Pipe Fitters' Welfare Fund, Local 597

Summary Plan Description and Plan Document

2021 Edition

PIPE FITTERS' WELFARE FUND, LOCAL 597

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(ADMINISTRATOR AS DEFINED BY LAW)

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CONSULTANT

The Segal Company

CERTIFIED PUBLIC ACCOUNTANTS

Legacy Professionals LLP

A MESSAGE FROM THE BOARD OF TRUSTEES

We are pleased to provide you with this updated booklet describing your health benefits under the Pipe Fitters' Welfare Fund, Local 597 ("Welfare Fund"), effective November 1, 2021, unless otherwise indicated. Although this booklet is meant to be an easy-to-understand description of your Plan benefits, it also serves as the Plan Document and the Plan's official rules and regulations.

Important terms used throughout this booklet are capitalized and defined. 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 REMINDERS

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.

PLAN VENDOR INFORMATION AS OF NOVEMBER 1, 2021

The **Fund Office** is responsible, under the oversight of the Board of Trustees of the Welfare Fund ("Trustees"), for providing various administrative services for the Plan, including maintaining eligibility records, ensuring that Plan provisions are followed on the payment of claims, handling member requests for information and for providing various reports and other services that the Plan requires. Please visit www.pf597.org/benefits/welfare-fund/welfare-fund for information regarding your benefits and to access additional links and services that you may find useful. You may also contact the Fund Office at (312) 633-0597 for any questions regarding your benefits or eligibility.

The **Preferred Provider Organization (the "PPO" or "network")** provides access to medical providers offering discounted fees in exchange for the Plan's reimbursement of their services at a higher level than for non-network providers. ***The Trustees selected Blue Cross and Blue Shield of Illinois ("BCBSIL") as the Plan's PPO for medical benefits***. The Blue Cross/Blue Shield ID card is accepted by an extremely wide range of Hospitals, Physicians and other health care providers who have agreed to participate in the network program. Please call BCBSIL at (800) 810-2583 or visit www.bcbsil.com to identify PPO providers.

The **Pharmacy Benefit Manager ("PBM")** provides access to pharmacies and mail order services offering discounted prices for covered Prescription Drugs. ***The Trustees selected Express Scripts to provide the Plan's preferred Prescription Drug coverage.*** The Express Scripts identifying information is included on the front of your BCBSIL ID card so that you are able to use the same card that provides access to medical services in order to access participating pharmacies for the purchase of covered Prescription Drugs. Please call Express Scripts at (877) 567-5547 for Active Employees and (877) 603-1028 for Retirees. You can also visit www.express-scripts.com for more information.

The **Family Wellness Centers** provide a broad scope of primary care services, routine annual exams and screenings, select laboratory services, chronic condition coaching, health screenings and health coaching at no cost to you or your Dependents (if eligible under the Plan). The Family Wellness Centers are staffed by experienced Physicians, registered nurses, medical assistants and physical therapists. For more information or to set up an appointment for services, please call the Family Wellness Centers at (708) 326-6270 (Mokena location) or (219) 472-4077 (Indiana location) or visit www.marathon-health.com.

The **Case Management Organization** helps you and the Welfare Fund reduce costs and wasteful expenses by reviewing, authorizing and certifying certain medical procedures, admissions and other medical expenses. ***The Trustees selected Medical Cost Management Corporation ("MCM") to provide case management services***. Please contact MCM for more information at (800) 367-9938.

The **Dental Preferred Provider Organization ("PPO")** provides access to dental providers offering discounted fees. ***The Trustees selected Delta Dental of Illinois ("Delta Dental") to provide the Plan's Dental PPO***. Please call Delta Dental at (800) 323-1743 or visit www.deltadentalil.com for more information.

The **Vision Benefit** is exclusively provided through a contract with a vision network that provides access to vision providers offering discounted prices for covered expenses under the Plan. ***The Trustees selected Eye-Med to provide Vision Benefits.*** Please call Eye-Med at (866) 723-0514 or visit www.eyemed.com for more information about the Vision Benefit.

The **Telemedicine Benefit Provider** provides access to Physicians and behavioral health specialists for consults in non-emergency situations by phone, mobile app, or online video. ***The Trustees selected MDLIVE through Blue Cross Blue Shield of Illinois to provide telemedicine services***. Telemedicine services are available 24 hours a day, 7 days a week by calling (888) 676-4202, texting 635843, visiting MDLIVE.com/BCBSIL or downloading the MDLIVE app. MDLIVE is not an exclusive provider for telemedicine services. You may still receive telemedicine services from other providers (not MDLIVE), which will be covered at the levels set forth in the applicable Schedule of Benefits.

The **Death Benefit** is provided through an insurance carrier and paid in accordance with the terms of the applicable policy. ***The Trustees selected Dearborn Life to provide the Death Benefit***. Please call the Fund Office for further information regarding the terms and limitations of this policy.

