

Pipe Fitters' Welfare Fund, Local 597
Summary Plan Description
and
Plan Document

2008 Edition

PIPE FITTERS' WELFARE FUND, LOCAL 597

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A MESSAGE FROM THE BOARD OF TRUSTEES

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

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

IMPORTANT REMINDER

TELL YOUR FAMILY, PARTICULARLY YOUR SPOUSE, ABOUT THIS BOOKLET AND WHERE IT IS LOCATED. PLEASE NOTIFY THE FUND OFFICE PROMPTLY IF YOU CHANGE YOUR ADDRESS. ONLY THE FULL BOARD OF TRUSTEES IS AUTHORIZED TO INTERPRET THE BENEFITS DESCRIBED IN THIS BOOKLET. NO EMPLOYER, THE UNION, NOR ANY REPRESENTATIVE OF ANY EMPLOYER OR UNION, IN SUCH CAPACITY, IS AUTHORIZED TO INTERPRET THIS PLAN, NOR CAN ANY SUCH PERSON ACT AS AGENT OF THE TRUSTEES.

THE TRUSTEES RESERVE THE RIGHT TO AMEND, MODIFY OR DISCONTINUE ALL OR PART OF THIS PLAN WHENEVER, IN THEIR JUDGMENT, CONDITIONS SO WARRANT. YOU WILL BE NOTIFIED IN WRITING OF ANY PLAN CHANGES.

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SECTION 1: SCHEDULES OF BENEFITS

A Schedule of Benefits is a list of benefit amounts and exclusions that apply to benefits. Each specific benefit is described in more detail in the section concerning that particular benefit. When reading the specific benefit section, you should reference the applicable Schedule of Benefits and vice versa. This Section provides information for each type of participant under the Plan. Sections 1.01(A) and (B) provide a Schedule for Active Employees and Retired Employees not yet eligible for Medicare. Section 1.01(C) provides a Schedule for Retired Employees who are eligible for Medicare. Section 1.02 provides Schedules for Prescription and Specialty Drug Benefits for Active and Retired Employees.

The following Schedule provides an overview of the benefits that apply to each type of participant.

1.01 Schedule of Benefits.

A. Active Employees.

<i>Death Benefit</i>	\$10,000	
<i>Accidental Death and Dismemberment Benefit</i>		
For loss of:		
Life	\$10,000	
Both hands, both feet or sight of both eyes	\$10,000	
One hand and one foot, one hand and sight of one eye, or one foot and sight of one eye	\$10,000	
One hand, one foot or sight of one eye	\$5,000	
<i>Weekly Accident and Sickness Disability Benefit</i>		
Weekly Benefit Amount	\$350 per Week for a Maximum of 26 Weeks	
<i>Calendar Year Deductible</i>	\$300 per person \$900 per family	
<i>Covered Expenses Payable by the Fund up to the Usual and Customary Fees</i>	<i>PPO Charges</i>	<i>Non-PPO Charges</i>
Physician, Hospital/Facility (Inpatient and outpatient)	85%	75%
Skilled Nursing Care	60 Days per Confinement	

Major Medical Out-of-Pocket Maximum	
Out-of-Pocket Maximum per Calendar Year	\$1,000 per Person for PPO Expenses \$2,500 per Person for non-PPO Expenses
Out-of-Pocket Maximum Does Not Include:	Once you reach the out-of-pocket maximum, the Fund pays 100% of allowable expenses for the calendar year up to the maximum benefit listed above. Expenses that apply towards the non-PPO out-of-pocket limits apply towards the PPO out-of-pocket limits and vice versa.
<ul style="list-style-type: none"> • Deductible Amount • Prescription Drug Co-payments • Dental Expense Payments • Vision Care Expense Payments • Physical/Speech/Occupational Therapy Co-payments above the \$3,500 Maximum • Co-payments for Outpatient Treatment of Mental and Nervous Disorders or Chemical Dependency 	
Maximum Benefit Paid Under Major Medical	
Maximum per Sickness or Accident	\$1,000,000 per Person per Lifetime
Spinal Manipulation and Naprapathy Maximum (including diagnostic tests)	\$1,000 per Calendar Year (for covered individuals age 16 and older)
Confinement in a Skilled Nursing Care Facility	60 Days per Confinement
Outpatient Physical/Speech Therapy Maximum	\$3,500 per Calendar Year*
Outpatient Occupational Therapy Maximum	\$3,500 per Calendar Year*

* After the \$3,500 outpatient maximum is reached, no other payment is made under the Plan with the following exceptions: if \$3,500 is reached for the outpatient treatment of cerebral palsy, cerebral vascular incident (stroke), intracranial bleed, other head trauma, spinal cord injuries, multiple or complicated fractures, other catastrophic diagnoses with neurological implications, significant multiple injuries and/or illnesses, or injuries and/or illnesses for which the \$3,500 outpatient maximum cannot be reasonably expected to cover a proper course of treatment, then the Plan pays 75% and the participant co-payment is 25%. However, in that situation, that 25% participant co-payment in excess of \$3,500 does not count towards the out-of-pocket maximum and regardless of whether the person otherwise meets the out-of-pocket maximum, the 25% participant co-payment continues to apply for outpatient physical, speech and occupational therapy in that situation.

Mental and Nervous Disorders	PPO Charges	Non-PPO Charges
Outpatient	50%	50%
Inpatient	85%	75%

<i>Chemical Dependency</i>	<i>PPO Charges</i>	<i>Non-PPO Charges</i>
Outpatient	50%	50%
Inpatient	85%	75%
Inpatient Maximum	\$6,000 per Course of Treatment Limited to Two Courses of Treatment per Lifetime	
<i>Wellness Benefit</i>		
Physical Exam (and specified lab tests)	100% - PPO only	
Weight Watchers	13-Week Session	
<i>Dental Expense Benefit</i>		
Dental Benefits Other than Orthodontia Care		
Maximum Benefit	\$1,250 per Person per Calendar Year	
Co-payment Paid by the Fund	80%	
Orthodontia Treatment	\$1,500 per Person per Lifetime	
TMJ Treatment	\$2,000 per Person per Lifetime	
<i>Vision Benefit</i>		
<i>Covered Expenses Once Every Calendar Year</i>	<i>Your In-Network Cost</i>	<i>Your Out-of Network Reimbursement</i>
Exam with Dilation as Necessary	\$0 Co-payment	\$40
Contact Lens Fit and Follow Up		
Standard Lenses	\$40 Co-payment, for fit and two follow up visits	Not Covered
Premium Lenses	\$40 Co-payment, then 10% off balance over \$40	Not Covered

Contact Lenses (In Lieu of Glasses)		
Conventional	\$0 Co-payment, \$150 Allowance, 15% off Balance over \$150	\$110
Disposable	\$0 Co-payment, \$150 Allowance, plus Balance over \$150	\$110
Frames	\$150 Allowance, 20% Off Balance over \$150	\$110 Allowance for Frame, Lenses and Options
Standard Plastic Lenses		
Single Vision	\$0 Co-payment	N/A
Bifocal	\$0 Co-payment	N/A
Trifocal	\$0 Co-payment	N/A
Lens Options		
UV Coating	\$15 Co-payment	N/A
Tint (Solid and Gradient)	\$15 Co-payment	N/A
Standard Scratch Resistance	\$15 Co-payment	N/A
Standard Polycarbonate	\$40 Co-payment	N/A
Standard Anti-Reflective Coating	\$45 Co-payment	N/A
Standard Progressive (Add-on to Bifocal)	\$65 Co-payment	N/A
Other Add-Ons and Services	20 % Off Retail Price	N/A
<i>Employee Assistance Plan (EAP)</i>		
Initial Counseling with EAP Staff	Up to Three Sessions Covered at No Charge	
<i>Hearing Aid Benefit</i>		
Hearing Aid and Exam	100% up to \$900 per Ear	
Frequency Limit	One per Ear for any 36 Consecutive Month Period	
<i>Hospice Benefits</i>		
Coverage	100% up to \$10,000 per Lifetime	
<i>Home Birth Benefits</i>		
Coverage	100% up to the \$3,500 per Pregnancy	

B. Retired Employees Not Yet Eligible for Medicare.

<i>Death Benefit</i>	\$5,000	
<i>Calendar Year Deductible</i>	\$300 per Person \$900 per Family	
<i>Covered Expenses Payable by the Fund up to the Usual and Customary Fees</i>	<i>PPO Charges</i>	<i>Non-PPO Charges</i>
Physician, Hospital/Facility (Inpatient and outpatient)	85%	75%
Skilled Nursing Care	60 Days per Confinement	
<i>Major Medical Out-of-Pocket Maximum</i>		
<i>Out-of-Pocket Maximum per Calendar Year</i>	\$1,000 per Person for PPO Expenses \$2,500 per Person for non-PPO Expenses	
Out-of-Pocket Maximum Does Not Include:	Once you reach the out-of-pocket maximum, the Fund pays 100% of allowable expenses for the calendar year up to the maximum benefit listed above. Expenses that apply towards the non-PPO out-of-pocket limits apply towards the PPO out-of-pocket limits and vice versa.	
<ul style="list-style-type: none"> • Deductible Amount • Prescription Drug Co-payments • Dental Expense Payments • Vision Care Expense Payments • Physical/Speech/Occupational Therapy Co-payments above the \$3,500 Maximum • Co-payments for Outpatient Treatment of Mental and Nervous Disorders or Chemical Dependency 		
<i>Maximum Benefit Paid Under Major Medical</i>		
Maximum per Sickness or Accident	\$1,000,000 per Person per Lifetime	
Spinal Manipulation and Naprapathy Maximum (including diagnostic tests)	\$1,000 per Calendar Year (for covered individuals age 16 and older)	
Confinement in a Skilled Nursing Care Facility	60 Days per Confinement	
Outpatient Physical/Speech Therapy Maximum	\$3,500 per Calendar Year*	
Outpatient Occupational Therapy Maximum	\$3,500 per Calendar Year*	

* After the \$3,500 outpatient maximum is reached, no other payment is made under the Plan with the following exceptions: if \$3,500 is reached for the outpatient treatment of cerebral palsy, cerebral vascular incident (stroke), intracranial bleed, other head trauma, spinal cord injuries, multiple or complicated fractures, other catastrophic diagnoses with neurological implications, significant multiple injuries and/or illnesses, or injuries and/or illnesses for which the \$3,500 outpatient maximum cannot be reasonably

expected to cover a proper course of treatment, then the Plan pays 75% and the participant co-payment is 25%. However, in that situation, that 25% participant co-payment in excess of \$3,500 does not count towards the out-of-pocket maximum and, regardless of whether the person otherwise meets the out-of-pocket maximum, the 25% participant co-payment continues to apply for outpatient physical, speech and occupational therapy in that situation.

<i>Mental and Nervous Disorder</i>	<i>PPO Charges</i>	<i>Non-PPO Charges</i>
Outpatient	50%	50%
Inpatient	85%	75%
<i>Chemical Dependency</i>	<i>PPO Charges</i>	<i>Non-PPO Charges</i>
Outpatient	50%	50%
Inpatient	85%	75%
Inpatient Maximum	\$6,000 per Course of Treatment Limited to Two Courses of Treatment per Lifetime	
<i>Wellness Benefit</i>		
Physical Exam (and specified lab tests)	100% - PPO only	
Weight Watchers	13-Week Session	
<i>Employee Assistance Plan (EAP)</i>		
Initial Counseling with EAP Staff	Up to Three Sessions Covered at No Charge	
<i>Hearing Aid Benefit</i>		
Hearing Aid and Exam	100% up to \$900 per Ear	
Frequency Limit	One per Ear for any 36 Consecutive Month Period	
<i>Hospice Benefits</i>		
Coverage	100% up to the \$10,000 per Lifetime	
<i>Home Birth Benefits</i>		
Coverage	100% up to the \$3,500 per Pregnancy	
<i>Dental Benefit</i>		
	Access to discounts for using Dental PPO network; however the Fund pays 0% for services	

C. Retired Employees Eligible for Medicare.

<i>Supplemental Medical Expense Benefit</i>	Amount Paid by Medicare in 2008	Amount Paid by Participant in 2008	Amount Paid by Fund
Amounts Payable During any Hospital Confinement			
First 60 Days	Amounts over \$1,024	\$372	\$652
61 st Day Through 90 th Day	Amounts over \$256 per day	\$18 per day	\$238 per day
91 st Day Until End of Lifetime Reserve	Amounts over \$512 per day	\$36 per day	\$476 per day
After Lifetime Reserve is Exhausted	0%	20%	80%
Pints of Blood			
First Three Pints			\$25 per pint
More Than Three Pints	100%	0%	0%
Medicare Part B Deductible	0%	0	100%
Medicare Part B Expenses After Deductible	80%	0%	20%
Outpatient Mental Health Services	50%	30%	20%
<i>Skilled Nursing Facility</i>			
First 20 Days	100%	0%	0%
21 st Day Through 100 th Day	Amounts over \$128 per day	\$9 per day	\$119 per day
Maximum payable by the Plan per Sickness or Accident	\$1,000,000 per Person per Lifetime		
<i>Employee Assistance Plan (EAP)</i>			
Initial Counseling with EAP Staff	Up to Three Sessions Covered at No Charge		
<i>Death Benefit</i>	\$5,000		

1.02 Schedules for Prescription and Specialty Drug Benefits for Active and Retired Employees.

<i>Specialty Drug Benefits Participant Co-Payment Percentage</i>		<i>20%</i>
<i>Prescription Drug Benefits Co-Payment Percentage (if greater than minimum co-payment amounts)</i>		<i>20%</i>
<i>Minimum Co-Payment Amount</i>	Retail (34-day supply)	Mail (90-day supply)
Generic	\$5	\$10
Preferred Brand Drugs on the preferred brand list are considered good values, both clinically and financially.	\$15	\$30
Non-Preferred Brand Drugs on the non-preferred brand list are the most expensive drugs available on the market. Always ask if there is a generic or preferred brand that is available.	\$30	\$60
Out-of-Pocket Maximum per year for Prescription Drug Benefit excluding prescription narcotics (narcotic agonists)		\$5,000 per Family
The participant co-payment for prescription narcotics (narcotic agonists) is always 20% and is not subject to any out-of-pocket maximum.		

SECTION 2: ELIGIBILITY

2.01 Eligibility for Active Employee Benefits.

A. Eligibility Hours and your Accumulation Account.

You are eligible for Active Employee Benefits based on the number of Eligibility Hours in your Accumulation Account.

1. Eligibility Hours are hours that are credited to your Accumulation Account which are used in determining eligibility for Active Employee Benefits. Eligibility Hours include hours in Covered Employment for which contributions are received by the Fund, and hours based on reciprocal contributions received from a Related Plan.
 - a. An Eligibility Hour will be credited for each hour you work in Covered Employment under a collective bargaining agreement or other written agreement that requires your Employer to contribute to the Plan on your behalf.
 - b. You will receive pro-rated credit for hours worked on or after September 1, 2003, for contributions received from a Related Plan. Related Plan means another welfare plan that has entered into a written agreement with this Welfare Plan that provides for the transmittal of contributions received on behalf of Employees who leave the jurisdiction of one plan to work temporarily under the jurisdiction of another plan. The calculation of Eligibility Hours for Initial Eligibility, Continued Eligibility and Reinstatement of Eligibility will be based on the dollar amount of related contributions received, divided by the hourly contribution rate of this Plan under the Area Agreement and/or Industrial Maintenance Agreement between the MCA and the Union. An Employee shall not be given credit for hours of work in respect to which related contributions are transmitted to a Related Plan.
2. Your Accumulation Account is a record of your Eligibility Hours used in determining eligibility for Active Employee Benefits. You can accumulate a maximum of 1,500 hours in your Accumulation Account once you meet Initial Eligibility Requirements.

Example of Pro-Rated Hours from a Related Plan:

Bruce works 1000 hours for an Employer who contributes \$6.00 per eligible hour to a Related Plan on Bruce's behalf. During the time Bruce works for that Employer, the contribution rate under the Area Agreement is \$7.66 per eligible hour for Welfare Plan benefits. After the Fund Office receives the \$6,000.00 (\$6.00 x 1000 hours) in contributions from the Related Plan, Bruce's Accumulation Account would then be credited with 783.29 Eligibility Hours ($\$6,000 / \$7.66 = 783.29$).

B. Benefit Quarters.

Eligibility for Active Employee Benefits is offered in three-calendar-month intervals, called Benefit Quarters. Benefit Quarters end on one of the following termination dates:

- March 31st;
- June 30th;
- September 30th; or
- December 31st.

Once you meet the Initial Eligibility Requirement (described below), you will continue to be covered for each Benefit Quarter if you have the necessary Eligibility Hours in your Accumulation Account.

C. Initial Eligibility Requirement.

You will become eligible for Active Employee Benefits on the first day of the second month after your Accumulation Account is credited with 450 Eligibility Hours. These 450 Eligibility Hours must be earned within a period not longer than six consecutive months. Once you become eligible, coverage will continue for the remainder of the current Benefit Quarter and for the entire next Benefit Quarter. Further, once you are eligible, 375 Eligibility Hours will be deducted from your Accumulation Account on the first determination date after you become eligible.

D. Continued Eligibility Requirements.

Once you meet the Initial Eligibility Requirement, you will continue to be covered for subsequent Benefit Quarters if you have at least 375 Eligibility Hours credited to your Accumulation Account as of the quarterly determination date.

On the determination date, 375 Eligibility Hours will be subtracted from your Accumulation Account. If you have more than 375 Eligibility Hours in your Accumulation Account, the excess will be carried forward, up to a maximum of 1,500 hours.

The Eligibility Hours subtracted from your Accumulation Account on each determination date provide coverage as shown in the following chart:

Determination Date You must have 375 Eligibility Hours in your Accumulation Account on:	To Be Eligible for Coverage in the following Benefit Quarter:
January 31st	April, May and June
April 30th	July, August and September
July 31st	October, November and December
October 31st	January, February and March

E. When Coverage Ends.

Coverage for you and your Dependents will end on the March 31st, June 30th, September 30th or December 31st that you do not have 375 hours in your Accumulation Account on the corresponding determination date. When your Plan coverage ends, your Dependents' coverage under the Plan also ends.

F. Reinstatement of Eligibility.

Your coverage will be reinstated if your Accumulation Account is credited with 375 or more Eligibility Hours by either the first or the second determination date immediately following the date your coverage ends. Coverage will begin on the first day of the next Benefit Quarter and will continue as long as you meet the Continued Eligibility Requirements described in Section 2.01(D). If your coverage is not reinstated during this six-month period, any remaining hours in your Accumulation Account will be canceled, and you will be required to meet the Initial Eligibility Requirement described in Section 2.01(C) to regain coverage.

