without charge, at the Plan administrator's office and at other specified locations, such as the union hall and work sites at which fifty or more participants are regularly employed, all Plan documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the plan administrator (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 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 have to pay for this coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation rights.
- Receive, without charge, a copy of the Plan's procedures for determining the validity of Qualified Medical Child support orders.

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 discharge you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial.

You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 domestic relations order or medical child support order you may file suit in Federal Court. If it should happen that Plan fiduciaries misused 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.

If you have any questions about the Plan, you should call the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington D.C. 20210.

XXI. PROVISIONS RELATING TO THE PLAN'S RELATIONSHIP WITH BLUE CROSS/BLUE SHIELD

This section along with the applicable services agreement ("Agreement") governs the relationship between the Plumbers' Welfare Fund, Local 130, U.A. (the "Fund") and Health Care Service Corporation, a/k/a Blue Cross/Blue Shield of Illinois ("Network Administrator") and does not in any way limit or override any other provision of the Trust or Plan to the contrary. Nothing in the Plan or the Agreement shall be construed to constitute the Fund as an agent of the Network Administrator.

1. Network Administrator's Separate Financial Arrangements with Providers

   The Fund acknowledges that the Network Administrator has contracts with certain Providers ("Network Administrator Providers") for the provision of, and payment for, health care services to all persons entitled to health care benefits under individual certificates agreements and contracts to which the Network Administrator is a party, including the Participants under this Plan, and that pursuant to the Network Administrator's contracts with Network Administrator Providers, under certain circumstances described in those contracts, the Network Administrator may receive substantial payments from Network Administrator Providers with respect to services rendered to all such persons for which the Network Administrator was obligated to pay the Network Administrator Provider, or the Network Administrator may pay Network Administrator Providers substantially less than their claim charges for services, by discount or otherwise, or may receive from Network Administrator Providers other substantial allowances under the Network Administrator's contracts with them. Neither the Fund nor Participants are entitled to receive any portion of any such payments, discounts and/or other allowances as part of any claim settlement or otherwise except as otherwise set forth in the Agreement.

2. Information and Records

   It is the Participant's responsibility to ensure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, governmental body or program, or any other person or entity, having knowledge of or records relating to (1) any illness or injury for which a claim or claims for benefits are made under this Plan, (2) any medical history which might be pertinent to such illness, injury, claim or claims, or (3) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such claim or claims, furnish to the Network Administrator, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, claim or claims. It is also the Participant's responsibility to furnish to the Fund and/or the Network Administrator information regarding the Participant's becoming eligible for Medicare, termination of Medicare eligibility or any change in Medicare eligibility status in order that the Network

Administrator be able to make claim payments in accordance with Medicare Secondary Payer laws.

3. Payment of Claims and Assignment of Benefits

   All payments by the Network Administrator for the benefit of any Participant may be made directly to any Provider furnishing Covered Services for which such payment is due, and the Network Administrator is authorized by the Participant to make such payments directly to such Providers.

   Once Covered Services are rendered by a Provider, the Participant has no right to request the Network Administrator not to pay the Claim submitted by such Provider and no such request by a Participant or his agent will be given effect.

   Benefits under the Plan will be paid either directly from the general assets of the Fund or by the Network Administrator on behalf of the Fund pursuant to the terms of the Agreement. No assets of the Network Administrator or amounts which have been paid to the Network Administrator by the Fund under the Agreement are assets of or under the Plan.

   Neither this Plan nor a Participant's claims for payment of benefits under this Plan are assignable in whole or in part to any person or entity at any time. Coverage under this Plan is expressly non-assignable or non-transferrable and will be forfeited if a Participant attempts to assign or transfer coverage or aids or attempts to aid any other person in fraudulently obtaining coverage under this Plan. However, if the Network Administrator makes payment because of a person's wrongful use of the identification card of a Participant, such payment will be considered a proper payment and the Network Administrator will have no obligation to pursue recovery of such payment.

4. Participant/Provider Relationship

   The choice of a Hospital and Physician is solely the choice of the Participant. It is expressly understood that the Network Administrator does not itself undertake to furnish hospital or medical service, but solely to make payment to a Hospital or Physician for the Covered Services received by Participants.

   Each Provider provides Covered Services only to Participants and does not deal with or provide any services to the Fund (other than as an individual Participant) or the Plan.