The **Employee Assistance Program ("EAP")** provides assistance with a variety of work and life issues, including mental health and substance abuse care to participants and their families. ***The Trustees selected CuraLinc, LLC to provide EAP services.*** EAP services are available 24 hours a day, 365 days a year by calling (888) 881-LINC (5462) or by visiting www.supportlinc.com with the user name: Pipe Fitters Local 597.

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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.

1.01 Schedule of Benefits for Active Employees.

Death Benefit	
Active Employees	$50,000
Accidental Dismemberment Benefit	
For loss of:	
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
Weekly Accident and Sickness Disability Benefit	
Weekly Benefit Amount	$350 per week for a maximum of 26 weeks

Medical Benefit		
Plan Deductibles for Covered Medical Expenses		
Calendar Year Deductible (Does not apply to Preventive Services)	\$500 per person \$1,500 per family	
Medical Benefit Out-of-Pocket Maximum	***PPO Charges***	***Non-PPO Charges***
Once you reach the out-of-pocket maximum, the Fund pays 100% of any additional Covered Medical Expenses, up to any specific Plan maximums, for the remainder of the calendar year. The out-of-pocket maximum does not include the Non-PPO Deductible Amount; Non-PPO Physical, Speech, Occupational Therapy Co-Payments above the 40 visit limit; Dental Benefit Payments (except for payments related to Diagnostic and Preventive Services for a Dependent child under age 19); Vision Benefit Payments; or Prescription Drug Co-Payments Expenses that apply towards the Non-PPO out-of-pocket limits apply towards the PPO out-of-pocket limits and vice versa.	\$1,950 per person \$5,850 per family	\$5,000 per person
Covered Medical Expenses Subject to Maximums		
Spinal Manipulation and Naprapathy Services	20 visits per person per calendar year (for covered individuals age 16 and older)	
Skilled Nursing Care	60 days per person per confinement	
Outpatient Physical/Speech Therapy	40 visits per person per calendar year (combined total for both physical and speech therapy), subject to Medically Necessary review (After 40 visits, Fund pays 75% and Participant pays 25%)	
Outpatient Occupational Therapy	40 visits per person per calendar year, subject to Medically Necessary review (after 40 visits, Fund pays 75% and Participant pays 25%)	
Infertility Treatment (Participant and Dependent spouse only)	\$20,000 per lifetime (for no more than two cycles to achieve conception)	
Genetic Testing	\$2,500 per person per calendar year \$10,000 per lifetime	

Medical Benefit		
Covered Medical Expenses Paid by the Fund up to the UCR Charges	***PPO Charges***	***Non-PPO Charges***
Physician Office Visit	85%	75%
Specialist Office Visit	85%	75%
Telemedicine Services	85%	75%
Telemedicine Services through the Plan's Telemedicine Benefit Provider	85%	Not Covered
Preventative Services	100%	75%
Emergency Room Services	85%	85%
Emergency Medical Transportation	85%	75%
Hospital/Facility	85%	75%
Mental and Nervous Disorders	85%	75%
Chemical Dependency/Substance Abuse	85%	75%
Spinal Manipulation and Naprapathy	85%	75%
Outpatient Physical/Speech Therapy	85%	75%
Outpatient Occupational Therapy	85%	75%
Skilled Nursing Care	85%	75%
Durable Medical Equipment	85%	75%
Infertility Treatment (Participant and Dependent spouse only)	85%	75%
Genetic Testing	85%	75%
TMJ Medical Services	85%	75%
Laser Eye Surgery (LASIK) for Participants with at least five years of participation	$500 per eye per lifetime	
Home Birth Services		
Expenses up to $3,500	100%	100%
Balance over $3,500	85%	75%
All Other Covered Medical Expenses	85%	75%

Prescription Drug Benefit		
Out-of-Pocket Maximum per Calendar Year (excluding prescription narcotics (narcotic agonists) and charges for specialty drugs under the Copayment Assistance Program)	\$5,000 per person \$5,000 per family	
Maximum Benefits paid under the Prescription Drug Benefit		
Infertility Treatment (Participant and Dependent spouse only)	\$10,000 per lifetime	
Your Co-Payment Amount	***Retail (34-day supply)***	***Mail (90-day supply)***
Generic	\$10	\$20
Preferred Brand	20% (\$25 minimum)	20% (\$50 minimum)
Non-Preferred Brand	30% (\$45 minimum)	30% (\$90 minimum)
Specialty (co-insurance)	Retail or Mail Order Co-Payments Apply	
Your Co-Payment for prescription narcotics (narcotic agonists) is always 20% if greater than the minimum Co-Payment amount and is not subject to any out-of-pocket maximum.		