G. Coverage During Your Disability.

If you cannot perform covered work because of a certified disability, you will be credited with disability hours to maintain your eligibility. A certified disability is a disability for which you are receiving the Weekly Accident and Sickness Disability Benefit through the Fund or weekly workers' compensation benefits. If you are receiving workers' compensation benefits, you must submit proof of your receipt of those benefits to the Fund Office. You will be credited with 29 disability hours for each full week of your certified disability. You are limited to 754 maximum hours per period of disability. These credited hours only apply to your Accumulation Account under the Welfare Plan and are not credited under the Pipe Fitters' Retirement Fund, Local 597. You are also limited to a maximum of 1,500 disability hours during your lifetime.

H. Industry Expansion Eligibility.

The Fund has established the Industry Expansion Program to provide immediate eligibility for newly organized Employees when it is determined that providing such coverage will advance the economic security of the industry and the Fund.

The Industry Expansion Program applies to Employees of a qualified Employer who previously employed persons in the trade and territorial jurisdiction of the Union without being signatory to a collective bargaining agreement with the Union.

The determination of whether an Employer is qualified under the Industry Expansion Program is delegated to the Business Manager of the Union who will report such determination at the following Board of Trustees meeting. In evaluating whether an Employer is qualified under the Industry Expansion Program the following factors will be considered:

1. Whether granting qualified status will advance the economic security of the industry and thus, the Fund.
2. Whether granting qualified status will significantly influence the Employer's decision to become a signatory contractor or significantly influence its Employees to choose to become unionized.
3. Whether the Employer maintained health care coverage for Employees prior to becoming a signatory contractor.

4. The number of Employees who could lose health care coverage if the Employer does not continue its existing health care coverage while its Employees establish initial eligibility.

Upon a determination that an Employer is qualified under the Industry Expansion Program, the Employees who are covered by the collective bargaining agreement will be eligible for coverage for the remainder of the current Benefit Quarter and for the entire next Benefit Quarter. Thereafter, the Employee will be covered for subsequent Benefit Quarters based on meeting the Continued Eligibility Requirements.

I. Effect of Military Service on Eligibility.

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

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

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

- Option 1: Suspend eligibility and rely on military coverage for you and your Dependents (as of the date active coverage is suspended, you will be offered the right to pay for COBRA Continuation Coverage for up to 24 months). This is the **DEFAULT OPTION**.
- Option 2: Suspend active coverage under the Plan for as long as Plan’s eligibility rules permit, and then elect COBRA coverage for up to 24 months.
- Option 3: Continue active coverage for as long as the Plan’s eligibility rules permit, and then elect COBRA coverage for up to 24 months.

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

Option 1

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

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

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

Option 2

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

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

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

Option 3

If you elect Option 3 (continue active coverage), you and your Dependents will receive active coverage for as long as your Accumulation Account permits. Thereafter you will be offered COBRA coverage for up to 24 months. The standard election and payment deadlines under COBRA apply.

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

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

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

J. Coverage Under the Family and Medical Leave Act (FMLA).

Under the Family and Medical Leave Act of 1993 (FMLA), you have the right to take up to 12 weeks (during any 12-month period) of unpaid leave for your own serious illness, the birth or adoption of a child or to care for a seriously ill spouse, parent or child and you meet the following criteria:

1. You worked for the same Employer for at least 12 months;
2. You have worked at least 1,250 hours during the previous 12 months; and
3. You work at a location where at least 50 Employees are employed by your Employer within a 75-mile radius.

When you take an FMLA leave, you must inform the Trustees in writing so that your rights to health care coverage are protected during your leave.

If you return to Covered Employment within 12 weeks, you will continue to receive coverage if you otherwise meet the Plan's eligibility requirements.

If your coverage terminates, you will then be eligible to purchase COBRA Continuation Coverage as described in Section 2.03. Contact the Fund Office for additional information about your coverage during FMLA leave or continuing your coverage under COBRA.

K. Dependent Eligibility.

1. Your Dependents' Initial Eligibility.

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

- a. The date you are eligible for coverage; or
- b. The date he or she meets the definition of Dependent in Section 20.01.

2. When Your Dependents' Coverage Ends.

Your Dependents' coverage will end on the last day of the month on the earliest of the following to occur:

- a. The date your eligibility ends;
- b. The date he or she no longer meets the definition of a Dependent in Section 20.01; or
- c. The date your Dependent enters military service.

3. Dependent Coverage Through a Qualified Medical Child Support Order (QMCSO).

A Qualified Medical Child Support Order (QMCSO) is a court order regarding medical coverage for the participant's children (called alternate recipients) in situations involving divorce, legal separation or a paternity dispute.

The Fund will honor the terms of a QMCSO regarding communication with the custodial parent of a Dependent and with regard to which plan is primary when a Dependent is covered by more than one group health plan as described in Section 17: Coordination of Benefits.

The Fund Office will notify affected participants and alternate recipients if a QMCSO is received. You may request a copy of the Fund's QMCSO procedures, free of charge, if you need additional information.

4. Coverage for Surviving Dependents.

If you die while you are eligible under the Plan, your Dependents' eligibility will continue until the later of:

- a. The last day of the third month following the month of your death; or

- b. The date your eligibility terminates based on your Accumulation Account (i.e. March 31, June 30, September 30 or December 31, depending on the hours in your Accumulation Account).

2.02 Retired Employee Eligibility.

A. Eligibility at Retirement.

When you retire, you and your Dependents will be eligible for Retired Employee Coverage if:

1. You are receiving a pension from the Pipe Fitters' Retirement Fund, Local 597 or a defined benefit pension plan sponsored by Local 597;
2. You were eligible for Welfare Plan benefits immediately before your retirement and for at least 12 of the preceding 20 Benefit Quarters; and
3. You pay the applicable premium for Retired Employee Coverage after the run-out of your Accumulated Account.

Eligibility for Retired Employee Coverage is conditioned on the retired Employee authorizing any applicable retiree self-payment or premium to be deducted from the retired Employee's monthly benefit received from the Pipe Fitters' Retirement Fund, Local 597. If the amount you receive from the Pipe Fitters' Retirement Fund, Local 597 does not cover the monthly premium, you must pay the difference in order to be eligible for Retired Employee Coverage. Note that in order to cover your Dependents, you must be eligible for Retired Employee Coverage.

B. Timely Payment.

If you do not pay the applicable self-payment premium, as provided in Section 2.04, your and your eligible Dependents' eligibility for Retired Employee Coverage will terminate and you will not be allowed to re-enroll at a later date.

However, there is one exception to this rule: if your eligible spouse is receiving medical benefits as a result of his/her current employment, you may defer covering your spouse under this Fund's retiree medical coverage until his or her employment-based coverage terminates. After your spouse's employment-based coverage terminates, you have 90 days to elect coverage and to pay the applicable premium back to the date coverage terminated.

C. Accumulation Account Eligibility.

An Employee who retires, is eligible for Retired Employee Coverage and has sufficient hours in his Accumulation Account to meet the Continued Eligibility Requirements in Section 2.01(D), will be considered a retired Employee for purposes of Section 17: Coordination Benefits. The benefits for a retired Employee who has sufficient hours in his Accumulation Account to meet the Continued Eligibility Requirements will be based on the Active Employee Schedule of Benefits in Section 1.01 for as long as the hours in his Accumulation Account provide eligibility. Thereafter, the benefits for a retired Employee will be based on the Retired Employee Schedule of Benefits in Sections 1.01.

D. Retiree Coverage and Medicare.

Retired Employee Coverage provides different benefits depending on whether the covered individual is eligible for Medicare as provided in Section 1: Schedule of Benefits.

If you are a retired Employee, when you become eligible for Medicare there are certain actions you must take. This Plan supplements medical benefits under Medicare Parts A and B. Therefore, when you and/or your eligible Dependent reach age 65 or otherwise become entitled to Medicare, you and your eligible Dependents **MUST** apply for Medicare Part A coverage and purchase Medicare Part B coverage. Further, if your spouse has coverage through her employer but chooses to maintain coverage under the Plan, you must still pay for Medicare Part B.

E. Prescription Benefits.

This Plan provides benefits as an alternative to Medicare Part D. When you and/or your eligible Dependent reach age 65 or otherwise become entitled to Medicare, you must choose between (1) Prescription Drug Benefits under this Plan or (2) prescription drug benefits under Part D.

If you are enrolled in Medicare Part D, after you retire, your prescription drug benefits under this Plan will terminate. If you later decide to stop coverage under Medicare Part D, you may reapply for prescription benefits under this Plan. More information can be found in Section 9.07.

F. If You Return to Work After Retirement.

If you are eligible for Retired Employee Coverage and you return to work in Covered Employment, you will continue to be eligible to make self-payments for Retired Employee Coverage until you become eligible for Active Employee Benefits. You will be eligible for Active Employee Benefits if you satisfy the Initial Eligibility Requirements described in Section 2.01. If you become eligible for Active Employee Benefits, such coverage will continue as long as you meet the Plan's eligibility requirements for Active Employee Benefits. If your eligibility for Active Employee Benefits ends and you re-retire, you will then resume Retired Employee Coverage.

2.03 COBRA Continuation Coverage.

A. COBRA Coverage in General.

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

The Plan provides two options for COBRA coverage: (1) medical only or (2) medical, dental and vision coverage. Further, both options include prescription drugs. However, COBRA coverage does not include the following benefits: Death, Accidental Death and Dismemberment and Weekly Accident and Sickness Disability Benefits.

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

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

B. Eligibility.

1. 18-Month COBRA Continuation Coverage.

You are eligible to elect COBRA coverage when you lose eligibility for benefits because of a Qualifying Event. In such event, you and your eligible Dependents may elect up to 18 months of COBRA coverage when your coverage terminates because of the loss of employment, lay-off, retirement or a reduction in your hours of work. An eligible beneficiary generally is an individual covered by the Plan on the day before the Qualifying Event occurs. This includes your spouse and your Dependent child. Also, any child born to or placed for adoption with you during the period of COBRA coverage is also considered an eligible beneficiary.

Under these circumstances, the Qualifying Event will result in loss of coverage based on when you no longer have sufficient hours in your Accumulation Account to meet the Continued Eligibility Requirements under Section 2.01(D).

2. Disability Extension of 18-Month COBRA Continuation Coverage.

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

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

3. 36-Month COBRA Continuation Coverage.

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

- a. Your death;
- b. Your divorce or legal separation;
- c. Your reaching eligibility for Medicare; or
- d. Your Dependent child no longer qualifies as a Dependent under the terms of the Fund.

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

C. COBRA Premiums.

1. Standard COBRA Premium.

The standard COBRA premium is determined by the Trustees and adjusted from time to time.

2. Employees Available for Work in the Industry.

A subsidized COBRA premium is established during the first six months of COBRA Continuation Coverage for Employees who are "Available for Work in the Industry." An Employee is Available for Work in the Industry if he or she is employed by a Contributing Employer or if the Employee is registered on the Pipe Fitters' Association, Local 597 U.A. out of work list and is currently eligible for a referral. An Employee is not Available for Work in the Industry if the Employee is retired and receiving a pension from the Pipe Fitters' Retirement Fund, Local 597. The subsidized COBRA premium is set at 50% of the regular COBRA premium. After the six-month period has elapsed, the Employee will be charged the regular COBRA premium.

D. The Notification Responsibilities of the Fund Office.

When the Fund Office is notified of a Qualifying Event, the Fund Office will send a COBRA Election Notice and COBRA Election Form to you and your Dependents who would lose coverage due to the Qualifying Event. The Fund Office will send the notice within 45 days of the time it receives notice of a Qualifying Event. The Election Notice tells you about your right to elect COBRA Continuation Coverage, the due dates for returning the Election Form, the amount of the payment for COBRA Continuation Coverage and the due dates for COBRA payments.

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

E. Electing Continuation Coverage.

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

1. Each member of your family who would lose coverage because of a Qualifying Event is entitled to make a separate election of COBRA Continuation Coverage.
2. If you elect COBRA Continuation Coverage for yourself and your Dependents, your election is binding on your Dependents. However, your Dependents have the right to revoke that election before the end of the election period.
3. If you do not elect COBRA Continuation Coverage for your Dependents when they are entitled to COBRA Continuation Coverage, your Dependents have the right to elect COBRA Continuation Coverage for themselves. Your spouse may elect COBRA Continuation Coverage for herself or

himself and any minor children who were covered by the Plan on the date of the Qualifying Event.

4. The person electing Continuation Coverage has 60 days after the COBRA Election Notice is sent or 60 days after coverage would terminate, whichever is later, to send back the completed Election Form. An election of Continuation Coverage is considered to be made on the date the COBRA Election Form is postmarked.
5. If the COBRA Election Form is not mailed back to the Fund Office within the allowable period, you and/or your Dependents will be considered to have waived your right to COBRA Continuation Coverage.

F. When the COBRA Coverage Period Begins.

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

G. When COBRA Coverage Ends.

1. COBRA Continuation Coverage may end for any of the following reasons:
 - a. You or your Dependent becomes covered under another group medical, dental or vision plan. However, coverage will continue if you or an eligible Dependent has a health problem for which coverage is excluded or limited under the other group plan.
 - b. The required premium is not timely paid.
 - c. The Trust Fund terminates the Welfare Plan.
 - d. You or your Dependent reaches the end of the 18-month, 29-month or 36-month Continuation Coverage period. Similarly, the enhanced Continuation Coverage for surviving spouses age 60 to 65 will end at the later of 36 months or the date the surviving spouse becomes eligible for Medicare.
 - e. Your coverage under the Plan ends and you become enrolled in Medicare. However, if your eligible Dependents are entitled to COBRA Continuation Coverage, their maximum coverage period is 36 months from the initial Qualifying Event, or
 - f. Your Dependents become entitled to Medicare.

When your COBRA Continuation Coverage ends, the Plan will provide you and your Dependents with certification of the length of coverage under this Plan, including the time you were covered under COBRA. This will help reduce or eliminate any preexisting condition limitation under a new group health plan.

2.04 Self-Payment Premiums.

A. Standard Premiums for Retiree Coverage.

If an eligible retiree self-pays for himself and two Dependents, no additional self-payment premium is required for the Welfare Fund to cover additional Dependents. Eligibility for Retired Employee Coverage

is conditioned on the retired Employee authorizing any applicable retiree self-payment or premium to be deducted from the retired Employee's monthly benefit received from the Pipe Fitters' Retirement Fund, Local 597. If the amount you receive from the Pipe Fitters' Retirement Fund, Local 597 does not cover the monthly premium, you must pay the difference in order to be eligible for Retired Employee Coverage.

Each January, the self-payment rate will be adjusted based on the new COBRA rates. The individual rate for a retiree or retiree's Dependent on Medicare will equal 9% of the **full** self-payment rate charged to Active Employees on COBRA for that year. The individual self-payment rate for a retiree or retiree's Dependent not on Medicare will equal 15% of the **full** self-payment rate charged an active Employee on COBRA.

However, depending on your employment status, the Standard Premium may not apply and you may be charged a higher amount based on the Related Employment Premium or the Premium for Substantially Employed Disability Pensioners as applicable under Section 2.04(B) and Section 2.04(C), respectively.

B. Related Employment Premium For Retirees Working in Non-Covered Employment for an Employer Engaged in the Pipe Fitting Industry.

1. Related Employment Premium.

Retirees who work in Non-Covered Employment are charged a Related Employment Premium. Non-Covered Employment is any work performed for an Employer which engages in the type of work within the Pipe Fitters' trade jurisdiction as defined in the Local 597 Area Agreement.

If you are retired and are eligible for Active Employee Benefits due to your Accumulation Account balance, you will receive Active Employee Benefits and will be charged the Standard Premium for retiree coverage while you are engaged in Non-Covered Employment. After your Accumulation Account balance runs out, you will receive Retired Employee Coverage and will be charged the Related Employment Premium during any additional months of Non-Covered Employment.

The amount of the Related Employment Premium depends on the number of persons in your family who are covered and whether each covered person is eligible for Medicare. In addition, the Related Employment Premium is capped at two persons per family (e.g., you will pay for coverage of two people regardless of how many Dependents you have); if you have more than two Dependents, the rates charged will be for you and your youngest covered Dependent.

If you work in Non-Covered Employment for any hours during a month, you must pay the current Related Employment Premiums for coverage. The individual rate will equal 18% of the current COBRA rate for the Medicare covered persons and 30% of the current COBRA rate for the non-Medicare covered persons. Each January, the self-payment rate will be adjusted.

The higher Related Employment Premium will be charged during the period of Non-Covered Employment. A retiree will qualify to have the lower Standard Premium reinstated as of the calendar month which follows the later of (1) the date the Non-Covered Employment ceases and (2) the end of any arrearages due because of a failure to report Non-Covered Employment.

2. Duty to Report Non-Covered Employment in the Pipe Fitting Industry.

As a condition of eligibility for any coverage, retirees are required to provide the Fund Office with written or electronic notice of any Non-Covered Employment.

3. Failure to Report Non-Covered Employment.

If you are a retiree and you fail to report Non-Covered Employment within seven days of commencing such work and therefore receive coverage without paying the Related Employment Premium, you will be subject to the following provisions:

- a. During the remainder of your Non-Covered Employment, you will be charged the applicable premium as follows: (1) the Standard Premium, if the Accumulation Account applies or (2) the Related Employment Premium, if the Accumulation Account does not apply.
- b. After terminating the Non-Covered Employment, you will be charged the applicable Related Employment Premium for a number of months equal to the number of months of Non-Covered Employment you failed to properly report. The amount of the applicable premium will be based on: (1) the current premium rates and (2) the type and order of coverage (Medicare eligible or non-Medicare eligible) received during the period of unreported Non-Covered Employment. In addition, you will pay an additional Failure to Report Premium of \$100.00 per month for each month of Non-Covered Employment you failed to report up to a maximum of \$1,200.00.

For Example:

Ben retires at age 62 with no Dependents. He has no Accumulation Account eligibility and is paying the Standard Premium for single coverage when he fails to report Non-Covered Employment within seven days of commencing such employment. As a result, he receives coverage for himself without paying the higher Related Employment Premium. After 18 months, the Fund becomes aware of his Non-Covered Employment and Ben is charged the higher Related Employment Premium while he continues to work in such employment. After six months, Ben terminates his Non-Covered Employment, but instead of the being charged the lower Standard Premium, he is charged the higher Related Employment Premium for the number of months that he failed to properly report (18 months). In addition, he is charged an additional Failure to Report Premium of \$100 per month for each month of Non-Covered Employment he failed to report up to a maximum of \$1,200.00.

C. Premium for Substantially Employed Disability Pensioners.

A Premium for Substantially Employed Disability Pensioners will be charged to all disability pensioners under age 59 who have a history of substantial employment as recorded on the earnings report provided by Social Security. The Premium for Substantially Employed Disability Pensioners is set at 25% of the non-subsidized COBRA premium as adjusted from time to time.