5. Host Plan's Separate Financial Arrangements with Host Plan Providers

   Other Blue Cross and Blue Shield Plans outside of Illinois (Host Plans) may have contracts similar to the agreements described in this section with certain Providers (Host Plan Providers) in their service area.

   When a Participant receives health care services outside of Illinois and from a Provider which does not have a contract with the Network Administrator, the Host Plan, if any, will process the claim in accordance with the Host Plan's applicable contract, if any, with the Host Plan Provider. Often, the agreed upon cost is a simple discount. Sometimes, however, the agreed upon cost may represent either an estimated discount or an average discount realized or expected by the Host Plan based on separate financial arrangements or other non-claims transactions with Host Plan Providers. In other instances, laws in a small number of states may dictate the basis upon which the Participant's liability is calculated.

6. BlueCard Access Fees

   Host Plans may charge the Network Administrator an access fee for making their negotiated payment rates and the resulting savings available on claims incurred by Participants outside of Illinois. When the Network Administrator is charged an access fee by a Host Plan for such services, the fee will be treated as a claim payment.

XXII. DEFINITIONS

For purposes of the Plan, the following definitions apply:

Affiliated Employers

The Plumbers' Union, Local 130, U.A., the Plumbers' Pension Fund, Local 130, U.A., the Plumbers' Welfare Fund, Local 130, U.A., the Apprentice and Journeymen Education and Training Trust Fund, Local 130, U.A., the Kankakee & Iroquois Counties Plumbing & Piping Contractors Association, the West Suburban Association of Plumbing Contractors, and the Plumbing Contractors' Association of Greater Chicago. An entity will not be an Affiliated Employer unless it executes a participation agreement with the Fund and that agreement is approved by the Trustees.

Board of Trustees or Trustees

The originally named Trustees, their successors who are duly appointed under this Plan's Trust Agreement, and the Alternate Trustees when authorized to act by a Trustee in the manner prescribed by the Trust. The Trustees will conduct the business of the Trust and execute all instruments in that name.

Contractor, Contributing Contractor, Employer or Contributing Employer

Any contractor contributing to this Fund under the terms of an agreement with the Union providing for contributions, is a Contributing Contractor for the period of time for which contributions are being made. Any Contractor contributing to this Fund pursuant to the terms of an agreement with the Technical Engineering Division, Local 130, U.A., AFL-CIO, providing for contributions to the Welfare Fund - Technical Engineering Division, Local 130, U.A., AFL-CIO, or to this Trust is a Contributing Contractor for the period of time for which contributions are being made.

A Contributing Contractor also includes any person or entity employing persons to perform work or is an Owner-Alumni that is party to a participation agreement or alumni agreement with the Fund, and approved by the Board of Trustees, which provides, in writing, for the payment of contributions to the Fund for work performed by the employer's Employees, provided such agreement provides that employer will be bound by the terms of the Trust Agreement. The Trustees have the unqualified right to reject the application for participation of any Owner-Alumni or employer who is not a Contractor under the customs and usage of the applicable trade, and their decision on any employer application is final and binding.

A Contributing Contractor also includes any person or entity required to contribute to the Plan pursuant to a participation agreement with the Plan, and subject to the approval by the Board of

Trustees, provided such agreement provides that employer will be bound by the terms of the Trust Agreement.

Covered Employment

The employment of an Employee within a bargaining unit represented by the Union, or within a bargaining unit represented by the Technical Engineering Division, Local 130, U.A., AFL-CIO, and on account of such employment the Contractor is required to make contributions to the Fund, either under a collective bargaining agreement or other written agreement. Covered Employment does not begin until your Employer is required to begin contributions (for example, after you have completed any required probationary period pursuant to the applicable agreement). Covered Employment also includes (i) any hours worked for a union that sponsored a welfare fund that has merged with this Fund; (ii) any hours worked as part of a reciprocal agreement; and (iii) any hours worked for an Affiliated Employer which is required to contribute to this Fund pursuant to a participation agreement.

Dependent

The spouse of a Participant. For purposes of this Plan the term "spouse" means an individual who is a husband or wife of a Participant pursuant to a marriage legally conducted in the state or jurisdiction in which the marriage was performed that is legally recognized under federal U.S. law. The spouse of a Participant will lose Dependent status upon divorce or legal separation from the Participant. A spouse will be considered divorced or legally separated from the Participant on the date of entry of the court order granting the divorce or legal separation.

A child of a Participant who is under the age of 26 years. A child of a Participant commences Dependent status as of his or her date of birth, adoption, or court order placing the child in the Participant's care. An Employee's child/children shall include:

- A natural child,
- A legally adopted child,
- A child placed for adoption with the employee,
- A child listed as an employee's alternate recipient in a Qualified Medical Child Support Order (QMCSO),
- A foster child,
- A step-child (i.e., the natural or legally adopted child (or a child placed for adoption with) of your current spouse), or
- Any child (by blood or marriage) for whom an Employee has legal guardianship.

An unmarried child of a Participant, 26 years of age or older, who is incapable of self-support due to a mental incapacity caused by a Mental Health Condition or physical handicap (which incapacity or handicap commenced to the child prior to attaining age 26) and is dependent upon the Participant for his or her principal support and maintenance.

The Fund reserves the right to request any documentation including, but not limited to, a marriage or birth certificate, or a copy of any applicable court order, to verify Dependent status.

Disability

For purposes of this definition, Disability is defined as the following:

- You are unable to perform the duties of Covered Employment because of an Injury, Illness or childbirth or, because you are required to be in quarantine or self-isolation as a result of contact with someone who has been diagnosed with coronavirus, because you yourself have been diagnosed with coronavirus, or because you have symptoms consistent with a coronavirus diagnosis and are awaiting test results.
- You are not working in any other occupation.
- You are under the care of a Physician.

Durable Medical Equipment

Equipment which is Medically Necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body member, is intended for general use, is appropriate for use in the home, and which is not generally useful to a person in the absence of an illness or injury. Durable Medical Equipment does not include equipment used primarily and customarily for a non-medical purpose, equipment that basically serves the comfort or convenience of a patient, or deluxe equipment when standard equipment is available and medically adequate. Oxygen and transcutaneous electrical nerve stimulation (TENS) is generally considered Durable Medical Equipment.

Emergency Medical Condition

A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the lack of immediate attention to result in: (1) the patient's health (or with respect to a pregnant woman, the health of her unborn child) being placed in serious jeopardy, (2) serious impairment of bodily function, or (3) serious dysfunction of a bodily organ or part.

Emergency Services

With respect to an Emergency Medical Condition, a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department (emergency room) to evaluate such Emergency Medical Condition, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital to stabilize the patient.

Employee

Any person employed by a Contributing Contractor and on whose behalf contributions are made to the Plan pursuant to a collective bargaining agreement or to any other written participation agreement with the Fund accepted by the Trustees requiring Employer contributions on behalf of the person, in accordance with the terms of the Trust Agreement. The term Employee also refers to any regular, paid, full-time employee of an Affiliated Employer on whose behalf the Affiliated Employer contributes to the Plan pursuant to the terms of a participation agreement.

ERISA

The Employee Retirement Income Security Act of 1974, as amended, and any regulations promulgated thereunder.

Essential Health Benefits

Items and services covered within the following general categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (meaning services provided to individuals under age 19), including oral and vision care. The Board of Trustees has the sole discretion and responsibility to determine in good faith whether a benefit is deemed to be an "essential health benefit" pursuant to the guidance under PPACA. The Board of Trustees also has the sole discretion for choosing the applicable benchmark plan for determining whether a benefit is deemed to be an "essential health benefit."

Experimental/Investigational

Items and services are considered experimental/investigational when there is insufficient evidence establishing that the service is generally accepted as standard medical care for the condition, disease, illness or injury being treated. Any drug or medicine which is not approved by the U.S. Food and Drug Administration ("FDA") or is limited in use whether or not approved by the FDA will be considered Experimental/Investigational.

Fund, Welfare Fund or Trust Fund

The Plumbers' Welfare Fund, Local 130, U.A., including all property of the Trust including any group insurance contracts purchased by the Trustees for the benefit of Participants.

Health Care Providers

Institutions or persons who are legally licensed and/or legally authorized to practice or provide medical care or diagnostic treatment to sick or injured persons under the laws of the state or jurisdiction in which the services are rendered. Health Care Providers include Physicians and Surgeons.

Home Health Care

The Reasonable and Customary Charges made by a home health care agency for the following Medically Necessary services or supplies furnished to a Covered Person in the person's home under a Home Health Care Plan providing for care in lieu of hospitalization for the same or related condition:

- Part-time or intermittent nursing care by or under the supervision of a registered nurse;
- Part-time or intermittent home health care aide services which consist primarily of caring for the Covered Person;

- Physical therapy, occupational therapy, speech therapy, and medical social services provided by the home health care agency; and
- Laboratory services by or on behalf of a certified home health care agency.
- Home health care expenses do not include charges for the following:
- Services or supplies not included in the Home Health Care Plan;
- Services of a person who is a member of the family of either the Participant or his spouse or a person who ordinarily resides in the Covered Person's home;
- Custodial care;
- Transportation; or
- Any period in which the Covered Person is not under the continuing care of a Physician.