A disability pensioner under age 59 will be charged the Standard Premium for Retired Employee Coverage until the first September 1 following the first full calendar year in which he received his disability pension benefit from the Pipe Fitters' Retirement Fund, Local 597. Thereafter, there are two conditions for being charged the lower Standard Premium: (1) the disability pensioner must request that Social Security furnish directly to the Fund Office a copy of the pensioner's most recent earnings record and (2) the disability pensioner's Social Security earnings for calendar years following the disability pension effective date cannot exceed \$24,000.

If the disability pensioner fails to meet either of the above conditions, the higher Premium for Substantially Employed Disability Pensioners will be charged beginning with the following September 1, determined in accordance with the above. Eligibility for the lower Standard Premium will be determined

each September 1 thereafter. The higher premium will continue to be charged until the disability pensioner meets conditions (1) and (2) above. After having demonstrated that the disability pensioner meets the above conditions, the lower Standard Premium will be charged beginning the following September 1. Thereafter, the lower Standard Premium will continue to be charged as long as the disability pensioner meets the two conditions stated above.

After attaining age 59, a disability pensioner will be charged the Standard Premium for Retired Employee Coverage regardless of the amount of his or her Social Security earnings.

D. Premiums for Surviving Spouse Medical Benefits (Age 60 or Older).

The earliest age a surviving spouse is eligible for Surviving Spouse Medical Benefits is age 60 as provided in Section 2.05(A).

1. **Benefits Prior to Medicare.** The Surviving Spouse Medical Benefit prior to Medicare is the same benefit provided to Dependent spouses of retired Employees not yet eligible for Medicare described in Section 1.01 and includes the Prescription and Specialty Drug Benefit described in Section 1.02. The amount charged will be determined from time to time by the Board of Trustees and is expected to equal approximately 50% of the Active Employee COBRA rate.
2. **Benefits After Medicare Entitlement.** The Surviving Spouse Medical Benefit after Medicare entitlement is the same benefit provided to Dependent spouses of retired Employees eligible for Medicare described in Section 1.01 and includes the Prescription and Specialty Drug Benefit described in Section 1.02. The amount charged will be determined from time to time by the Board of Trustees and is expected to approximately equal the full cost of such coverage.

2.05 Eligibility for Surviving Spouse Medical Benefits.

As noted in the Section on COBRA, your eligible Dependents, including your surviving spouse, are allowed to purchase up to 36 months of COBRA coverage upon your death. Effective for participant deaths occurring on or after April 1, 2005, the Fund will provide Surviving Spouse Medical Benefits as an alternative to COBRA to your surviving spouse under certain circumstances. This benefit does not apply to other Dependents who will continue to have the option of electing COBRA.

A. Eligibility.

As an alternative to COBRA, your surviving spouse may be able to purchase Surviving Spouse Medical Benefits if each of the following conditions are met: (1) you die while covered as an active or retired Employee, (2) your surviving spouse is at least age 60 on the date you die and (3) your spouse is eligible to receive a surviving spouse benefit from the Pipe Fitter's Retirement Fund, Local 597 immediately following your death. If these conditions are met, your spouse will have three months to make a one-time election to purchase this coverage. If the spouse declines coverage, or fails to make timely payment for such coverage, this option terminates and will not be offered a second time.

B. Termination of Eligibility.

A surviving spouse is not eligible to purchase the Surviving Spouse Medical Benefits if any of the following events occur.

1. Failure to make timely payments in accordance with the Fund Office procedures.

2. Remarriage of the surviving spouse.

SECTION 3: HEALTH REIMBURSEMENT ARRANGEMENT

3.01 General Provisions and Eligibility.

If you are receiving a monthly pension benefit from the Pipe Fitters' Retirement Fund, Local 597 and you: (1) are eligible for Retired Employee Coverage under the Plan or (2) were previously an Employee eligible for benefits under this Plan, the Trustees have created an HRA account for you for the reimbursement of certain medical expenses you incur.

3.02 Reimbursable Expense Periods.

A Reimbursable Expense Period is the period of time during which you and your eligible spouse incur Eligible Expenses which are reimbursable from your HRA account. The first Reimbursable Expense Period began on January 1, 2008 (upon the creation of the HRA and the eligible Retirees' enrollment in the HRA program), and ends on October 31, 2008. All subsequent Reimbursable Expense Periods will begin on November 1 and end the following October 31.

3.03 Account Funding and Reimbursement for Expenses.

Each November 1, your HRA will be credited. The amount credited will be determined by multiplying \$50 by the number of Pension Years you have accumulated under the Pipe Fitters' Retirement Fund, Local 597. However, this amount cannot exceed 200% of the monthly pension check you received from the Pipe Fitters' Retirement Fund, Local 597.

Some time prior to your HRA being credited, your Automatically Reimbursable Eligible Expenses identified in Section 3.04 and incurred during the Reimbursable Expense Period will be totaled and you will receive a letter stating the amount of your annual reimbursement check and the anticipated mailing date of such check.

If, however, you do not have Automatically Reimbursable Eligible Expenses or if those expenses do not meet or exceed the amount credited in your account, you will receive detailed instructions on how to receive reimbursement for the Eligible Expenses identified in Section 3.05.

At the end of the Reimbursable Expense Period, any unused credited amount will roll over for use in subsequent Reimbursable Expense Periods. Claims for reimbursement of Eligible Expenses from a rolled-over balance may be submitted at any time but no more than once per calendar quarter.

Please remember that in order for your Automatically Reimbursable Eligible Expenses and Eligible Expenses to be reimbursable from your HRA, you cannot receive reimbursement for these expenses from any other source or take a tax deduction on these expenses. If you have questions, or would like more information on this HRA benefit, please contact the Fund Office.

3.04 Automatically Reimbursable Eligible Expenses.

Automatically Reimbursable Eligible Expenses are Eligible Expenses that you and/or your eligible spouse incur which are automatically reimbursed from your HRA annually (up to your credited HRA amount). Automatically Reimbursable Eligible Expenses are limited to the following: (1) Local 597 Welfare premium payments, (2) Medicare premium payments on record with the Fund Office, (3) prescription co-payments on record with the Fund Office and (4) out-of-pocket medical, prescription drug, and/or dental expenses on record with the Fund Office.

3.05 Eligible Expenses.

Eligible Expenses are “qualified medical expenses” under Section 213 of the Internal Revenue Code that you and/or your eligible spouse incur which are not Automatically Reimbursable Eligible Expenses as defined in Section 3.04.

Eligible Expenses are limited to the following:

- A. Expenses for dental treatment, including orthodontia;
- B. Guide dogs for blind or deaf persons;
- C. Travel expenses of the patient when necessary to receive medical care, and the travel and lodging expenses of another family member whose presence is necessary for the treatment as certified by the patient’s Physician;
- D. Special telephone or television equipment for hearing-impaired persons;
- E. Hearing aids and examinations;
- F. Medical expenses not covered by or in excess of benefits provided by another benefit plan, insurer or Medicare;
- G. Certain costs of modifying a home or vehicle to accommodate a disabled Dependent;
- H. Healthcare insurance premiums not paid by any other source;
- I. Special schooling for the mentally impaired or physically disabled;
- J. Acupuncture;
- K. Vision expenses including surgery or laser treatments to correct vision;
- L. Smoking cessation programs;
- M. Weight loss programs which are medically necessary;
- N. Treatment for alcoholism or chemical dependency;
- O. Convalescent home charges that are necessary for medical care;
- P. Nursing services, including board and meals, that are necessary for medical care;
- Q. Insulin treatments;
- R. Prescription medications; and
- S. Orthopedic shoes.

The following expenses are not considered Eligible Expenses under the Plan:

- A. Athletic club, health and/or spa or gym memberships;

- B. School fees for boarding schools or schools fees not related a medical necessity;
- C. Food, food supplements, non-prescribed vitamins and over-the-counter drugs;
- D. Cosmetic surgery, procedures and supplies;
- E. Babysitting and childcare;
- F. Funeral expenses;
- G. Hair transplants;
- H. Household help other than that qualifying as long-term care;
- I. Personal use items;
- J. Teeth whitening; and
- K. Expenses not identified as Eligible Expenses above.

3.06 Payment of Benefits Upon the Retiree's Death.

If you die while there is a balance in your HRA, your surviving spouse (or if there is no surviving spouse, your Dependents) may use your balance by submitting claims to the Fund Office for reimbursement of those Eligible Expenses identified in Section 3.05. Such claims may be submitted at any time but no more than once per calendar quarter. The remaining HRA account balance not used in this manner will be forfeited if the account is inactive for a period of two calendar years.

However, if you die and there is no surviving spouse or Dependents, your HRA account balance, if any, will be forfeited.

SECTION 4: DEATH BENEFIT

4.01 Death Benefit for Active Employees.

If you are eligible for Active Employee Benefits, the Plan provides for a Death Benefit of \$10,000 to be paid to your beneficiary in the event of your death. Your beneficiary must submit an application for benefits and proof of your death.

4.02 Death Benefit for Retired Employees.

If you are covered under the medical benefit Plan for retired Employees, the Plan provides for a Death Benefit of \$5,000 to be paid to your beneficiary in the event of your death.

4.03 Designating Your Beneficiary.

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

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

- A. Your spouse;
- B. Your children;
- C. Your parents;
- D. Your brothers and sisters; or
- E. Any person the Trustees determine is entitled to payment.

SECTION 5: ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

5.01 AD&D Benefits for Active Employees Only.

If you are eligible for Active Employee Benefits, your coverage includes the Accidental Death and Dismemberment (AD&D) Benefit. This benefit is payable to you if you sustain one of the losses listed in the Schedule of Benefits as the result of an Accident. The loss must occur within 90 days of the Accident. The benefit amounts are shown in the Schedule of Benefits and are in addition to any other benefits you may receive under the Plan. If you die, the benefit is paid to your beneficiary.

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

5.02 Limitations on AD&D Benefits.

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

- A. Suicide or any attempted suicide, unless the suicide or attempt arises as a result of a physical or mental health condition;
- B. Disease or infection, except pyogenic or septic infection of a visible wound accidentally sustained;
- C. Bodily or mental infirmity;
- D. Criminal activity;
- E. A self-induced drug overdose; or
- F. Any of the circumstances listed under the General Plan Exclusions in Section 16.

SECTION 6: WEEKLY ACCIDENT AND SICKNESS DISABILITY BENEFITS

6.01 Weekly Accident and Sickness Disability Benefits for Active Employees Only.

If you are eligible for Active Employee Benefits, your coverage includes the Weekly Accident and Sickness Benefit. If you are disabled due to an Accident or Sickness that prevents you from performing your job, the Fund will pay you 1/5 of the weekly benefit amount listed in the Schedule of Benefits for each day (excluding Saturday and Sunday) or the weekly benefit amount listed in the Schedule of Benefits for each full week. You must also be under the care of a Physician to receive this benefit.

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

Benefits are paid for a maximum of 26 weeks for any one period of disability. Benefits will be paid for no more than two periods of disability during any 60-month period. Your disability is considered a separate and distinct disability period if you return to full-time work for a least one continuous week between periods of disability.

However, a disability that is determined to be work-related will not count towards the two-period limit, provided the Fund receives reimbursement for 100% for all benefits advanced, including any weekly benefits.

Your Weekly Accident and Sickness Benefit is subject to taxes. Social Security taxes will be deducted before you receive your check. You will be responsible for any federal and state income taxes. The Fund Office will send you a Form 1099 or W-2 after the end of the year indicating the amount you received and the amount deducted from your check.

6.02 When Your Weekly Accident and Sickness Disability Benefits Begin.

The Weekly Accident and Sickness Disability Benefits begin on the:

- A. First business day following your disability due to an Accident; or
- B. Five business days following your disability due to a Sickness.

For Example:

John is disabled due to an Accident on December 22, 2007. On Monday, December 24, 2007, the first business day after the Accident, he begins receiving Weekly Accident and Sickness Disability Benefits for 26 weeks through June 20, 2008. John returns to work and suffers a second disability due to a Sickness on July 19, 2008. On Friday, July 25, 2008, the fifth working day after his Sickness begins, he begins receiving benefits. He receives these benefits for a three week period from July 25, 2008, through August 15, 2008. Because he has received benefits for two periods of disability, he will not be eligible for disability benefits again until 60 months after the end of his first period of disability. This 60 month period will end June 20, 2013. If he otherwise qualifies, he will be eligible for disability benefits if he commences a period of disability on or after June 21, 2013.

6.03 Limitations on Your Weekly Accident and Sickness Disability Benefits.

If your loss is caused by any of the items listed in the General Plan Exclusions in Section 16, then you are not entitled to Weekly Accident and Sickness Disability Benefits under the Plan.

SECTION 7: COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFIT FOR ACTIVE EMPLOYEES AND RETIRED EMPLOYEES NOT YET ELIGIBLE FOR MEDICARE

7.01 Eligibility.

You are eligible for the Comprehensive Major Medical Expense Benefit if you are eligible for Active Employee Benefits, or if you are eligible for Retired Employee Coverage and are not yet eligible for Medicare.

7.02 The Deductible.

The deductible is the amount of covered medical expenses that you and each of your eligible Dependents pay each calendar year before benefits begin.

The deductible is listed in your Schedule of Benefits in Section 1 of this booklet.

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

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

7.03 Percentage of Benefits Payable.

Once you pay the annual deductible, the Fund will pay the percentage of your covered expenses listed in the Schedule of Benefits (generally 75% or 85% for PPO network Hospitals and providers) of the Usual and Customary Fees, up to any Plan maximums. The Fund pays 50% of Usual and Customary Fees for outpatient treatment for Mental/Nervous Disorders and chemical dependency.

7.04 Out-of-Pocket Maximum.

After paying your deductible, the maximum amount you pay for covered health care expenses each year is the out-of-pocket maximum listed in the Schedule of Benefits. If you reach this annual out-of-pocket maximum for expenses subject to the maximum, the Fund pays 100% of all covered expenses for the rest of the calendar year.

7.05 Maximum Benefit Payable.

The maximum benefit amount per Sickness or Accident per person under the Comprehensive Major Medical Benefit is listed in the Schedule of Benefits. Other Plan maximums for different types of benefits are listed in the Schedule of Benefits.

7.06 Preferred Provider Organization (PPO).

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

To minimize your out-of-pocket costs, contact the Fund Office for information about which Hospitals and providers belong to the Plan's PPO. When you use PPO Hospitals and providers rather than non-PPO

Hospitals and providers, you can reduce costs for both you and the Fund. The Plan provides for a greater payment percentage (generally 85% instead of 75%) of your Usual and Customary Fees when you use a Hospital or provider in the PPO network. The Fund will provide you with information on PPO providers at your request.

If an out-of-network provider is used, the patient will have larger out-of-pocket expenses, a lower percentage paid and may have to pay the difference between the Usual and Customary Fees and the total billed amount.

7.07 Case Management.

The Fund has contracted with a provider to perform case management if your claim for benefits involves ongoing treatment.

Case management is a process in which you as the patient, your family, Physician and/or other health care providers and the Fund Office work together under the guidance of the Fund's independent case management company to coordinate a quality, timely and cost-effective treatment plan. Case management services may be particularly helpful for patients who require complex, high-technology medical services and who may therefore benefit from professional assistance to guide them through the maze of choices of health care services, providers and practices.

You will be notified if your claim is subject to case management.

7.08 Covered Expenses and Exclusions.

Under the Comprehensive Major Medical Expense Benefit, certain expenses are Covered Expenses and others are excluded.

A. Covered Expenses.

The Plan covers the Usual and Customary Fees for the following services and supplies provided or ordered by a Physician (except as specifically provided otherwise) that you receive for the treatment of a non-occupational Accident or Sickness when Medically Necessary:

1. Hospital services and supplies for:
 - a. room and board fees up to:
 - i. the Hospital's regular daily semi-private rate; or
 - ii. the Hospital's regular daily rate for a private room, when required.
 - b. drugs, medicines and other Hospital services for medical care and treatment, exclusive of professional services while hospitalized.
 - c. outpatient Hospital services including fees incurred for:
 - i. outpatient surgical procedures; and
 - ii. emergency treatment for an injury or Sickness.

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

2. Medical care and treatment, including surgery, by a legally qualified Physician or Surgeon.
3. Outpatient skilled nursing care furnished by a licensed RN or LPN under the direction of a Physician.
4. X-ray treatment, x-ray examinations and radioactive therapy.
5. Whole blood or blood plasma and the cost of its administration.
6. Casts, splints, trusses, braces, crutches, artificial limbs and/or artificial eyes.
7. Purchase and/or rental of durable medical equipment, provided advance authorization is obtained from the Fund. The Fund reserves the right to purchase the equipment instead of paying for rental if purchase would cost less than the reasonable and customary rental amount.

Durable medical equipment means equipment, recognized as such by Medicare Part B, that: (1) can withstand repeated use, (2) is primarily and customarily used to serve a medical purpose related to the person's physical disorder, (3) generally is not useful in the absence of illness or injury and (4) is appropriate for use in the home.

Examples of durable medical equipment include: wheel chairs, Hospital beds and equipment for giving oxygen.

Coverage for durable medical equipment is not provided for (1) equipment that serves as a comfort or convenience item or (2) equipment used for environmental control or to enhance the environmental setting or surroundings of an individual.

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

8. Charges for oxygen and its administration.
9. Transfer by local ambulance to the nearest Hospital where suitable treatment is available if such treatment is not available in the Hospital where the patient is located, provided such transfer is necessary and approved in advance by the Fund.
10. Up to 60 days of care provided in a Skilled Nursing Care Facility when:
 - a. your confinement begins within 14 days after a Hospital admission of at least three days duration;

- b. your care and treatment are for the Sickness or Accident that caused the Hospital confinement immediately before admission to the Skilled Nursing Care Facility; and
- c. you are under the regular care of a legally qualified Physician or Surgeon.

The maximum covered expense per day of confinement is 50% of the semi-private room rate expense by the Hospital from which you were discharged. The applicable co-payments for PPO and non-PPO charges will then be applied to the covered expense.