A "Home Health Care Plan" is a program for care and treatment established and approved in writing by the covered person's attending Physician within seven days after termination of the covered person's Hospital confinement, together with a certificate by the Physician that the proper treatment of the injury, sickness, or infirmity requires continuing confinement as a bed patient in a Hospital or Skilled Nursing Facility in the absence of the services and supplies provided in the home health care plan.

A "Home Health Care Agency" is an organization which (1) is primarily engaged in providing skilled nursing and other therapeutic services, (2) is duly licensed by appropriate governmental authority, if legally required in the jurisdiction of the agency, (3) provides for full-time supervision of the services by a Physician or registered nurse, and (4) maintains a complete medical record of each patient.

Hospital

An institution fully accredited as a Hospital by the Joint Commission on the Accreditation of Hospitals and State licensed that (1) is equipped with facilities for diagnosis and surgery, except that surgical facilities are not required if the medical care or services rendered are for a Mental Health Condition, (2) maintains on a 24-hour basis registered nurses who are in attendance, on duty or on call, and (3) is not operated by the U.S. Government or any agency thereof or by any State (or political subdivision thereof) or any agency thereof. For the purposes of this Plan, the term "Hospital" includes an ambulatory surgical treatment center licensed by the State of Illinois or a similar facility licensed by another State; Skilled Nursing Facilities; and facilities for treatment of Mental Health Conditions and Substance Abuse that are licensed and operated according to law.

Hospital also includes Residential Treatment Centers that are structured, rehabilitative treatment programs designed by licensed practitioners acting within the scope of their licenses, but does not include programs or services consisting primarily of counselling by individuals not licensed or any court ordered evaluations, programs which are primarily diagnostic evaluations, or screening of mental health or learning disabilities, care in lieu of incarceration, family retreats, half-way houses, boarding houses or other facilities that are primarily a supportive environment, even if counselling is provided in that setting.

Notwithstanding the foregoing, Hospital does not include an institution which is a convalescent home; a custodial home; a rest home; or a health resort.

Illness

A sickness, disorder, or disease. Pregnancy is treated the same as an Illness under the Plan for an Employee or Dependent Spouse and Child who are Plan Participants.

Infertility

The inability to conceive a child after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. The one year requirement will be waived if a Physician determines a medical condition exists that renders conception impossible through unprotected sexual intercourse, including but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to chemotherapy or radiation treatments.

Unprotected sexual intercourse means sexual union between a male and a female without the use of any process, device or method that prevents conception, including but not limited to, oral contraceptives; chemical, physical or barrier contraceptives; natural abstinence; or voluntary permanent surgical procedures.

Injury

A physical damage to the body of a Plan Participant. Only Injuries that are not employment related are considered benefits under this Plan, except for the Death and Accidental Death and Dismemberment benefits.

Medically Necessary or Medical Necessity

1. A medical or dental service or supply will be determined to be **"Medically Necessary"** by the Plan Administrator or its designee if it:
    (a) is provided by or under the direction of a Physician or other duly licensed Health Care Provider who is authorized to provide or prescribe it or Dentist if a dental service or supply is involved; and
    (b) is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical and dental standards; and
    (c) is determined by the Plan Administrator or its designee to meet <u>all</u> of the following requirements:
        i) It is consistent with the symptoms or diagnosis and treatment of an Illness or Injury; and
        ii) It is not provided solely for the convenience of the patient, Physician, Dentist, Hospital, Health Care Provider, or Health Care Facility; and
        iii) It is an **"Appropriate"** service or supply given the patient's circumstances and condition; and
        iv) It is a **"Cost-Efficient"** supply or level of service that can be safely provided to the patient; and

v) It is safe and effective for the Illness or Injury for which it is used.

2. A medical or dental service or supply will be considered to be **"Appropriate"** if:

   (a) It is a diagnostic procedure that is called for by the health status of the patient, and is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both with respect to the Illness or Injury involved and the patient's overall health condition.

   (b) It is care or treatment that is as likely to produce a significant positive outcome as **and** no more likely to produce a negative outcome than any alternative service or supply, both with respect to the Illness or Injury involved and the patient's overall health condition.