11. Treatment for chemical dependency limited to the amounts listed in the Schedule of Benefits. Each course of inpatient treatment must consist of a written individualized treatment plan. You must successfully complete the course of treatment before the Plan provides for payment of benefits.
12. Outpatient treatment by a Physician, licensed psychologist, licensed clinical professional counselor in the appropriate field, or licensed clinical social worker for Mental and Nervous Disorders and chemical dependency in accordance with the Schedule of Benefits.
13. Surgical removal of tumors or cysts from the mouth.
14. Expenses incurred as a result of an accidental injury to sound natural teeth when the expense is incurred within 90 days of the Accident.
15. Spinal manipulation and naprapathic services as follows:
 - a. Detection, treatment or correction of structural imbalance, subluxation or misalignment of the vertebral column by a Physician or licensed chiropractor, up to the maximum shown in the applicable Schedule of Benefits. The calendar year maximum includes any treatments that are ordered by the treating Physician or licensed chiropractor and includes diagnostic tests required for such treatment. No benefits are provided for covered individuals under age 16.
 - b. Naprapathic practices performed by a state licensed naprapath including, but not limited to, the treatment of contractures, muscle spasms, inflammation, scar tissue formation, adhesions, lesions, laxity, hypotonicity, rigidity, structural imbalance, bruising, contusions, muscular atrophy and partial separation of connective tissue fibers up to the maximum shown in the applicable Schedule of Benefits. The calendar year maximum includes any treatments that are ordered by the treating Physician or naprapath and includes diagnostic tests required for such treatment. No benefits are provided for covered individuals under age 16.
16. Non-experimental or non-investigative organ and bone marrow transplants including a maximum of \$15,000 toward donor expenses when the transplant recipient is covered under this Plan.
17. Medical and surgical benefits for mastectomies as required by federal law under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"), including the following, when requested by the patient in consultation with her Physician:
 - a. reconstruction of the breast on which the mastectomy has been performed;
 - b. surgery and reconstruction of the other breast to produce a symmetrical appearance; and

- c. prostheses and physical complications of all stages of mastectomy including lymphedemas.
18. Medical care and treatment by a certified nurse anesthetist if such treatment would otherwise be covered under the Plan if by or under the supervision of a legally qualified Physician.
- For purposes of this section, certified nurse anesthetist shall mean: a person who (1) has graduated from a nurse anesthesia educational program accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs or its predecessor, (2) passed the certification examination administered by the Council on Certification of Nurse Anesthetists or its predecessor, (3) is licensed in the state or jurisdiction where the services are rendered to provide or administer anesthetics to patients and (4) is acting within the scope of his or her license.
19. Per diem or per service charges for outpatient treatment of Mental Disorders and chemical dependency at a free standing treatment center approved by the Fund Office. Approval of free standing treatment centers shall be based on accreditation or licensing from appropriate organizations or agencies.
20. Medical care and treatment by a surgical assistant or surgical technician who assists a Surgeon in performing surgical procedures.
21. Licensed ambulatory surgery center services.
22. Routine well newborn and child care.
23. Routine immunizations.
24. Operating and recovery room charges.
25. Allergy serums.
26. Provided there is an appropriate Medically Necessary reason for conducting the test, genetic testing is covered for determining the existence of inherited mutations which creates a susceptibility to (1) medullary carcinoma of the thyroid, (2) colon cancer and (3) breast or ovarian cancer (inherited BRCA1 or BRCA2 mutations).

The determination of whether genetic testing is Medically Necessary is subject to the following requirements and restrictions:

- a. For medullary carcinoma of the thyroid, genetic testing for RET proto-oncogene point mutations will be eligible for coverage in family members who are:
 - i. Symptomatic patients with defined RET gene mutations;
 - ii. Patients known to be affected by inherited medullary thyroid cancer or to multiple endocrine neoplasia type 2, but not previously evaluated for RET mutations; and
 - iii. Patients with medullary thyroid cancer with no family history of such cancer (sporadic incidence).
- b. For colon cancer, the determination of whether genetic testing is Medically Necessary is subject to the following requirements and restrictions:

- i. Genetic testing to determine carrier status of the adenosis polyposis coli gene (APC) is eligible for coverage in:
 - 1. Patients with greater than 20 colonic polyps; or
 - 2. First-degree relatives (i.e., siblings, off-spring, or parents) of patients diagnosed with familial adenomatous polyposis (FAP).
 - ii. Genetic testing is considered Investigative and is not eligible for coverage for the following:
 - 1. Identification specifically for I1307K mutation; and
 - 2. Identifying which patients should undergo HNPCC genetic testing by using the replication error (RER) phenotype test, also referred to as the micro-satellite instability (MSI) test.
 - c. For breast or ovarian cancer, the determination of whether genetic testing is Medically Necessary is subject to the following requirements and restrictions:
 - i. Genetic testing is eligible for coverage for:
 - 1. Individuals who have breast or ovarian cancer and are from families with a high risk of BRCA1 or BRCA2 mutations.
 - 2. Unaffected individuals (male or female) who come from families with a known BRCA1 or BRCA2 mutation.
 - ii. Genetic testing is Investigative and not eligible for coverage for:
 - 1. Unaffected family members in the absence of a known BRCA1 or BRCA2 mutation in the family, unless the family history reveals at least four first and/or second-degree relatives with breast, ovarian or colon cancer and there is no affected family member available for testing;
 - 2. Unaffected individuals of potentially high-risk populations (e.g., Ashkenazi Jewish descent) with no significant family history; and
 - 3. Minors for BRCA1 or BRCA2 mutations.
27. Physical therapy which is the treatment of a disease, injury or condition by physical means by a Physician, licensed physical therapist, licensed physical therapist assistant or licensed pulmonary therapist that is designed and adapted to promote the restoration of a useful physical function that has a reasonable expectation of achieving measurable improvement in a reasonable and predictable period of time. Covered expenses do not include educational training or services designed and adapted to develop a physical function, except if such expenses are provided in conjunction with the treatment of a condition that is the result of a Mental Illness or a developmental delay related to the medical conditions of cerebral palsy, cerebral vascular incident (stroke), intracranial bleed, other head trauma, spinal cord injuries, multiple or complicated fractures, other catastrophic diagnoses with neurological implications, significant or multiple injuries and/or illnesses.

28. Occupational therapy which is constructive therapeutic activity by a Physician, licensed occupational therapist or licensed occupational therapy assistant that is designed and adapted to promote the restoration of a useful physical function that has a reasonable expectation of achieving measurable improvement in a reasonable and predictable period of time. Covered expenses do not include educational training or services designed and adapted to develop a physical function, except if such expenses are provided in conjunction with the treatment of a condition that is the result of a Mental Illness or a developmental delay related to the medical condition of cerebral palsy, cerebral vascular incident (stroke), intracranial bleed, other head trauma, spinal cord injuries, multiple or complicated fractures, other catastrophic diagnoses with neurological implications, significant or multiple injuries and/or illnesses.
29. Speech therapy which is the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies or previous therapeutic processes by a Physician or licensed speech therapist and that is designed and adapted to promote the restoration of a useful physical function that has a reasonable expectation of achieving measurable improvement in a reasonable and predictable period of time. Covered expenses do not include educational training or services designed and adapted to develop a physical function, except if such expenses are provided in conjunction with the treatment of a condition that is the result of a Mental Illness or a developmental delay related to the medical conditions of cerebral palsy, cerebral vascular incident (stroke), intracranial bleed, other head trauma, spinal cord injuries, multiple or complicated fractures, other catastrophic diagnoses with neurological implications, significant or multiple injuries and/or illnesses.
30. Diabetes self-management training, education and medical nutrition therapy rendered by a Physician, or a duly certified, registered or licensed health care professional with expertise in diabetes management.
31. Home oxygen therapy and supplies are covered when all of the following criteria are met:
 - a. The person's arterial blood gas level meets Group I or Group II criteria under Medicare;
 - b. Alternative treatment measures have been tried or considered clinically ineffective; and
 - c. The treating Physician determines that the person has a severe lung disease or hypoxia related symptoms that might improve with oxygen therapy.

Situations that May Be Covered.

Conditions for which oxygen therapy may be covered include: (1) a severe lung disease, such as chronic obstructive pulmonary disease, diffuse interstitial lung disease, cystic fibrosis bronchiectasis and widespread pulmonary neoplasm or (2) hypoxia-related symptoms or findings that might be expected to improve with oxygen therapy, such as pulmonary hypertension, recurring congestive heart failure due to chronic cor pulmonale, ethracytosis, impairment of cognitive process, nocturnal restlessness and morning headache.

Situations that Are Not Covered.

Conditions for which oxygen therapy is not covered include, but are not limited to, the following: (1) angina pectoris in the absence of hypoxemia, (2) breathlessness without cor pulmonale or evidence of hypoxia, (3) severe peripheral vascular disease resulting in clinically evident

desaturation in one or more extremities and (4) terminal illnesses that do not affect the lungs. Oxygen services furnished by an airline are not covered by the Plan.

Type of Equipment.

Standard oxygen equipment includes: (1) an oxygen concentrator and (2) a gaseous tank system.

Non-standard oxygen equipment is a light weight gaseous tank system where the tank is less than ten pounds. An example of such a system is an Oxylite either with or without an oxygen regulator.

Standard oxygen equipment does not need advance authorization by the Fund, provided you meet the criteria above in 7.08(A)(31)(a), (b) and (c).

Non-standard oxygen equipment is covered, if you meet the following requirements: (1) you meet the requirements for standard oxygen equipment; (2) you are not primarily confined to the home and leave home for several hours daily for work or school; (3) you submit a letter of medical necessity from your doctor; and (4) you receive advance authorization from the Fund.

32. Elective medical and surgical sterilization procedures.

33. Services and expenses relating to the use of an intrauterine device (IUD).

B. Expenses Not Covered by the Plan.

Certain expenses are excluded from coverage. The Comprehensive Major Medical Benefit does not cover:

1. Custodial Care, maintenance care or medical care treatment, services and/or supplies made by a nursing home, rest home, convalescent home or similar establishment, except as specifically provided under Covered Expenses for a Skilled Nursing Care Facility.
2. Custodial or long-term care provided in the home.
3. Dental x-rays and/or dental services performed on or to the teeth, wisdom teeth, nerves within the teeth, gingivae or alveolar process, except as specifically provided under Covered Expenses. Coverage for inpatient and/or out-patient hospitalization in connection with a covered dental procedure is covered as a Major Medical Expense only when the patient has a medical condition that makes such hospitalization necessary to safeguard the patient's health. This condition must be certified by a Physician. (However, dental expenses may be covered under the Plan's Dental Expense Benefit described in Section 10.)
4. Eye refractions or the fitting or cost of eyeglasses or contact lenses, other than those required following cataract surgery. (However, vision expenses may be covered under the Plan's Vision Care Expense Benefit described in Section 11.)
5. Dental services (including orthodontia) for treatment of temporomandibular joint syndrome (TMJ). These services are covered with limitations under the Plan's Dental Expense Benefit described in Section 10.

6. Prescription drugs, except those provided when the claimant is an Inpatient in a Hospital or Skilled Nursing Care Facility.
7. Any losses, expenses or charges for cosmetic surgical procedures and related expenses, except:
 - a. for the repair of congenital defects of your Dependent child if the child was covered at the time of birth;
 - b. for the repair of defects resulting from a surgery for which benefits were paid under the Plan; or
 - c. for conditions resulting from accidental injuries, scars, tumors or diseases that occur while eligible.
8. Services and supplies for or related to: (1) conception, (2) artificial inseminations, (3) in-vitro fertilizations, (4) embryo transfers, (5) reversals of sterilizations, (6) genetic counseling and testing and (7) implants and devices except:
 - a. IUDs as provided in Section 7.08(A)(33);
 - b. contraceptive drugs (except as provided in Section 9.02(D) under the Prescription Drug Benefit); and
 - c. initial diagnostic genetic tests and procedures done solely to identify the cause or causes of infertility.
9. Any expenses or charges due to complications of non-covered procedures (e.g., breast reductions or breast implants when originally performed as a cosmetic procedure).
10. Any expenses or charges for sex transformation.
11. Any expenses or charges for treatment related to sexual dysfunction.
12. Any expenses for evaluations or treatments required by third parties, including, but not limited to, those ordered by a court or those required for insurance, employment or special licensing purposes.
13. Any expenses or charges for chelation therapy except for acute arsenic, gold, mercury or lead poisoning.
14. Marriage counseling.
15. Travel expenses for health care.
16. Ambulatory surgical center services or doctor's surgery suites that are not licensed by the state in which they operate.
17. Wigs or toupees (except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury), hair transplants or hair weavings.

18. Examples of items that are not covered include, but are not limited to, the following: personal hygiene items, items to improve physical appearance, first aid kits, televisions, telephones, exercise equipment, elevators, posture chairs, air conditioners, heaters, humidifiers, dehumidifiers, air filters, saunas, hot tubs, whirlpool tubs and portable jacuzzi pumps.
19. Any services, supplies or foods in connection with weight control, except surgical procedures when (1) you are at least 100 pounds or more above your ideal weight, (2) you are considered morbidly obese and (3) the surgery is pre-determined by the Fund to be Medically Necessary. You must submit documentation from your Physician that you have a history of unsuccessful results from less intrusive weight loss methods.
20. Treatment for smoking cessation programs or devices, except for Chantix as provided for in Section 9.02(H) (e.g., patches and gum).
21. Herbal medicines, holistic or homeopathic care and/or drugs, ecological or environmental medicines and/or treatments. Alternative treatments not standardly recognized as medical treatment or therapy.
22. Long-term maintenance therapy, work hardening programs, group or individual exercise programs, swimming and/or physical fitness programs.
23. Nutritional counseling.
24. Telephone consultations.
25. Special home construction or vehicle modification.
26. Surgical and/or laser correction of refractive errors and refractive keratoplasty procedures including radial keratotomy surgery.
27. Any Hospital expenses or charges incurred on Friday and/or Saturday when you are admitted on Friday or Saturday as an Inpatient, except:
 - a. for a medical emergency;
 - b. when surgery is performed within one day of your admission; or
 - c. for childbirth.
28. Inpatient or outpatient expenses resulting from behavioral problems, conduct disorders, learning disabilities and developmental delays that are not the result of a Mental Illness.
29. Any expenses or charges for orthopedic shoes.
30. Hearing aids except as provided under Section 14: Hearing Aid Benefit.
31. Genetic manipulation or genetic testing, except for the genetic testing provided in Section 7.08(A)(26).
32. Charges incurred for physical or medical examination, including routine examinations, or for any test administered for check-up purposes where such examination or test is not incidental to and

necessary for diagnosis or treatment of a Sickness or Accident, including, but not limited to, employment physical examinations, unless specifically covered in Section 13.02.

33. Charges incurred for treatment, care, services, supplies or procedures which are preventive in nature.
34. Charges incurred for any type of Custodial Care (milieu therapy). Custodial Care means that type of care, wherever furnished and by whatever name called, including room and board or any other type of care, which is designed primarily to assist an individual in meeting the activities of daily living. This exclusion applies to all such care regardless of what the care is called, including skilled nursing care for days that exceed the amount covered in Section 7.08(A)(10).
35. Charges incurred for special education provided to any individual. This exclusion does not apply to diabetes education as provided in Section 7.08(A)(30).
36. Charges incurred for any Hospital confinement or other medical care or service which an eligible Employee or retiree or other eligible individual would not be legally required to pay.
37. Charges incurred for education, training or room and board while the eligible individual is confined in an institution which is primarily residential in nature or a school or institution of learning or training.
38. Charges incurred for any service, supply or treatment for social, rehabilitative, educational, vocational purposes or related diagnostic testing. This exclusion applies to services, supplies and programs designed to improve a person's health through diet, exercise or control of harmful habits, regardless of the purpose of the services or supplies, the qualifications or locations of the persons providing or recommending them or the patient's medical history. This exclusion does not apply to diabetes education as provided in Section 7.08(A)(30).
39. Massage therapy.
40. Recreational therapy.
41. Hot and cold therapy of any nature.
42. Charges for any of the circumstances listed under the General Plan Exclusions in Section 16.

7.09 Extension of Medical Benefits.

If you or your eligible Dependents are disabled as a result of a Sickness or Accident when coverage under the Plan would normally end, Comprehensive Major Medical Benefits will be extended only for that Sickness or Accident if the following conditions are met:

- A. The expense would have been covered if the eligibility had continued;
- B. You remain disabled until the expense is incurred;
- C. You are under the regular care of a legally qualified Physician; and
- D. You are not entitled to similar benefits under any other group plan when the expense is incurred.

The Fund will pay benefits for treatment of the Sickness or Accident that caused your disability, subject to the limitations and maximums in effect under the Plan at the time your eligibility ended. In addition, you will be required to pay a new deductible when the new calendar year begins.

The Fund will continue your extension of medical benefits until the earliest of:

- A. The date you are no longer disabled;
- B. The date you become covered under another group plan; or
- C. 12 months after your coverage under this Plan for the Comprehensive Major Medical Benefit ends.

SECTION 8: SUPPLEMENTAL MEDICAL BENEFITS FOR RETIRED EMPLOYEES ELIGIBLE FOR MEDICARE

8.01 Eligibility for Supplemental Medical Benefits.

You are covered by the Supplemental Medical Benefits if you are eligible for Retired Employee Coverage, pay the applicable premium under Section 2.04, and are eligible for Medicare.

If you are retired and you and/or your Dependent are eligible for Medicare, the benefits under the Comprehensive Major Medical Expense Benefit for the person covered by Medicare are replaced with these benefits designed to supplement Medicare.

Once you are retired and eligible for Medicare, the Fund pays benefits only if you are enrolled in both Parts A and B of Medicare. If you are not enrolled in Medicare, the Fund will not pay benefits. Therefore, you **MUST** contact your local Social Security Administration office for information on how to enroll for Medicare Parts A and B when you retire.

This Plan only pays the portion of your medical expenses towards the Medicare deductibles up to the amounts listed in Section 1.01. Although Medicare revises the amount of benefits they pay each year, this Plan does not automatically change its benefit level.

8.02 Covered Supplemental Medical Benefit Expenses.

This Plan pays the following expenses:

- A. Hospital expenses you actually incur while confined in a Hospital as an Inpatient for room and board and for medical care and treatment (exclusive of professional services), subject to the Plan's maximums during any one continuous period of Hospital Confinement (see Schedule of Benefits at Section 1).
- B. 100% of the amount of the Medicare Part B deductible.
- C. 20% of Medicare Part B expenses based on Medicare's Limiting Charge or Medicare's Approved Charge as applicable.
- D. A portion towards the Medicare deductible as stated in the Schedule of Benefits for charges actually incurred for treatment provided in a Skilled Nursing Care Facility from the 21st through the 100th day of any period of confinement.

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

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

Medicare's Approved Charge is the fee Medicare sets as reasonable for a covered medical service based on payment being assigned directly to the provider. It may be less than the actual amount charged by a doctor or supplier. Medicare pays 80% of Medicare's Approved Charge after the deductible is paid.

Benefits are assigned directly to your Physician, so Medicare sends the reimbursement to your Physician. The Fund pays the other 20% of the Medicare Approved Charge.

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

8.03 Expenses Not Covered.

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

- A. Not Medicare-approved;
- B. Above Medicare's Limiting Charge or Medicare's Approved Charge; or
- C. Any of the circumstances listed under the General Plan Exclusions in Section 16.

SECTION 9: PRESCRIPTION DRUG BENEFITS

9.01 Eligibility of Active Employees and Retired Employees.

The Prescription Drug Benefit applies to you if you are eligible for Active Employee Benefits or Retired Employee Coverage. The benefit amounts are shown in Schedule 1.02. The Prescription Drug Benefit also applies to your Dependents and is subject to the Plan's coordination of benefits rules. Dependents that have primary coverage through another group plan should use those prescription drug benefits first and then this Plan will provide secondary coverage under Section 17: Coordination of Benefits.

This Fund's Prescription Drug Benefit is administered by a prescription benefit manager (PBM). The Fund Office provides the PBM with eligibility data including primary and secondary coverage information. In most cases, the pharmacist has access to this information and will coordinate benefits at the point of purchase. Where the coordination of benefits does not take place at the point of purchase, a claim will need to be submitted directly to the PBM.

Under the Prescription Drug Benefit, you have two programs available to you: the Retail Card Program and the Mail Order Program.

9.02 Covered Prescription Drugs.

Unless otherwise excluded, both parts of the program cover prescriptions by a Physician for the following:

- A. All federal legend drugs;
- B. State restricted drugs;
- C. Compound medications;
- D. Federal legend oral contraceptives, Ortho Evra patch, NuvaRing vaginal ring, Depo-Provera 150mg/ml syrn and Depo-Provera150mg/ml vial;
- E. Insulin on prescription, including test strips, lancets and all diabetic supplies;
- F. Needles and syringes on prescription;
- G. Specialty injectable prescriptions as described in Section 9.06.
- H. Up to a three-month supply of Chantix per year.
- I. Aerochambers and similar devices used to maximize the delivery of metered-dose inhaler medications into the lungs.

9.03 Drugs Not Covered.

This Prescription Drug Benefit does not cover the following:

- A. Fertility drugs or agents;

- B. Over-the-counter medications not requiring a prescription;
- C. Investigational or Experimental drugs;
- D. Prescription drugs covered under federal, state or local programs, including workers' compensation, for which there is no charge;
- E. Medications for sexual dysfunction, inadequacies or enhancements, including Viagra;
- F. Amphetamines and/or anorexiant for weight loss;
- G. Vitamins and minerals (prescribed or over-the-counter, but not including prescribed prenatal vitamins), nutritional supplements, food supplements or substitutes;
- H. Retin-A, except for the treatment of acne vulgaris;
- I. Any item classified as a device or supply through the prescription card program, unless specifically included in Section 9.02;
- J. Drugs or medicines which are not prescribed to treat a mental or physical condition for which the U.S. Food and Drug Administration (FDA) has approved usage of such product, or that are not prescribed or used in a manner consistent with the FDA's intended and approved usage.
- K. Rogaine or similar drugs and preparations to promote hair growth.
- L. Drugs to help stop smoking tobacco, with the exception of Chantix as described in Section 9.02(H).
- M. Allergy serums.
- N. Drugs for any of the circumstances listed under the General Plan Exclusions in Section 16.

9.04 The Retail Card Program.

A. Using a Participating Pharmacy.

The Retail Card Program offers benefits for short-term prescriptions (up to a 34-day supply). When you become eligible for benefits, you will receive a medical ID card which includes your prescription coverage. You can use your card at any participating pharmacy.

To receive benefits, you must present your ID card and your prescription to your pharmacist. When you use a participating pharmacy, you pay only the co-payment listed in your Schedule of Benefits.

You will receive the quantity prescribed by your Physician, up to the maximum described above and in the Schedule of Benefits. You do not need to submit any forms, receipts or claims. The pharmacist will submit the claim. You simply pay the necessary co-payment when you fill your prescription. The co-payment is not reimbursable under the Comprehensive Major Medical Expense Benefit or Supplemental Medical Benefit and does not count toward your Major Medical out-of-pocket maximum. Co-payments do, however, count towards your prescription drug out-of-pocket maximum show in Section 1.02.

B. If You Do Not Use A Participating Pharmacy.

You should be able to find a participating pharmacy near your home and wherever you travel. If you choose to fill your prescription at a non-participating pharmacy, you pay the full cost of the prescription and then you must request a claim form for reimbursement from our pharmacy benefits manager (Express Scripts) or from the Fund Office, or you may download the form from the Welfare Fund's website. You will only be reimbursed the amount the Fund normally pays for that prescription minus your co-payment.

9.05 The Mail Order Program.

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

If your Physician prescribes a long-term medication that you need right away, ask the Physician to write two prescriptions — a one-month prescription to be filled at a participating pharmacy using the Retail Card Program, and a 90-day prescription to be submitted to the Mail Order Program, which is provided through Express Scripts.

You will be responsible for paying only the co-payment listed in your Schedule of Benefits for each prescription ordered.

Follow these steps to obtain prescriptions through the mail or by using the Express Scripts website:

- A. Request a new patient home delivery form by calling Express Scripts or the Fund Office, or by downloading the form from the Welfare Fund's website;
- B. Complete all required information on the form;
- C. Enclose the Physician's prescription for a 90-day supply of medication (and up to three refills);
- D. Enclose the co-payment, include credit card information on the form, or call Express Scripts with your credit card information for each prescription, if applicable.

The Mail Order Program will deliver your order within three weeks from the time it receives your prescription. Another mail-order form will be enclosed with your medication. You should send your reorders 30 days before your prescription will run out. You can also phone in your refills or use the website for refills.

If you do not receive your medication within 10 to 12 days, call the Mail Order Program's customer service department at the Express Scripts number on the back on your Welfare Fund ID card. This number is also on the mail order form or you may call the Fund Office for it.

9.06 Specialty Drug Benefits.

Specialty injectable prescription drugs and ancillary supplies are covered exclusively under the Express Script Drug Plan through CuraScript except for specialty oncology drugs, which are covered under the Major Medical Benefit. These specialty drugs are covered under the Specialty Drug Benefits schedule shown in Section 1.02. A list of the drugs covered under this new benefit is available upon request to the Fund Office.

Specialty medications treat chronic, complex conditions such as hepatitis C, multiple sclerosis and rheumatoid arthritis. Specialty medications are defined as injectable and noninjectable drugs having one of more of several key characteristics, including:

- A. Requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity, and increase the probability for beneficial treatment outcomes;
- B. Need for intensive patient training and compliance assistance to facilitate therapeutic goals;
- C. Limited or exclusive product availability and distribution;
- D. Specialized product handling and/or administrative requirements; and
- E. Costs in excess of \$500 for a 30-day supply.

9.07 Medicare Part D.

If you are eligible for Medicare, you may choose to enroll in the Medicare Prescription Drug Benefit (Medicare Part D). Persons with prescription benefits under this Plan are unlikely to receive an additional benefit and generally should not sign up for Medicare Part D. Persons who are not eligible under this Plan should sign up for Medicare Part D.

The annual enrollment period is November 15 through December 31. There is also a special enrollment period if your eligibility for prescription drug benefits under this Plan ends on a date outside of the open enrollment period.

Because the Plan provides on average, equal or greater prescription benefits than Medicare Part D, the Plan's Prescription Drug Benefit is considered "creditable coverage." If you are eligible for Medicare, the Plan will send you a Notice of Creditable Coverage before November 15 of each year. This Notice will allow you to avoid payment of a late enrollment penalty if your prescription drug benefits under the Plan end and you decide to elect Medicare Part D. A late penalty under Part D applies to individuals who go 63 days or longer without prescription benefits that are at least as good as Medicare Part D.

If the Employee has not retired, eligible persons may elect Medicare Part D in addition to receiving Prescription Drug Benefits under this Plan. This is known as "dual coverage." When you have dual coverage, this Plan is the primary payer and Medicare is the secondary payer.

If the Employee has retired, eligible persons must choose between (1) prescription drug benefits under this Plan or (2) prescription drug benefits under Part D. If -- subsequent to the Employee's retirement -- you are enrolled in Medicare Part D, your Prescription Drug Benefits under this Plan will terminate. If you later decide to stop coverage under Medicare Part D, you may reapply for Prescription Drug Benefits under this Plan.

9.08 Prescription Drug Cost Savings Incentive Programs.

From time to time the Fund may adopt programs offered by its pharmacy benefits manager to provide incentives to participants to use lower cost prescription drugs, such as generic drugs. These incentives may include a waiver of the prescription drug co-payments that would otherwise be required under Schedule 1.02.

The Fund may also include a program called Step-Therapy in which Express Scripts works with the participant and his Physician to identify and try the most affordable, safe and appropriate medication when there are equivalents to certain costly brand name prescriptions.

SECTION 10: DENTAL EXPENSE BENEFIT FOR ACTIVE EMPLOYEES

10.01 Eligibility for Dental Expense Benefits.

The Dental Expense Benefit applies to you if you are eligible for Active Employee Benefits. If you are eligible, the Dental Expense Benefit also applies to your Dependents. The Dental Expense Benefit pays benefits for covered dental expenses up to the Usual and Customary Fees.

10.02 Predetermination of Dental Benefits.

Although not required, predetermination of whether a treatment is covered provides you with advance notice of which services are covered by the Plan. If you expect a dental treatment to cost \$500 or more, the Fund Office strongly urges you to submit a predetermination of benefits claim form that includes:

- A. A description of the proposed dental treatment; and
- B. The Dentist's estimated charges.

The Fund Office will review the information, estimate the benefits payable under the Plan and return the form to your Dentist. The predetermination is valid for dental work that begins within 45 days of the date the Fund Office returns the predetermination of benefits claim form to you and before your Eligibility terminates.

10.03 Alternate Course of Dental Treatment.

In determining the amount of benefits payable, the Fund Office may consider alternate courses of treatment appropriate to your condition and capable of accomplishing the desired results. The determination of such an alternative may be based on treatment that is:

- A. Customarily used nationwide in the treatment of the condition; and
- B. Recognized by the profession to be appropriate in accordance with broadly accepted nationwide standards of dental practice.

Once you know the exact amount of benefits payable for the treatment, you and your Dentist can discuss the dental treatment that is most appropriate for you. If an alternate course of treatment is suggested, and both you and your Dentist agree to proceed with the original course of treatment, or agree to charges that are higher than the amount allowed by the Fund Office, you will be responsible for paying any excess cost you incur.

10.04 Percentage of Dental Benefits Payable.

The Dental Expense Benefit pays the percentage listed in the Schedule of Benefits for covered dental expenses other than orthodontia work, up to the dollar maximum listed in the Schedule of Benefits per covered person per calendar year. Orthodontia care is subject to the lifetime maximum benefit per covered person listed in the Schedule of Benefits.

Covered dental expenses are considered to have been incurred on the day the service is rendered. When the complete service is not performed in one day, only the expense for that portion of the completed service will be considered incurred.

10.05 Covered Dental Expenses.

Covered dental expenses include dental services that are Medically Necessary in the treatment of an injury resulting from an Accident, dental disease or defect. Covered dental expenses include the following dental services provided by a Dentist or provided under a Dentist's supervision:

- A. Two routine oral examinations per calendar year.
- B. Two routine prophylaxis treatments by a Dentist or dental hygienist per calendar year.
- C. Dental x-ray, when professionally indicated and Medically Necessary. Full-mouth dental x-rays are limited to one full-mouth dental x-ray per calendar year.
- D. Dental sealants for each Dependent child under the age of 16.
- E. One topical application of sodium or stannous fluoride by a Dentist or dental hygienist per calendar year.
- F. Extractions of teeth (including wisdom teeth) and cutting procedures to the teeth and/or gums, including pre-operative and post-operative care.
- G. Anesthetics administered in connection with oral surgery covered under this benefit.
- H. Injections of antibiotic drugs by the attending Dentist.
- I. Periodontic treatment and surgery, including periodontal cleaning, scaling and other treatment for diseases of the gums and tissues of the mouth.
- J. Endodontic treatment, including root canal therapy and pupal therapy.
- K. Emergency treatment for the relief of dental pain when no other treatment is given during the same visit.
- L. Fillings, inlays, and crowns. Gold restorations will only be covered if amalgam, silicate or plastic materials will not adequately restore the tooth.
- M. Replacement of previously existing gold restorations, provided that amalgam, silicate or plastic materials will not adequately restore the tooth and if the previous restoration was installed at least five years before the replacement.
- N. Initial installation of a full or partially removable denture, temporary denture or fixed bridgework.
- O. Dental (tooth) implants.
- P. The scaling and cleaning of teeth by a licensed dental hygienist or dental assistant if performed under the supervision and direction of a Dentist and a charge is made for such service by a Dentist, but not more than once in any period of six consecutive months.
- Q. Laboratory services for preparation of dental restoration and dental prosthetic devices if the Dentist includes the cost of such services or devices in the charges for these services.

10.06 Orthodontia Care Coverage.

If you or your eligible Dependent receives treatment from an orthodontist, the Fund pays the Usual and Customary Charges for the initial and subsequent installation of orthodontia appliances, as well as for all orthodontia treatment preceding and subsequent to the installation. The Plan's lifetime maximum orthodontia benefit is \$1,500 per covered person.

10.07 TMJ Coverage.

If you or your eligible Dependent receives treatment for temporomandibular joint syndrome (TMJ), the Fund pays the Usual and Customary Charges for the treatment of TMJ. The Plan's lifetime maximum TMJ benefit is \$2,000 per covered person.

10.08 Extension of Dental Benefits.

Coverage for dental expenses ends when your eligibility for Active Employee Benefits terminates. However, the Fund will pay applicable amounts beyond that date for the following:

- A. A prosthesis (such as full or partial denture), if the Dentist took the impressions and prepared the abutment teeth while you were eligible, and installs the device within 31 days after eligibility ends.
- B. A crown, if the Dentist prepared the crown while you were eligible and installs the crown within 31 days after eligibility ends.
- C. Root canal treatment, if the Dentist opened the tooth while you were eligible and completes the treatment within 31 days after eligibility ends.

10.09 Limitations and Exclusions on Payment of Dental Benefits.

The Dental Expense Benefit described above does not cover retired Employees or eligible Dependents of retired Employees. In addition, this benefit does not cover dental expenses incurred:

- A. After eligibility ends;
- B. Solely for cosmetic reasons;
- C. For the repair of congenital oral defects or primarily for the restoration of the vertical dimension of the face;
- D. Installation, manufacture or fitting of dental inlays, crowns, bridgework, and dentures begun before you were eligible for benefits; or
- E. Veneers.
- F. Any of the items listed in the General Plan Exclusions in Section 16.

10.10 Dental PPO Network Access for Active Participants.

This Plan offers the Blue Cross Blue Shield Dental PPO as an additional option with no change in benefits. If you use a Dentist who is in the Blue Cross network, the Dentist's charges will be lower and, as a result, both you and the Fund pays less.

10.11 Dental PPO Network Access For Retirees.

If you are eligible for Retired Employee Coverage, you now have access to the discounts under a dental PPO network. The Fund does not pay for the services provided by your Dentist. However, the Fund pays a fee so that you will have access to discounts under the dental PPO network. The retiree pays the full cost of the discounted dental services directly to the provider.

SECTION 11: VISION CARE EXPENSE BENEFIT FOR ACTIVE EMPLOYEES

11.01 Eligibility for Vision Care Expense Benefits.

The Vision Care Expense Benefit applies to you if you are eligible for Active Employee Benefits. If you are eligible, the Vision Care Expense Benefit also applies to your Dependents. As of January 1, 2007, the Vision Care Expense Benefit is provided exclusively through a contract with a vision care network - EyeMed.

11.02 Limitations and Exclusions on Vision Care Benefits.

This Vision Care Expense Benefit does not cover retired Employees or covered Dependents of retired Employees. In addition, this benefit does not cover vision expenses incurred for:

- A. More than one eye examination, one frame and/or one pair of lenses per calendar year;
- B. Medical and/or surgical treating of the eye, eyes or supporting structures;
- C. Services or supplies covered under any other benefit of this Plan or under any other medical expense benefit or vision benefit provided by the Employer;
- D. Services or materials provided by any other group benefit providing for vision care;
- E. Services provided as a result of any worker's compensation law;
- F. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing;
- G. Visual analysis that does not include refraction;
- H. Plano (cosmetic) non-prescription lenses and non-prescription sunglasses;
- I. Duplicate or spare lenses and/or frames;
- J. Lost or broken materials;
- K. Two pair of glasses in lieu of bifocals;
- L. Aniseikonic lenses;
- M. Services or supplies not listed as covered vision care expenses; and
- N. Any of the items listed in the General Plan Exclusions in Section 16.

SECTION 12: THE EMPLOYEE ASSISTANCE PROGRAM

12.01 Eligibility.

You are eligible for the Employee Assistance Program Benefit if you are eligible for Active Employee Benefits, or if you are eligible for Retired Employee Coverage.

12.02 The Employee Assistance Program.

Employee Resource Systems, Inc. provides the Employee Assistance Program (EAP) and managed mental health care services to participants and their families. The EAP defines "family" as in- and out-of-state parents, children and significant others of the same or opposite sex.

These confidential EAP services were developed to help Employees and their families cope with personal difficulties that can affect their lives both at home and at work. Persons eligible to use the EAP have access to up to three **FREE** counseling sessions per problem, situation or issue.

The EAP assists people with a variety of life problems including alcohol and drug abuse; stress, anxiety, and depression; marital, family, and relationship discord; child and adolescent behavioral problems; domestic violence; child care; elder care; financial and legal concerns; and educational and career-related problems at no cost to the Employee. The EAP does not address difficulties related to salaries, job assignments or other work-related issues.

All contact with the EAP is confidential. The EAP counselor will not speak with a supervisor, co-worker or family member without permission from the person using the assistance program. Confidentiality is compromised only when a threat to life exists (i.e., suicidal or homicidal risk, stalking or child abuse).

Services may include a comprehensive evaluation, brief counseling and a referral, if necessary. Some services not covered by the Fund's benefits may be provided by the EAP.

EAP services are available Monday through Friday from 8:30 a.m. to 5:30 p.m. by calling **(800) 292-2780**. Calls are always answered directly by clinical professionals who provide immediate service, even after standard business hours. The 800 hotline number can be used anywhere in the United States.

SECTION 13: WELLNESS EXPENSE BENEFIT

13.01 Wellness Expense Benefits.

The Wellness Expense Benefit has two components: (1) the Routine Physical Exam Benefit and (2) the Weight Loss Program.

13.02 Routine Physical Exam Benefit.

A. Eligibility for Routine Physical Exam Benefit.

The Routine Physical Exam Benefit applies to active and retired Employees and their Dependent spouses, except persons with Retired Employee Coverage who are Medicare eligible. Persons with Retired Employee Coverage who are Medicare eligible are not eligible for this benefit because they already receive coverage for many of these services through Medicare and the Fund's Supplemental Medical Benefits.

B. Routine Physical Exam Benefit.

Under the Routine Physical Exam Benefit, the Fund will pay the **full** Usual and Customary Fee for the covered service instead of the 85% or 75% provided under the Medical Expense Benefit provided in Section 1.01. However, if you go to an out-of-network provider, this amount may be substantially less than the amount charged by your provider. Under the Routine Physical Exam Benefit you can receive the following services once per calendar year:

1. Routine physical examination by a Physician.
2. Wellness laboratory tests as follows:
 - a. Comprehensive metabolic panel;
 - b. Lipid panel (cholesterol);
 - c. Complete blood count with differential WBC (diseases);
 - d. Complete urinalysis (infections, diseases); and
 - e. Blood glucose (diabetes).
3. PSA screen (prostate) for men over 40 and mammogram for women over 40.