3. A medical or dental service or supply will be considered to be **"Cost-Efficient"** if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

4. The fact that your Physician or Dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be Medically Necessary for the medical or dental coverage provided by the Plan.

5. A Hospitalization or confinement to a Health Care Facility will not be considered to be Medically Necessary if the patient's Illness or Injury could safely and appropriately be diagnosed or treated while not confined.

6. A medical or dental service or supply that can safely and appropriately be furnished in a Physician's or Dentist's office or other less costly facility will not be considered to be Medically Necessary if it is furnished in a Hospital or Health Care Facility or other more costly facility.

7. The non-availability of a bed in another Health Care Facility, or the non-availability of a Health Care Provider to provide medical services will not result in a determination that continued confinement in a Hospital or other Health Care Facility is Medically Necessary.

8. A medical or dental service or supply will not be considered to be Medically Necessary if it does not require the technical skills of a Dental or Health Care Provider or if it is furnished mainly for the personal comfort, convenience or preference of the patient, the patient's family, any person who cares for the patient, any Dental or Health Care Provider, Hospital or Health Care Facility.

9. Any drug or medicine which is not approved by the U.S. Food and Drug Administration ("FDA") or is experimental or limited in use whether or not approved by the FDA will not be considered Medically Necessary.

10. In the absence of illness or injury, a prophylactic surgery or treatment may be considered Medically Necessary if:

    (a) the individual is a high risk individual (e.g. has a significant genetic or hereditary predisposition to a serious illness or injury);

    (b) the surgery or treatment is proven to reduce the risk of a serious illness or injury; and

(c) the surgery or treatment is not considered to be Experimental/Investigational. The Plan reserves the right to consult medical professionals to assist in the determination of high risk, serious illness or injury, and Experimental/Investigational. When a prophylactic mastectomy is determined to be Medically Necessary by the Plan Administrator or its designee, the Plan complies with the Women's Health and Cancer Rights Act ("WHCRA") in covering reconstruction. Reconstruction is explained in the Schedule of Medical Benefits in the Reconstructive Services row.

Medicare or Medicare Benefits

The Hospital and medical benefits provided under Part A of Title XVIII of the Social Security Act, as amended.

Mental Health Condition

A Mental Health Condition is a condition or illness that affects an individual's emotional or psychological well-being. Mental Health Conditions include, but are not limited to, dementia, delirium, anxiety disorder, schizophrenia, depression, bipolar disorder, delusions, obsessive-compulsive behavior, Anorexia, Bulimia, attention deficit disorder, mental retardation, and autism. Mental Health Condition shall be further defined to include any condition or disorder specified in the International Classification of Diseases, 11th Revision (ICD-11) or the most current revision of the International Classification of Diseases (ICD) commonly used in the medical community.

Non-Bargaining Unit Employee

Any full-time employee of a Contributing Contractor who is not an apprentice or journeyman plumber, Trainee, or serviceman included within a bargaining unit represented by the Union or a member of any other labor organization providing pension and welfare benefits to its members.

Participant

An individual who is participating in the Plan and is eligible for a benefit or benefits under the Plan.

Pediatric Care

Treatment and services provided to a Dependent who is under the age of 19.

Physician or Surgeon

A doctor of medicine duly licensed by a State to practice medicine in all of its branches. For purposes of this Plan, the term Physician or Surgeon also includes a practitioner licensed to practice as a podiatrist, chiropodist, optometrist, chiropractor, psychologist, mental health or substance abuse professional, or licensed to treat human ailments without the use of drugs or medicine or without operative surgery, if the practitioner is duly licensed under an appropriate state licensing authority, the benefit claimed is for services within the scope of the practitioner's license, and the services would be reimbursed under this Plan if performed by a doctor of medicine.

Plan

The Plumbers' Welfare Fund, Local 130, U.A. sponsored by the Fund's Board of Trustees.

PPACA

The Patient Protection and Affordable Care Act of 2010, as amended and any regulations promulgated thereunder.

PPO Hospital, Provider, or Facility

Any Physician or Surgeon, Hospital, Provider or Facility, having a written agreement with Health Care Service Corporation, a/k/a Blue Cross/Blue Shield of Illinois governing participation in the Blue Cross/Blue Shield of Illinois Hospital, Accountable Care Organization or Physician Preferred Provider Organization.