No deductible or co-payments will need to be paid for the above services. Any other Medically Necessary tests and services ordered by the Physician are covered under the Comprehensive Major Medical Benefit and subject to deductible and co-payments.

13.03 Weight Loss Program Benefit.

A. Eligibility for Weight Loss Program.

The Weight Loss Program applies to you if you are eligible for Active or Retired Benefits. If you are eligible for the Weight Loss Program, your Dependent spouse is also eligible for this benefit.

B. Weight Loss Program Benefit.

The Weight Loss Program is provided exclusively through Weight Watchers®. The Welfare Fund will pay the full cost of the Weight Watchers® 13-week program on a once per lifetime basis for an Active or retired Employee and/or Dependent spouse.

Alternatively, the cost of the 13-week program will be applied to any extended program or options you may choose, including Weight Watchers Online and Weight Watchers At-Home Kits.

You may contact Weight Watchers® at a special toll free number (1-866-204-1141) to enroll. You will need to provide your first and last name, your billing address and your Union identification number.

SECTION 14: HEARING AID BENEFIT

14.01 Eligibility.

You are eligible for the Hearing Aid Benefit if you are eligible for Active Employee Benefits, or if you are eligible for Retired Employee Coverage and are not yet eligible for Medicare.

14.02 Hearing Aid Benefit.

The Fund provides you and your Dependents with hearing aid devices up to the maximums shown in the Schedule of Benefits during a consecutive three-year period. Payments will be made for a hearing device only if:

- A. An examination indicates a need for a hearing aid; and
- B. The examination and the hearing aid are both furnished by a Physician or by an audiologist who is certified by the American Speech-Language Hearing Association.

You are not required to pay a deductible or co-payment before the Fund pays hearing aid benefits.

SECTION 15: HOSPICE BENEFIT

15.01 Eligibility.

You are eligible for the Hospice Benefit if you are eligible for Active Employee Benefits, or if you are eligible for Retired Employee Coverage and are not yet eligible for Medicare.

15.02 Hospice Benefit.

The Fund provides you and your Dependents with hospice benefits, up to the maximums shown in the Schedule of Benefits. To be eligible for hospice benefits, the hospice care must be rendered as part of a hospice care program by a licensed hospice care agency. Before a covered individual enrolls in a hospice care program, they should contact the Fund Office to verify that services will be covered under this benefit.

The following services are covered under the Hospice Benefit subject to the maximum limits in Section 1.01.

A. Home Care.

Allows patient to receive care in his or her own home. Services and equipment covered at 100% include:

1. Physician services;
2. Physical, respiratory and occupational therapies;
3. Drugs, medications and medical supplies when provided under the hospice care program through a hospice care agency;
4. Private duty nursing services by a registered nurse (RN) or licensed practical nurse (LPN), if certified by a Physician;
5. Rental of durable medical equipment, as described in Section 7.08(A)(7);
6. Oxygen and its administration.

B. Outpatient Care.

Care that you receive in a licensed medical facility. Services covered at 100% include:

1. Physician services;
2. Laboratory, x-ray and diagnostic testing;
3. Ambulance service or alternative types of transportation.

C. Inpatient Care.

Care received while you are an admitted patient in a Hospital or hospice facility. Services covered at 100% include:

1. Room and board which may include overnight visits by family;
2. Nursing services;
3. All other related Hospital expenses;
4. Physician services;
5. Ambulance service or alternative types of transportation.

D. Other Services.

In addition to the services outlined above, certain other services for you and your family are also covered. Other services covered at 100% include, but are not limited to:

1. Visits by a licensed social worker to evaluate the social, psychological and family problems related to the terminal illness. In addition, this professional will help develop a plan to assist in resolving these problems;
2. Emotional support services to help relieve stress, cope with the anticipated loss, complete unfinished family business and maintain the patient in the most appropriate environment;
3. Special incidental services for the patient, such as special dietary requirement, transportation between home and other sites of care.

SECTION 16: GENERAL PLAN EXCLUSIONS

16.01 Exclusions from Coverage.

The following expenses are not covered under the Plan:

- A. Accidents, Sicknesses or dental treatments for which you are entitled to benefits under a workers' compensation or occupational disease law. This exclusion does not apply to the Death or Accidental Death and Dismemberment Benefits, however.
- B. Any expenses or charges for services or supplies that are provided by Hospitals or medical institutions owned or operated by a federal, state or local government, or their medical practitioners, unless you are required to pay such charges.
- C. Any expenses or charges caused by your voluntary participation in a riot.
- D. Any expenses or charges caused by war or any act of war, whether declared or undeclared.
- E. Any expenses or charges incurred during the commission of a felony or involvement in a criminal enterprise.
- F. Any expenses or charges incurred while in the military service of any country, or civilian non-combatant unit serving with such forces. The effect of military service on eligibility under the Plan pursuant to USERRA is explained in Section 2.01(I).
- G. Any expenses or charges for which you do not have to pay.
- H. Any expenses or charges for services or supplies not prescribed by a Physician or Dentist, unless such services or supplies are provided under the supervision of a Physician or Dentist or as specifically provided under the Plan.
- I. Any expenses or charges for services or supplies:
 - 1. not provided in accord with generally accepted professional medical standards;
 - 2. not Medically Necessary; or
 - 3. for drug therapy programs not available in the United States or available in the United States only under special license by the federal government for practitioners engaged in research.
- J. Any expense or charge for Experimental or Investigative Treatments and Procedures.
- K. Any expenses or charges for services and supplies that exceed the Usual and Customary Fees.
- L. Any expenses, charges or treatments received in any penal facility or jail or equivalent institution.
- M. Any treatments, services or supplies furnished by a person who resides in your home, or who is a member of your immediate family (i.e., your spouse, child, brother, sister or parent).
- N. Any expenses or charges for third party ordered care, such as a pre-employment physical.

- O. Any expenses or charges (1) for failure to keep scheduled visits, (2) for completion of claim forms or (3) for reports or medical requests not requested by the Fund.
- P. Charges that would not have been made if this Plan did not exist.

SECTION 17: COORDINATION OF BENEFITS

17.01 Benefits Are Coordinated.

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

17.02 Another Group Plan Defined.

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

- A. Group blanket or franchise insurance coverage (such as coverage provided to college students);
- B. Group Blue Cross or group Blue Shield coverage and other group prepayment coverage;
- C. Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, employee benefits organization plans or any other arrangement of benefits or individuals of a group;
- D. Any coverage under governmental programs;
- E. Any coverage required or provided by statute; and
- F. The Pipe Fitters' Welfare Fund, Local 597 when you are covered as:
 - 1. an Employee and as a Dependent; or
 - 2. a Dependent child of more than one Employee.

17.03 How Benefits are Paid.

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

When health care coverage is available from more than one group plan, the primary plan pays benefits first. Your primary plan determines benefits as if that plan was the only coverage available. Then the secondary plan pays according to their coordination of benefits rules. When this Plan is secondary, it will pay the difference between your allowable expenses under this Plan (as though there was no other coverage) and what your primary plan paid.

If the Plan provides benefits in the form of service rather than cash payments, the reasonable cash value of each service rendered will be considered both an allowable expenses and a benefit paid, as long as the service is covered under this Plan.

If you or a Dependent is covered by another group plan or source in addition to the Pipe Fitters' Welfare Fund, Local 597, the order of benefit payment will be determined according to the guidelines outlined in Section 17.04.

17.04 Order of Benefit Payment.

For coordination with other plans the following rules apply:

- A. A plan without coordination of benefits rules will be primary and will pay benefits before this Plan.
- B. A plan that covers a person other than as a Dependent is primary and pays benefits before a plan that covers the person as a Dependent.
- C. For claims on behalf of Dependent children whose parents are not divorced or separated or for claims on behalf of Dependent children whose parents share custody, the plan that covers the parent whose birthday (month and day) falls first in the calendar year is primary and will pay benefits first. If both parents have the same birthday, the plan covering the parent for the longer period of time will be primary and pay benefits first.
- D. For claims on behalf of Dependent children whose parents are divorced or separated, the following rules apply:
 - 1. If there is a court decree that establishes financial responsibility for medical expenses, the plan covering the parent who has such financial responsibility will be primary.
 - 2. If there is no court decree and the parent with custody has not remarried, the plan that covers the parent with custody will be primary.
 - 3. If there is no such court decree and the parent with custody has remarried, the order of benefit coordination will be as follows:
 - a. the plan of the parent with custody is primary and pays benefits first;
 - b. the plan of the step-parent with custody pays benefits second;
 - c. the plan of the parent without custody pays benefits third; and
 - d. the plan of the step-parent without custody, if any, pays benefits fourth.
- E. A plan that covers you as an employee who is not laid off or retired is primary and pays benefits before a plan that covers you as a laid-off employee or retired employee.
- F. A plan that covers you as a current full-time employee or as a Dependent of that current full-time employee is primary and pays benefits before a plan that covers you as a part-time or seasonal employee or as an employee who is eligible because of contributions or payroll deductions previously made to the plan.
- G. If none of the above rules apply, the plan that has covered the claimant for the longer period of time will be primary and pay benefits first.

17.05 Coordination of Benefits Implementation Rules.

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

- A. Release or obtain information considered necessary;
- B. Authorize payment directly to another group plan or source that paid claims which should have been paid by this Plan; and
- C. Recover payments in excess of the amount that should have been paid by this Plan.

17.06 Coordination of Benefits with Medicare.

A. When You are an Active Employee.

If you are an active Employee, this Plan will be primary and pay benefits first. If you are an Active Employee whose eligible Dependent is entitled to Medicare, this Plan will be primary to Medicare for that Dependent.

B. When You are a Retired Employee.

If you retire and are eligible for Retired Employee Coverage, Medicare will have primary responsibility and this Plan will pay second. Medicare is primary even if you have sufficient hours in your Accumulation Account to be eligible for the Active Employee Schedule of Benefits.

C. End Stage Renal Disease (ESRD).

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

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

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

If during the initial 30-month period the Employee becomes eligible for Retired Employee Coverage, the Plan will continue to pay as the primary plan during the balance of the 30-month period.

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

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

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

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

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

SECTION 18: SUBROGATION OR REIMBURSEMENT

18.01 Reimbursement to the Plan.

Subrogation or reimbursement rules apply if the Fund pays medical bills or weekly disability benefits that arise out of an Accident or Sickness that results in a claim against a third party. Under these circumstances, the Fund is entitled to reimbursement of its expenditures from all third party recoveries. However, in the case of a non-work related incident, the Fund will not seek reimbursement for weekly disability benefits.

18.02 Third Parties Defined.

Other sources may include, but are not limited:

- A. Any person or entity legally responsible for your injury;
- B. Other benefit plans;
- C. An insurance company;
- D. Workers' compensation; or
- E. Any other person or entity that is obligated to make payments, which the Fund would otherwise be obligated to make.

18.03 Your Responsibilities.

- A. You and/or your Dependent must immediately notify the Fund Office whenever a claim against a third party is made for yourself and/or your Dependent regarding any loss for which benefits are received from the Fund.
- B. You and/or your Dependent must cooperate with the Fund by providing, among other things, information requested by the Fund concerning subrogation or reimbursement. You must provide the Fund Office with:
 - 1. a signed *Subrogation and Reimbursement Agreement*;
 - 2. the names and addresses of all potential third parties and their insurer, adjusters and claim numbers;
 - 3. Accident reports; and
 - 4. any other information the Fund Office requests.
- C. If you fail to meet your responsibilities, the Fund Office may withhold future benefit payments until you comply with these requirements.
- D. By accepting benefits under the Plan for these expenses, you and/or your Dependent agree to give the Fund Office the right to prosecute your claim and maintain an action against the third party on your behalf.

18.04 If You Are Reimbursed by a Third Party.

If you and/or your Dependent receive payment from a third party for benefits paid by the Fund, you or the third party must reimburse the Fund Office. The proceeds from the settlement or judgment must be divided as follows:

- A. First, you or your representative must pay the Fund a sum sufficient to fully reimburse the Fund Office for all (100%) benefits advanced. No reductions or deductions are allowed for attorneys' fees (the Illinois common fund doctrine or any other state law affecting these rights are preempted); then
- B. Any remainder may be paid to you and/or your Dependent.

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

You and, if applicable, your Dependents shall be responsible for compliance with these provisions and the provisions of any subrogation/reimbursement agreement. You will also be responsible for compliance by your or your Dependents' agents and attorneys.

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

- A. Initiating a claim to compel compliance with these terms or the terms of the subrogation/reimbursement agreement;
- B. Withholding benefits payable to you or your Dependents until you or your Dependents comply;
or
- C. Initiating such other equitable or legal action it deems appropriate.

SECTION 19: CLAIMS AND APPEALS PROCEDURES

19.01 General Information.

A. Exhaustion of Remedies.

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

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

B. Discretionary Decision Making Authority of the Trustees.

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

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

19.02 Filing Your Initial Claim for Benefits.

A. What is a Claim?

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

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

When you present a prescription to a participating pharmacy to be filled out under the terms of this Fund, that request is not a claim under these procedures. However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal regarding the denial by using these procedures.

B. How to File a Claim for Active and Non-Medicare Retirees.

To file a claim for benefits offered under this Plan, you must submit a completed claim form. However, if you use the services of a PPO or other network provider, the provider will generally file your claims for you.

If you choose to file a claim on your own, you may obtain a claim form from the Fund Office by calling (312) 633-0597.

1. Hospital, Physician and Medical Claims

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

- a. Employee's name;
- b. Patient's name;
- c. Patient's date of birth;
- d. Social Security or unique ID number of Employee or retiree;
- e. Date of service;
- f. CPT-4 (the code for Physician services and other health care services found in the *Current Procedural Terminology, Fourth Edition*, as maintained and distributed by the American Medical Association);
- g. ICD-9 (the diagnosis code found in the *International Classification of Diseases, 9th Edition, Clinical Modification*, as maintained and distributed by the U.S. Department of Health and Human Services);
- h. Billed charge;
- i. Number of units (for anesthesia and certain other claims);
- j. National Provider Identifier (NPI) of the provider; and
- k. Billing name and address.

2. All other Benefits

You should contact the Fund Office about how to file a claim for life insurance, dental, vision, wellness, disability, hearing or Accidental Death and Dismemberment Benefits.

C. Medicare Crossover for Retirees Eligible for Medicare.

In September 2006, the Fund became the first Building Trades Health and Welfare Fund in the Chicagoland area to contract directly with Medicare to receive supplement to Medicare claims electronically from Medicare.

This process is known as Medicare Crossover and it works this way: Your health care provider files his bill with Medicare. Medicare processes the bill, paying its share to the provider. Medicare then electronically transmits the charge and payment information directly to the Fund. The Fund then pays the provider the supplemental amount due under the Plan and sends you an explanation of benefits at the same time.

This all means that Retired Employees eligible for Medicare will not have to file a claim for their supplemental benefits with the Fund Office.

D. Where to File a Claim.

1. Hospital, Physician, and Medical Claims

All Hospital, Physician and medical claims in general, (both PPO and non-PPO providers) for services performed in Illinois, should be filed with BlueCross BlueShield of Illinois. The Fund will consider your claim to have been filed as soon as it is received at the Fund Office from BlueCross BlueShield. Both PPO and non-PPO providers should complete the claim form for you and send it to following address:

BlueCross BlueShield of Illinois
P.O. Box 805107
Chicago IL 60680

OUT OF STATE CLAIMS: For services performed outside of Illinois, all Hospital, Physician and medical claims in general, should be filed with the local BlueCross BlueShield plan.

2. All other Benefits

You should file your prescription claims with Express Scripts as stated in Section 9.04 and 9.05. Your vision claims should be filed with EyeMed (see Section 11.01).

You should file your dental, death, hearing and weekly disability claims at the following address:

Pipe Fitters' Welfare Fund, Local 597
45 North Ogden Avenue
Chicago, Illinois 60607

19.03 Initial Claim Determination Timeframes.

A. Claim Filing Deadline.

You must file your claim for benefits as soon as possible following the date you incurred the charges. If you fail to file your claim as soon as possible, it will not invalidate or reduce your claim if it was not reasonably possible for you to file the claim within a reasonable time. However, you must submit your claim no later than 12 months from the date you incurred the charges, unless you can show good cause for filing a claim beyond the 12-month deadline. The Board of Trustees will determine whether you have shown good cause.

B. Decision Timeframes.

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

1. Weekly Sickness and Accident Disability Claims

The Fund will make a decision on your Weekly Sickness and Accident Disability claim and notify you of the decision within 45 days. If the Fund requires an extension of time due to matters beyond the control of the Fund, the Fund will notify you (within the 45-day period) of the reason for the delay and the time when the decision will be made. The Fund will make its decision within 30 days of the time the Fund notifies you of the delay. The Fund may delay the period for making a decision for an additional 30 days, provided the Fund Administrator notifies you, before the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Fund expects to render a decision.

If an extension is needed because the Fund needs additional information from you to process your claim, the extension notice will specify the information needed. In that case, you will have 45 days from the time you receive the notification to supply the additional information. If you do not provide the information within that time, your claim will be decided on the basis of the information that the Fund has at the time and may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). Once you respond to the Fund's request for the information or at the expiration of the 45 days if you do not respond, the Fund will make its decision on the claim and notify you within 30 days.

2. All Other Claims

Ordinarily, the Fund will notify you of the decision on your claim within 30 days from the Fund's receipt of the claim. The Fund may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the Fund. If an extension is necessary, the Fund will notify you before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Fund expects to render a decision.

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

19.04 Notice of Initial Decision.

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

- A. The specific reason or reason(s) for the denial of benefits or other adverse benefit determination;
- B. A specific reference to the pertinent provisions of the Plan upon which the decision is based;
- C. A description of any additional material or information that is needed to process your claim and an explanation of why the information is needed;
- D. A copy of the review procedures and time periods to appeal your claim, a statement of your right to bring a civil action under ERISA following an adverse benefit determination on review;
- E. If an internal rule, guideline, protocol or similar criteria was relied on in the process of making a decision on your claim, a copy of that internal rule, guideline, protocol, or similar criteria or a statement that a copy is available to you at no cost upon request; and
- F. If your health or Weekly Accident and Sickness Disability claim was denied on the basis of Medical Necessity, Experimental Treatment or similar exclusion, a copy of the scientific or clinical judgment that was relied on in the process of making a decision on your claim or a statement that it is available to you at no cost upon request.

19.05 Appeal Procedures.

A. Appeal Filing Deadline.

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

B. Appeal Process.

The appeal process works as follows:

1. You have the right to review documents relevant to your claim. A document, record or other information is relevant if:
 - a. it was relied upon by the Fund in making the decision;
 - b. it was submitted, considered or generated in the course of making the decision (regardless of whether it was relied upon);
 - c. it demonstrates compliance with the Fund's administrative processes for ensuring consistent decision-making; or

- d. it constitutes a statement of Plan policy regarding the denied treatment or service.
2. Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Fund on your claim, without regard to whether their advice was relied upon in deciding your claim.
3. A different person will review your claim than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of a full and fair review of the record, including such additional documents and comments that you may submit.
4. If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was Investigational or Experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

C. Timing of Notice of Decision on Appeal.

1. Health Claims

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

2. Weekly Accident and Sickness Disability

The decision will be made in the same manner as for health claims.

3. Death Benefit and Accidental Death and Dismemberment Claims

The Fund will send you a notice of the decision on appeal within 60 days of a decision being reached by the Board of Trustees.

19.06 Notice of Decision on Appeal.

The Fund will provide you with a written decision on any appeal of your claim. The notice of a denial of a claim on appeal will state:

- A. The specific reason(s) for the determination;
- B. Reference to the specific Plan provision(s) on which the determination is based;
- C. A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge;

- D. A statement of your right to bring a civil action under ERISA following an adverse benefit determination on appeal; and
- E. If an internal rule, guideline or protocol was relied upon by the Fund, you will receive either a copy of the rule or a statement that it is available upon request at no charge. If the determination was based on Medical Necessity or because the treatment was Experimental or Investigational or other similar exclusion, the Fund will provide you with an explanation of the scientific or clinical judgment for the determination applying the terms of the Fund to your claim, or a statement that it is available upon request at no charge.

19.07 Physical Examination.

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

19.08 Payment of Claims.

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

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

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

- A. Your spouse;
- B. Your Dependent children, including legally adopted children;
- C. Your parents;
- D. Your brothers and sisters; or
- E. Any person the Trustees determine is entitled to payment.

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

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

19.09 Authorized Representatives.

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

19.10 Benefit Payment to an Incompetent Person.

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

- A. Directly to such person;
- B. To the legally appointed guardian or conservator of such person;
- C. To any spouse, child, parent, brother or sister of such person for the welfare, support and maintenance of that person; or
- D. By the Trustees directly for the support, maintenance and welfare of such person.

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

19.11 Misstatement by Plan Participant.

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

19.12 Workers' Compensation.

The Plan does not cover any work-related injuries and does not affect any requirement for your coverage under any workers' compensation or occupational disease act or law.

SECTION 20: DEFINITIONS

20.01 Definition of Plan Terms.

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

- A. **Accident** means an injury caused by a sudden unforeseen event. Such injury must be the result of an external source.
- B. **Board of Trustees and/or Trustees** means the Trustees and Board of Trustees designated in the Trust Agreement, together with their successors designated and appointed in accordance with the terms of the Trust Agreement for the Pipe Fitters Welfare Fund, Local 597. The Board of Trustees is the “administrator” of this Plan as that term is used in the Employee Retirement Income Security Act of 1974.
- C. **Contributing Employer or Employer** means any person, firm, association, partnership or corporation which is a signatory to a collective bargaining agreement which requires contributions to this Fund. Contributing Employer also means the Union, the Certified Welding Bureau and the Pipe Fitters’ Training Fund, Local Union 597, the Pipe Fitters’ Welfare Fund, Local 597 and the Pipe Fitters’ Retirement Fund, Local 597 and any other entity that has entered into a participation agreement with the consent of the Trustees which does in fact make contributions to the Fund as provided for in the Fund’s Trust Agreement and has agreed in writing to be bound by such Trust Agreement.
- D. **Covered Employment** means employment of an Employee by an Employer for which contributions to this Fund are required.
- E. **Custodial Care** means care designed to help a disabled person with daily living activities when:
 - 1. there is no plan of active medical treatment to reduce the disability; or
 - 2. the plan of active medical treatment cannot be reasonably expected to reduce the disability.
- F. **Dentist** means a legally qualified Dentist practicing within the scope of his or her license or a legally qualified Physician authorized by his or her license to perform the particular dental service rendered.
- G. **Dependent** means any one of the following individuals:
 - 1. An Employee’s spouse (marriage license and birth certificate required).
 - 2. Each unmarried child of an Employee from birth to the end of the calendar year in which such child attains age 18 (birth certificate required).
 - 3. Each unmarried child, -- until the end of the calendar year such child attains age 18 or the end of the month in which the child attains 23 years of age, if he or she is enrolled as a full-time student in an accredited school, college or university, -- who is dependent upon the Employee for financial support. Proof of enrollment is required. The Fund will require proof of full-time student status at the beginning of each academic period in which the child

is attending school; pre-registration letters or schedules are not acceptable. A child who is enrolled full-time for the academic period prior to the summer will be covered for the summer provided the child is enrolled as a full-time student for the academic period following the summer.

4. An unmarried child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, provided:
 - a. such incapacity began before the end of the calendar year such child attains age 18; and
 - b. such child is chiefly dependent upon the Employee for financial support and maintenance; and
 - c. proof of such incapacity is submitted to the Trustees within 31 days of the date such Dependent's eligibility would otherwise terminate.

An Employee's children include natural and legally adopted children, children placed in the Employee's home for adoption, and step children. Step children will only be covered if they live with the Employee and are financially dependent on the Employee for a majority of their support and maintenance.

In order to cover a step child, the Employee must provide authorization for the Fund to obtain a copy of the Employee's latest federal tax return directly from the federal government.

If the spouse is divorced, the Employee must provide a certified copy of the spouse's divorce decree that indicates joint responsibility for health insurance. If the spouse is a widow or widower, the Employee must provide the Plan with a certified copy of the death certificate of the former spouse.

The Plan does not cover (1) a foster child unless legally adopted or (2) a child over whom the Employee has legal guardianship unless legally adopted.

H. **Employee** means (1) all Employees of Contributing Employers for which the Contributing Employer is required, under the terms of a collective bargaining agreement, to pay contributions to this Plan on their behalf; (2) Employees of the Certified Welding Bureau, and (3) all active full-time Employees of the Union (4) all active, full-time Employees of Pipe Fitters' Welfare Fund, Local 597, Pipe Fitters' Retirement Fund, Local 597, and Pipe Fitters' Training Fund, Local 597; and (5) other Employees of a Contributing Employer covered by a participation agreement with the Fund that provides for Employer contributions on their behalf.

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

1. Such treatment or procedure has failed to obtain final approval for a specific diagnosis from the appropriate governmental body;
2. Reliable evidence does not establish a consensus conclusion among experts recognizing the safety and effectiveness of such treatment or procedure on health outcomes for a specific diagnosis;

3. Such treatment or procedure, or the patient-informed consent document utilized with such treatment or procedure was reviewed and approved by the treating facility “institutional review board” or other body serving a similar function, or if federal law requires such review or approval;
4. Reliable evidence shows that such treatment or procedure is (1) the subject of ongoing phase I or phase II clinical trials, (2) the subject of on-going phase III clinical trials or (3) otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
5. Reliable evidence shows that the prevailing opinion among experts regarding such treatment or procedure is that further studies or clinical trials are needed to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

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

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

J. **Fund and/or Welfare Fund** means the Pipe Fitters’ Welfare Fund, Local 597.

K. **Fund Office** means the office of the Pipe Fitters’ Welfare Fund, Local 597.

L. **Hospital** means a lawfully operating institution for the care and treatment of sick and injured persons with organized facilities for diagnosis and treatment, medical supervision, 24-hour nursing service by registered nurses, and surgery (or provides for surgical facilities on a formal arrangement). In no event, however, does the term Hospital include any institution or part of an institution which is used principally as a rest facility or facility for the aged, nor does it include a Hospital operated by the United States Government, unless the claimant is required to pay such expense.

M. **Inpatient** means a person who, while confined in a Hospital or Skilled Nursing Care Facility, is assigned a bed in any department of a Hospital or Skilled Nursing Care Facility other than in its outpatient department and for whom a charge for room and board is made by Hospital or Skilled Nursing Care Facility.

N. **Medically Necessary** means a service or supply that:

1. is consistent with the symptoms of diagnosis and treatment of the person’s injury or Sickness;
2. is appropriate with regard to standards of good medical practice and recognized by an established medical society in the United States; and

3. could not have been omitted without adversely affecting the person's condition or the quality of medical care.
- O. **Medicare** means the Hospital and Supplementary Medicare Insurance Plans established by Title XVIII of the Social Security Act of 1965, as then constituted or as later amended.
- P. **Mental Illness** means those illnesses classified as a disorder in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.
- Q. **Mental or Nervous Disorder** means (1) a Mental Illness or (2) a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind, regardless of whether such disease or disorder has causes or origins which are organic, physiological, traumatic or functional.
- R. **Plan and/or Welfare Plan** means this document as adopted by the Trustees and as thereafter amended by the Trustees.
- S. **Physician and/or Surgeon** means a person licensed as a medical doctor (MD) or doctor of osteopathy (DO) and authorized to practice medicine, to perform surgery and to administer drugs under the laws of the state or jurisdiction where the services are rendered and who is acting within the scope of such license.
- T. **Qualifying Events** are certain events that would cause an individual to lose health coverage. Qualifying events include voluntary or involuntary termination of employment (for reasons other than gross misconduct), reduction in the number of hours of employment, covered employee's becoming entitled to Medicare, divorce or legal separation of the covered Employee, death of the covered Employee or loss of Dependent child status under the Plan rules.
- U. **Sickness** includes pregnancy, childbirth, abortion and related medical conditions among other illnesses.
- V. **Skilled Nursing Care Facility** means a lawfully operated institution for the care and treatment of persons convalescing from a Sickness or injury which provides room and board and 24-hour nursing service by registered licensed nurses and is under the full-time supervision of a legally qualified Physician or Surgeon or a registered nurse (RN).
- W. **Usual and Customary Fee or Charges** means the following:
1. For service or supply covered under a Plan PPO or similar organization contract, the fee shall be the amount the service provider has agreed to accept as payment in full under its contract with a Plan PPO or similar organization.
 2. For service or supply where the fee is not determined under (1) above, the amount the Fund would have paid if the item had been covered under any such Plan PPO contract.
 3. For service or supply where the fee cannot be determined under (1) or (2) above, the fee shall be based on 125% of the amount that would be allowed by Medicare, except as described in (4) below.

4. For outpatient facility charges and ambulatory surgical center charges where the fee cannot be determined under (1) or (2) above, the fee shall be based on 150% of the Medicare grouper rate.

The Board of Trustees reserves the right under extenuating circumstances to pay an amount greater than the fee determined under subsections (1), (2), (3) and (4) above.

X. **Union** means the Pipe Fitters’ Association, Local Union 597.

Y. **Welfare Fund and/or Fund** means the Pipe Fitters’ Welfare Fund, Local 597.

Z. **Other Terms**

Additional terms are defined within the Plan at the corresponding Section.

Terms	Section
1. Accidental Death and Dismemberment (AD&D) Benefit	5.01
2. Accumulation Account.....	2.01
3. Active Employee Benefits.....	2.01
4. Automatically Reimbursable Eligible Expenses	3.04
5. Available for Work in the Industry	2.03
6. Benefit Quarters	2.01
7. COBRA Continuation Coverage.....	2.03
8. Comprehensive Major Medical Expense Benefit.....	7.01
9. Continued Eligibility.....	2.01
10. Covered Expenses	7.08
11. Death Benefit	4.01
12. Dental Expense Benefit.....	10.01
13. Eligible Expenses	3.05
14. Eligibility Hours.....	2.01
15. Employee Assistance Program Benefit.....	12.02
16. Failure to Report Premium.....	2.04
17. Hearing Aid Benefit	14.01
18. Hospice Benefit.....	15.01
19. Hospital Confinement	8.02
20. Industry Expansion Program.....	2.01
21. Initial Eligibility	2.01
22. Lifetime Reserve	8.02
23. Mail Order Program	9.05

24.	Medicare’s Approved Charge	8.02
25.	Medicare’s Limiting Charge	8.02
26.	Non-Covered Employment	2.03
27.	Premium for Substantially Employed Disability Pensioners	2.04
28.	Prescription Drug Benefit	9.01
29.	Qualified Medical Child Support Order.....	2.01
30.	Reimbursable Expense Period.....	3.02
31.	Reinstatement of Eligibility	2.01
32.	Related Employment Premium	2.04
33.	Related Plan	2.01
34.	Retail Card Program.....	9.04
35.	Retired Employee Coverage	2.02
36.	Routine Physical Exam Benefit	13.02
37.	Schedule of Benefits	1.01
38.	Standard Premium.....	2.04
39.	Step-Therapy	9.08
40.	Supplemental Medical Benefits	8.01
41.	Surviving Spouse Medical Benefits	2.05
42.	Vision Care Expense Benefit	11.01
43.	Weekly Accident and Sickness Benefit	6.01
44.	Weight Loss Program Benefit.....	13.03
45.	Wellness Expense Benefit.....	13.01

SECTION 21: ADDITIONAL PLAN INFORMATION

21.01 Plan Name.

Pipe Fitters' Welfare Fund, Local 597.

21.02 Board of Trustees.

A Board of Trustees is responsible for the operation of this Fund. The Board of Trustees consists of an equal number of Employer and Union representatives, selected by the Employers and the Union which have entered into collective bargaining agreements relating to this Plan. If you wish to contact the Board of Trustees, you may use the address and the telephone number below:

Board of Trustees of the Pipe Fitters' Welfare Fund, Local 597
45 North Ogden Avenue
Chicago, Illinois 60607
(312) 633-0597

As of January 1, 2008, the Trustees of the Fund are:

Union Trustees	Employer Trustees
Mr. James Buchanan Pipe Fitters' Welfare Fund, Local 597 45 North Ogden Avenue Chicago, Illinois 60607	Mr. John D. Curran Mecon Industries, Inc. 2703 Bernice Road Lansing, Illinois 60438
Mr. Thomas J. Kotel Pipe Fitters' Welfare Fund, Local 597 45 North Ogden Avenue Chicago, Illinois 60607	Mr. Victor W. Giometti Independent Mechanical Industries, Inc. 4455 West Monroe Avenue Chicago, Illinois 60641-2090
Mr. John E. Kuszynski Pipe Fitters' Welfare Fund, Local 597 45 North Ogden Avenue Chicago, Illinois 60607	Mr. Stephen Lamb Mechanical Contractors Association 7065 Veterans Blvd Burr Ridge, IL 60527
Mr. Gregory J. Watson Pipe Fitters' Welfare Fund, Local 597 45 North Ogden Avenue Chicago, Illinois 60607	Mr. Frederick S. Oyer International Piping Systems, Inc. 444 East State Parkway, Suite 123 Schaumburg, Illinois 60173-4538

21.03 Plan Sponsor and Administrator.

The Board of Trustees is the Plan Sponsor and Plan Administrator.

21.04 Plan Numbers.

The Plan number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501.

The Employer Identification Number assigned to the Board of Trustees by the Internal Revenue Service is 36-2141703.

21.05 Agent for Service of Legal Process.

Peter A. Driscoll
Administrative Manager
Pipe Fitters' Welfare Fund, Local 597
45 North Ogden Avenue
Chicago, Illinois 60607

Service of legal process also may be made on the Board of Trustees or any individual Trustee at the above address.

21.06 Fund's Website.

The Fund Office's website can be found by logging onto Pipe Fitters Local 597 website, www.pf597.org, and following the links to the Benefit Funds and then to the Welfare Plan. Once you have reached this Fund's website, you may access various forms and information about this Plan.

21.07 Source of Contributions.

The benefits described in this Welfare Fund booklet are provided through Employer contributions, retiree self-payments, self-payments made under COBRA and self-payments made by widows of participants. The amount of Employer contributions and the Employees on whose behalf contributions are made are determined by the provisions of the collective bargaining agreements. The amount of COBRA contributions is determined by the Trustees.

21.08 Collective Bargaining Agreement.

The Fund is maintained in accordance with a collective bargaining agreement between Mechanical Contractors Association (MCA) and the Pipe Fitters' Association, Local 597 U.A. Other agreements may be in effect from time to time. The agreements specify the contributions required.

The Fund Office will provide you, upon written request, information as to whether a particular Employer is contributing to this Fund on behalf of participants working under a collective bargaining agreement or a list of participating Employers.

21.09 Trust Fund.

All assets are held in Trust for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses. All of the benefits are provided on a self-funded basis.

The Fund's assets are managed by professional asset managers selected by the Board of Trustees.

21.10 Discretionary Authority of Fund Administrator.

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

21.11 Plan Year.

The records of the Plan are kept separately for each plan year. The plan year is the calendar year that begins on January 1 and ends on December 31.

21.12 Type of Plan.

This Plan is maintained for the purpose of providing accidental death and dismemberment, disability, medical, dental, vision, wellness, prescription drug, hearing aid, hospice and employee assistance benefits to participants in the event of death, Sickness or Accident. The Plan benefits are shown in the applicable Schedules of Benefits in Section 1 of this booklet.

21.13 Gender.

Except as the context may specifically require otherwise, use of the masculine gender will be understood to include both masculine and feminine genders.

21.14 Assignment.

No participant, Dependent or beneficiary entitled to any benefits under this Welfare Plan shall have the right to assign, alienate or impair in any manner his legal or beneficial interest, or any interest in assets of the Welfare Fund, or benefits of this Welfare Plan. Neither the Welfare Fund nor any of the assets thereof, shall be liable for the debts of any participant, Dependent or beneficiary entitled to any benefits under this Plan, nor be subject to attachment or execution or process in any court action or proceedings.

Notwithstanding the above, the Fund shall pay benefits to the service provider on behalf of a participant and/or a Dependent upon authorization of such payment by the execution of a claim form assignment statement and if the Physician or supplier agrees to accept the Usual and Customary Charge as the full charge for the items or services provided (except co-payments and deductibles). The Fund does not guarantee the legal validity or effect of such assignment.

21.15 Amendment and Termination.

You do not earn a vested right to health benefits. The Trustees expressly reserve the right, in their sole discretion, acting in accordance with the provisions of the Trust Agreement regarding Trustee acts, to amend or terminate the Plan in whole or in part at any time.

The Plan may be terminated under circumstances allowed by ERISA and the terms of the governing Trust Agreement. If the Trustees amend or terminate the Plan, they will notify you in writing of the changes that are made to your coverage.

21.16 HIPAA.

A. Privacy Policy.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice. The privacy notice is available from the Fund Administrator.

This Plan and the Plan Sponsor, will not use or further disclose information ("protected health information") that is protected by HIPAA, except as necessary for treatment, payment, health plan operations and plan administration or as permitted or required by law. In particular, the Fund 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 Fund also hires professionals and other companies to assist it in providing health care benefits. The Fund will require all of its business associates to also observe HIPAA's privacy rules.

You will have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You will also have the right to file a complaint with the Fund 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 Fund maintains a privacy notice, that provides a complete description of your rights under HIPAA's privacy rules. Please contact the Fund Office if:

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

B. HIPAA Security Procedures.

The Fund will comply with the security regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. 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 protected health information ("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.