Prescription Drug

A drug or medicine, which may be self-administered, intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease; which is:

- classified as a drug by Federal law;
- dispensed only upon the prescription of a practitioner licensed by law to administer the drug; and
- bears the legend: "Caution: Federal law prohibits dispensing without prescription."

For purposes of the Plan, the term "Prescription Drug" includes insulin if prescribed by a Physician; but does not include devices or their components, parts or accessories. The term "Prescription Drug" includes needles and accessories needed to take insulin or any other injectable Prescription Drug that may, from time to time, be covered as a Prescription Drug. An over-the-counter medicine is not a Prescription Drug even if prescribed by a Physician.

Preventive Services

Preventive Services means those services, as defined and described in Section 5.14, required by the PPACA.

Prohibited Employment

The following shall constitute Prohibited Employment:

- The conduct of a plumbing enterprise which is not, but could be, a party to a collective bargaining agreement with a local union affiliated with the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada ("the United Association");
- The conduct of an enterprise which performs work within the occupational jurisdiction of the Technical Engineering Division, Local 130, U.A., AFL-CIO, and is not a party to a collective bargaining agreement with the Technical Engineering Division, Local 130, U.A., AFL-CIO;

- Employment with a contractor which is not a party to a collective bargaining agreement with a local union affiliated with the United Association or the Technical Engineering Division, Local 130, U.A., AFL-CIO; or
- Continued employment with a contractor by a Participant who receives notice that an order has been issued by the Union, or a local union affiliated with the United Association or the Technical Engineering Division, Local 130, U.A., AFL-CIO to withdraw its members from employment with the contractor because of the contractor's noncompliance with the terms of the collective bargaining agreement with the Union or the Technical Engineering Division, Local 130, U.A., AFL-CIO.

Prosthetic Device

An artificial part which aids or replaces a body part or function and which is designed, manufactured, or adjusted to fit a particular individual. A one-size-fits-all device that can be adjusted by the individual for a better fit would not qualify as a Prosthetic Device. A Prosthetic Device does not include a deluxe device when a standard device is available and medically adequate.

Reasonable and Customary Charges or Fees

Charges for medical or dental care, services or supplies of the level usually furnished for cases of the nature and severity of the case being treated and that are, as determined by the Trustees, within the range of usual and customary representative fees or charges in the same geographic area for the same services, under similar or comparable circumstances.

Residential Treatment Center

A facility providing physical or mental rehabilitation, including treatment for Mental Health Conditions, alcoholism and/or Substance Abuse, on an inpatient basis. The facility must be licensed to provide the treatments by the state where it is located. A Residential Treatment Center does not include programs consisting primarily of counselling by individuals not licensed or any court ordered evaluations, programs which are primarily diagnostic evaluations, or screening of mental health or learning disabilities, care in lieu of incarceration, family retreats, half-way houses, boarding houses or other facilities that are primarily a supportive environment, even if counselling is provided in that setting.

Schedule A Agreement

The current Residential & Light Commercial Construction "Schedule A" Agreement. Any Employee who is classified as a "Trainee" or other sub-classification of a Trainee under the Schedule A Agreement and working for a Contributing Contractor that is a party to the Schedule A Agreement will be eligible for the benefits applicable to Trainees as set forth in this Plan/SPD.

Skilled Nursing Facility

An institution or a distinct part of an institution that:

1. Has a transfer agreement with one or more Hospitals,

2. Is primarily engaged in providing comprehensive post-acute Hospital and rehabilitative Inpatient care, and
3. Is duly licensed by the appropriate governmental authority to provide such services.

Skilled Nursing Facility does not mean institutions that provide only minimum care, custodial care services, ambulatory or part-time care services or institutions that primarily provide for the care and treatment of Mental Health Conditions, pulmonary tuberculosis or Substance Abuse.

Substance Abuse

Substance Abuse is the uncontrollable or excessive abuse of addictive substances and the resultant physiological or psychological dependency, which develops with continued use, requiring medical care as determined by a qualified Physician. Addictive substances include, but are not limited to, alcohol, morphine, cocaine, heroin, opium, cannabis and other barbiturates, tranquilizers, amphetamines, hallucinogens, and tobacco. Substance Abuse shall be further defined to include any condition or disorder specified in categories 291 and 292 and categories 303 through 305 of the International Classification of Diseases, 11th Revision ("ICD-11") or the most current revision of the International Classification of Diseases ("ICD") commonly used in the medical community.

Union

The Plumbers' Local Union No. 130 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada, or in the case of a dissolution or disaffiliation of the Union, any successor to the Union.