The above HIPAA Security Procedures do not apply to PHI (1) that the Plan receives pursuant to an appropriate authorization (as described in 45 C.F.R. § 164.504(f)(1)(ii) or (iii)) or (2) that qualifies as Summary Health Information and that the Fund receives for the purpose of either (a) obtaining premium bids for providing health insurance coverage under the Plan or (b) modifying, amending or terminating the Plan (as authorized under 45 C.F.R. §164.508). Unless defined otherwise in the Plan booklet, all capitalized terms in this provision have the definition given to them by the Security Regulations which are incorporated herein by reference.

21.17 The Fund's Use and Disclosure of Your Protected Health Information.

A. How the Fund Uses and Discloses Your Protected Health Information.

The Fund will use your PHI to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Fund will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

The Fund 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 Fund will disclose PHI to the Pipe Fitters' Retirement Fund, Local 597, reciprocal benefit plans or workers' compensation insurers for purposes related to administration of those plans.

B. Definition of Payment.

Payment includes activities undertaken by the Fund to determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

1. Determination of eligibility, coverage and cost sharing amounts (e.g., cost of a benefit, Plan maximums and co-payments as determined for an individual's claim);
2. Coordination of benefits;
3. Adjudication of health benefit claims (including appeals and other payment disputes);
4. Subrogation of health benefit claims;
5. Establishing Employee contributions;
6. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
7. Billing, collection activities and related health care data processing;
8. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant (and their authorized representatives') inquiries about payments;
9. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

10. Medical necessity reviews, or reviews of appropriateness of care or justification of charges;
11. Utilization review, including precertification, preauthorization, concurrent review and retrospective review;
12. Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
13. Reimbursement to the Fund.

C. Definition of Health Care Operations.

Health Care Operations include, but are not limited to, the following activities:

1. Quality assessment;
2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;
3. Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;
4. Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies;
7. Business management and general administrative activities of the entity, including, but not limited to:
 - a. management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;
 - b. customer service, including the provision of data analyses for policyholders, Plan Sponsors, or other customers;
 - c. resolution of internal grievances; and
 - d. due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.

D. The Fund's Disclosure of Protected Health Information to the Board of Trustees.

For purposes of this section the Board of Trustees is the Plan Sponsor. With respect to PHI, the Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by this Summary Plan Description and Plan Document, or as required by law;
2. Ensure that any agents, including a subcontractor to whom the Plan Sponsor provides PHI received from the Fund, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
3. Not use or disclose the information for employment-related actions and decisions unless authorized by the individual;
4. Not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual;
5. Report to the Fund any use or disclosure of the information of which it becomes aware that is inconsistent with the uses or disclosures provided for in this document;
6. Make PHI available to the individual in accordance with the access requirements of HIPAA;
7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
8. Make the information available that is required to provide an accounting of disclosures;
9. Make internal practices, books and records relating to the use and disclosure of PHI received from the Fund available to the Secretary of HHS for the purposes of determining compliance by the Fund with HIPAA;
10. If feasible, return or destroy all PHI received from the Fund that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

Adequate separation between the Fund and the Plan Sponsor will be maintained. Therefore, in accordance with HIPAA, only the following Employees or classes of Employees will be given access to PHI.

1. The Plan Administrator; and
2. Staff designated by the Plan Administrator.

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

21.18 Statement of ERISA Rights.

As a participant in Pipe Fitters' Welfare Fund, Local 597, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to the following rights.

A. Receive Information About Your Plan And Benefits.

You have the right to:

1. Examine, without charge, at the Plan Administrator's office, all documents governing the Plan. These include insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may assess a reasonable charge for the copies.
3. Receive a summary of the Fund's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

B. Continue Group Health Plan Coverage.

You also have the right to:

1. Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.
2. Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when:
 - a. You lose coverage under the Plan;
 - b. You become entitled to elect COBRA Continuation Coverage; or
 - c. Your COBRA Continuation Coverage ceases.

You must request the certificate of creditable coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

C. Prudent Actions By Plan Fiduciaries.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called

“fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one, including your Employer, your Union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

D. Enforce Your Rights.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Fund and do not receive them within 30 days, you may file a lawsuit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a lawsuit in a court. In addition, if you disagree with the Fund’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file a lawsuit in court. You must exhaust all the Plan’s claims and appeals procedures before filing a lawsuit. If it should happen that Plan fiduciaries misuse the Fund’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file a lawsuit. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

E. Receive Assistance With Your Questions.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or:

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

You may also find answers to your Plan questions, your rights and responsibilities under ERISA and a list of EBSA field offices by contacting the EBSA:

- A. By calling (866) 444-3272;
- B. Sending electronic inquires to www.askebsa.dol.gov; or
- C. Visiting the website of the EBSA at www.dol.gov/ebsa.

APPENDIX A: OFFICE EMPLOYEE ELIGIBILITY FOR LOCAL 597 AFFILIATED ORGANIZATIONS

Full-time Employees of Local 597 affiliated organizations are eligible for benefits under these provisions (“covered”), except for bargaining unit alumni and employees covered by a collective bargaining agreement. Bargaining unit alumni of affiliated organizations are eligible based on the quarterly accumulation account rules in Section 2.01. Employees who have contributions made to a separate medical plan pursuant to a collective bargaining agreement are not eligible to participate in this Plan.

In order to be considered full-time, an employee of a Local 597 affiliated organization must be regularly scheduled to work 32 or more hours per week. Part-time employees are not eligible to participate. Local 597 affiliated organizations include the (1) Pipe Fitters’ Welfare Fund, Local 597, (2) Pipe Fitters’ Retirement Fund, Local 597, (3) Pipe Fitters’ Training Fund, Local 597 and (4) Pipe Fitters’ Association, Local Union 597, U.A.

A. INITIAL ELIGIBILITY.

Covered individuals employed by a Local 597 affiliated organization will be eligible for benefits on the first day of the month following three months of employment. For example, Maria was first employed by an affiliated organization on January 15, 2008, and will complete three months of employment on April 14, 2008; so she is eligible for benefits on May 1, 2008.

B. TERMINATION OF ELIGIBILITY.

Covered individuals who terminate employment with an affiliated organization on or after July 1, 2005, will be eligible for benefits three months following the end of the month in which their employment terminated. For example, Kirk’s last day of employment with an affiliated organization was January 15, 2008. He will continue eligibility through the end of that month and have three additional months of eligibility through April 30, 2008.

C. ELIGIBILITY FOR RETIREE MEDICAL.

If covered, employees of an affiliated organization are eligible for retiree medical benefits under these provisions and not under Section 2.02. Bargaining unit alumni of affiliated organizations will be eligible for retiree medical based on the provisions of Section 2.02. In either case, the retiree medical benefits provided to retired Employees of affiliated organizations are the same as those provided to other eligible retirees as described in Section 1: Schedules of Benefits.

When you retire, you and your eligible Dependents will be eligible for Retired Employee Coverage, if you meet each of the following conditions:

1. You are receiving either, (1) a pension from the Pipe Fitters’ Retirement Fund, Local 597; or (2) a Normal, Early or Disability Pension from The United Association Full-time Salaried Officers and Employees of Local Unions District Councils, State and Provincial Associations Pension Plan.
2. You were eligible for Welfare Plan benefits for the five-year period immediately preceding your retirement.
3. You pay the applicable premium beginning with the month following termination of employment pursuant to the applicable Fund Office procedures.

D. COVERAGE DURING YOUR DISABILITY

If covered, you will continue to be eligible for benefits under the Plan while receiving Weekly Accident and Sickness Disability Benefits. If you exhaust the maximum number of weeks of Weekly Accident and Sickness Disability Benefits and continue to be disabled due to an injury or Sickness that prevents you from performing your job, you will continue to be eligible for benefits under the Plan (1) for the month during which the disability benefits terminate and (2) for up to an additional six months thereafter.

APPENDIX B: BLUECROSS BLUESHIELD OF ILLINOIS DISCLOSURE NOTICE



Blue Cross Disclosure Notice

This Blue Cross Disclosure Notice is being sent to The Pipe Fitters' Welfare Fund, Local 597 participants pursuant to requirements under its PPO contract with Blue Cross.

I. LIMITED BENEFITS FOR NON-PARTICIPATING PROVIDERS

When Covered Persons elect to utilize the services of Non-PPO Provider, benefit payments to such Non-PPO Providers are not based upon the amount billed. The basis of the benefit payment will be determined according to the Welfare Fund's usual and customary fee schedule as provided for under the Welfare Fund's Plan Document ("Plan"). Non-PPO Providers may bill you for any amount up to the billed charge after Blue Cross has paid the Welfare Fund's portion of the bill. PPO Providers have agreed to accept discounted payments for services with no additional billing to you other than applicable coinsurance and deductibles you may owe under the terms of the Plan. You may obtain further information about the whether a particular Provider is a PPO Provider by calling the toll free number on your Blue Cross identification card.

II. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

- A.** All payments by Blue Cross for the benefit of any Covered Person will typically be made by Blue Cross directly to the Provider furnishing Covered Services for which payment is due. Blue Cross is authorized by the Covered Person to make such payments directly to the Providers. In some cases Blue Cross may make payment directly to the Covered Person. However, Blue Cross reserves the right in its sole discretion to pay any benefits that are payable under the terms of the Plan directly to the Provider furnishing Covered Services. All benefits payable to a Covered Person which remain unpaid at the time of the death of the Covered Person will be paid to the estate of the Covered Person.
- B.** Once Covered Services are rendered by a Provider, the Covered Person has no right to request Blue Cross not to pay the Claim submitted by such Provider and no such request by a Covered Person or his agent will be given effect. Furthermore, Blue Cross will have no liability to the Covered Person or any other person because of its rejection of such request.
- C.** Neither the Plan nor a Covered Person's claims for payment of benefits under the Plan are assignable in whole or in part to any person or entity at any time. Coverage under the Plan is expressly non-assignable or non-transferable.

III. COVERED PERSON/PROVIDER RELATIONSHIP

- A.** The choice of a Provider is solely the choice of the Covered Person and Blue Cross will not interfere with the Covered Person's relationship with any Provider.
- B.** It is expressly understood that Blue Cross does not itself undertake to furnish hospital or medical service, but solely to make payment to a Provider for the Covered Services received by Covered Persons. Blue Cross is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to a Covered Person. Professional services which can only be legally performed by a Provider are not provided by Blue Cross. Any contractual relationship between a Provider and Blue Cross shall not be construed to mean that Blue Cross is providing professional service.
- C.** The use of an adjective such as Approved, Administrator or Participating in modifying Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of Approved, Administrator, Participating or any similar modifier or the use of a term such as Non-Approved, Non-Administrator, or Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.
- D.** Each Provider provides Covered Services only to Covered Persons and does not deal with or provide any services to the Welfare Fund.

IV. INFORMATION AND MEDICAL RECORDS

- A.** All Claim information, including but not limited to medical records, received by the Welfare Fund and Blue Cross in the performance of their duties hereunder will be kept confidential and except for reasonable necessary use in connection with the performance of their duties hereunder, the parties shall not disclose such confidential Claim information without the authorization of the Covered Person or as otherwise required or permitted by applicable state and federal law.
- B.** The Fund and Blue Cross shall release to each other information regarding the provision of Covered Services to Covered Persons and copies of records to the extent required or permitted by applicable law including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Any information so obtained by the Employer shall be kept confidential, as required by applicable law.
- C.** It is the Covered Person's responsibility to insure 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 the 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 Blue Cross, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, Blue Cross may furnish similar information and records (or copies of records) to other Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance-type benefits requesting the same. It is also the Covered Person's responsibility to furnish to the Welfare Fund and/or the Blue Cross information regarding the Covered Person becoming eligible for Medicare,

termination of Medicare eligibility or any change in Medicare eligibility status in order that Blue Cross be able to make Claim Payments in accordance with MSP laws.

V. THE BLUE CROSS'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

Blue Cross has contracts with certain Providers (“Blue Cross 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 Blue Cross is a party, including the Covered Persons under the Network Administration Agreement, and that pursuant to the Blue Cross’s contracts with Blue Cross Providers, under certain circumstances described therein, the Blue Cross may receive substantial payments from Blue Cross Providers with respect to services rendered to all such persons for which the Blue Cross was obligated to pay the Blue Cross Provider, or the Blue Cross may pay Blue Cross Providers substantially less than their Claim Charges for services, by discount or otherwise, or may receive from Blue Cross Providers other substantial allowances under the Blue Cross’s contracts with them. The Fund understands that the Blue Cross may receive such payments, discounts and/or other allowances during the term of the Network Administration Agreement and that the compensation to the Blue Cross specified in the Network Administration Agreement reflects the amount of additional consideration expected to be received by the Blue Cross in the form of such payments, discounts or allowances. Neither the Fund nor Covered Persons hereunder 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 such items may be directly or indirectly reflected in the compensation to the Blue Cross pursuant to the terms of the Network Administration Agreement and the maximum amount of benefits payable by the Blue Cross under the Network Administration Agreement and all required deductible and Coinsurance amounts under the Network Administration Agreement shall be calculated on the basis of the Provider’s Eligible Charge less the ADP, unless otherwise directed in writing by the Fund, for Covered Services rendered to a Covered Person, irrespective of any separate financial arrangement between any Blue Cross Provider and the Blue Cross as referred to above.

VI. DEFINITIONS

A. Average Discount Percentage (“ADP”) - means a percentage discount determined by the Blue Cross that will be applied by the Fund to a Provider’s Eligible Charge for Covered Services rendered to Covered Persons by Hospitals and certain other health care facilities for purposes of calculating Coinsurance amounts, deductibles, out-of-pocket maximums and/or any benefit maximums. The ADP will often vary from Claim to Claim. The ADP applicable to a particular Claim for Covered Services is the ADP current on the date the Covered Service is rendered, that is determined by the Blue Cross to be relevant to the particular Claim. The ADP reflects the Blue Cross’s reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with Hospitals and other facilities under circumstances similar to those involved in the particular Claim. (See provisions of the Network Administration Agreement regarding “THE BLUE CROSS’S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS.”) In determining the ADP applicable to a particular Claim, the Blue Cross will take into account differences among Hospitals and other facilities, the Blue Cross’s contracts with Hospitals and other facilities, the nature of the Covered Services involved and other relevant factors. The ADP shall not apply to Eligible Charges when the Covered Person’s benefits under the Blue Cross are secondary to Medicare and/or coverage under any other group program. (See Exhibit

V of the Network Administration Agreement regarding “BLUE CROSS’S AVERAGE DISCOUNT PERCENTAGE TABLE [“ADP TABLE”].”)

- B. Claim** - means notification in a form acceptable to both parties that service has been rendered or furnished to a Covered Person. This notification must set forth in full the details of such service including, but not limited to, the Covered Person’s name, age, sex and identification number, the name and address of the Provider, a specific itemized statement of the service rendered or furnished, the date of service, applicable diagnosis and the Claim Charge for such service.
- C. Claim Charge** - means the amount which appears on a Claim as the Provider’s regular charge for service rendered to a patient, without further adjustment or reduction and irrespective of any separate financial arrangement between the Blue Cross and the particular Provider. (See provisions of the Network Administration Agreement regarding “THE BLUE CROSS’S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS.”)
- D. Claim Payment** - means the benefit calculated by the Blue Cross or the Fund, plus any related Surcharges, upon submission of a Claim determination to the Blue Cross by the Fund or upon a Claim determination by the Fund, in accordance with the benefits specified in the Plan. All Claim Payments shall be calculated on the basis of the Provider’s Eligible Charge for Covered Services rendered to the Covered Person, irrespective of any separate financial arrangement between the Blue Cross and the particular Provider. (See provisions of the Network Administration Agreement regarding “THE BLUE CROSS’S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS.”)
- E. Coinsurance** - means a percentage of an eligible expense that a Covered Person is required to pay toward a Covered Service.
- F. Covered Person** - means the Participant and the Participant’s eligible Dependent(s) as defined in the Plan.
- G. Covered Service** - means a service or supply specified in the Plan for which benefits will be provided.
- H. Hospital** - shall mean a duly licensed institution for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged or similar institutions.
- I. Maximum Allowance** - means the amount determined by Blue Cross which Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Professional Providers, whether Participating or Non-Participating, will be based on the Schedule of Maximum Allowances as amended periodically by the Blue Cross.
- J. Medicare Secondary Payer (“MSP”)** means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implementing regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses, and in some cases, Dependent children. (See Section XVII. of the Network Administration Agreement regarding Medicare Secondary Payer [“MSP”] Provisions.)
- K. Net Claim Payment** - means the net benefit payment calculated by the Fund, upon submission of a Claim, in accordance with the benefits specified in the Plan, plus any

related Surcharges. All Net Claim Payments shall be calculated by the Fund on the basis of the Provider's Eligible Charge for Covered Services rendered to the Covered Person as determined by the Fund, less the ADP as determined by the Blue Cross if applicable, irrespective of any separate financial arrangement between Blue Cross and the particular Provider. (See provisions of the Network Administration Agreement regarding "BLUE CROSS'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS.")

- L. Non-Participating Provider ("Non-PPO Provider")** - means (i) a Hospital or Professional Provider which/who does not have a written agreement with Blue Cross to participate in the PPO, or (ii) a facility which has not been designated by Blue Cross as a Participating Provider.
- M. Participant** - shall have the same meaning as defined in the Fund's Plan.
- N. Participating Provider ("PPO Provider")** - means (i) a Hospital or Professional Provider which/who has a written agreement with the Blue Cross at the time Covered Services are rendered to participate in the PPO, or (ii) a facility which has been designated by Blue Cross as a Participating Provider of Covered Services to Covered Persons under the PPO.
- O. Participating Provider Option ("PPO")** - means a program of health care benefits designed to provide Covered Persons with economic incentives for utilizing designated Providers of health care services.
- P. Professional Provider** - means a Physician, Dentist, Podiatrist, Optometrist, Registered Clinical Psychologist or any Provider designated as a Professional Provider by Blue Cross.
- Q. Provider** - means any Hospital, health care facility, laboratory, person or entity duly licensed to render Covered Services to a Covered Person or any other provider of medical services, products or supplies which are Covered Services.
- R. Provider's Eligible Charge** - means (a) in the case of a Provider which has a written agreement with Blue Cross to provide care to Covered Persons at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider which does not have a written agreement with Blue Cross to provide care to Covered Persons at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services, not to exceed the reasonable charge therefore as reasonably determined by Blue Cross.
- S. Surcharges** - means state or federal taxes, surcharges, or other fees paid by Blue Cross which are imposed upon or resulting from the Network Administration Agreement.

VIII. ADDITIONAL DEFINITIONS

- A. ERISA** - shall mean the Employee Retirement Income Security Act of 1974, as amended.
- B. Inpatient** - means the Covered Person is a registered bed patient and treated as such in a Hospital or health care facility.
- C. Outpatient** - means the Covered Person is treated while not an Inpatient.