Dental Benefit			
Covered Expenses Paid by the Fund	***Delta Dental PPO Charges***	***Delta Premier Charges***	***Non-Participating Charges***
Maximum Benefit per Calendar Year	\$2,500 per person (does not apply to Dependent children under age 19 for Diagnostic and Preventive services)		
Diagnostic and Preventive Services	100% of PPO amount	100% of maximum approved fee	100% of UCR Charges
All Other Covered Services	80% of PPO amount	80% of maximum approved fee	80% of UCR Charges

Orthodontia Care under the Dental Benefit			
Covered Expenses Paid by the Fund	***Delta Dental PPO Charges***	***Delta Premier Charges***	***Non-Participating Charges***
Maximum Benefit per Calendar Year	$2,000 per person per lifetime		
Covered Services	100% of PPO amount	100% of maximum approved fee	100% of UCR Charges
Orthodontia for Children under age 19 meeting or exceeding a score of 42 from the modified Salzmann index or as Medically Necessary as determined by Utilization Review	80% of PPO amount	80% of maximum approved fee	80% of UCR Charges

Vision Benefit		
Your Co-Payment Amount (Once Every Calendar Year)	***PPO Charges***	***Non-PPO Charges***
Exam with Dilation as Necessary	$0 Co-Payment	$0 Co-Payment for eligible Dependents under age 19 Balance over $40 for Participants and eligible Dependents over age 19
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	Balance over $110
Disposable	$0 Co-Payment, $150 allowance	Balance over $110
Frames	80% of balance over $150	Balance over $110 for frame, lenses and options

Vision Benefit		
Your Co-Payment Amount (Once Every Calendar Year)	***PPO Charges***	***Non-PPO Charges***
Standard Plastic Lenses Single Vision Bifocal Trifocal	 $0 Co-Payment $0 Co-Payment $0 Co-Payment	Not Covered
Lens Options UV Coating Tint (Solid and Gradient) Standard Scratch Resistance Standard Polycarbonate Standard Anti-Reflective Coating Standard Progressive (Add-on to Bifocal) Other Add-Ons and Services	 $15 Co-Payment $15 Co-Payment $15 Co-Payment $40 Co-Payment $45 Co-Payment $65 Co-Payment 20% Off Retail Price	Not Covered
Employee Assistance Program (EAP)		
Counseling with EAP Staff Members	No charge for up to five sessions of counseling per problem, situation or issue	
Wellness Benefits		
Covered Expenses paid by the Fund up to UCR Charges	***PPO Charges***	***Non-PPO Charges***
Physical Exam (and specified lab tests)	100%	Not Covered
Weight Watchers (Participant and Dependent spouse only)	$8 monthly Co-Payment per person for digital only membership $19 monthly Co-Payment per person for digital and workshops membership	
Hearing Aid Benefit		
Covered Expenses paid by the Fund up to UCR Charges	***PPO Charges***	***Non-PPO Charges***
Benefit Amount (hearing aid and exam)	100% up to $900 per ear	
Frequency Limit	One per ear for any 36 consecutive month period	

Hospice Benefit		
Covered Expenses paid by the Fund up to UCR Charges	***PPO Charges***	***Non-PPO Charges***
Benefit Amount	85%	75%

1.02. Schedule of Benefits for Pre-Medicare Retirees.

Death Benefit		
Pre-Medicare Retirees	$10,000	
Medical Benefit		
Plan Deductibles for Covered Medical Expenses		
Calendar Year Deductible (Does not apply to Preventive Services)	$500 per person $1,500 per family	
Medical Benefit Out-of-Pocket Maximum	***PPO Charges***	***Non-PPO Charges***
Once you reach the out-of-pocket maximum, the Fund pays 100% of any additional Covered Medical Expenses, up to any specific Plan maximum, for the remainder of the calendar year. The out-of-pocket maximum does not include the Non-PPO Deductible Amount; Non-PPO Physical, Speech, Occupational Therapy Co-Payments above the 40 visit limit; Dental Benefit Payments (except for payments related to Diagnostic and Preventive Services for a Dependent child under age 19); Vision Benefit Payments; or Prescription Drug Co-Payments. Expenses that apply towards the Non-PPO out-of-pocket limits apply towards the PPO out-of-pocket limits and vice versa.	$1,950 per person $5,850 per family	$5,000 per person
Covered Medical Expenses Subject to Maximums		
Spinal Manipulation and Naprapathy Services	20 visits per person per calendar year (for covered individuals age 16 and older)	
Skilled Nursing Care	60 days per person per confinement	
Outpatient Physical/Speech Therapy	40 visits per person per calendar year (combined total for both physical and speech therapy), subject to Medically Necessary review (after 40 visits, Fund pays 75% and Participant pays 25%)	
Outpatient Occupational Therapy	40 visits per person per calendar year, subject to Medically Necessary review (after 40 visits, Fund pays 75% and Participant pays 25%)	
Infertility Treatment (Participant and Dependent spouse only)	$20,000 per lifetime (for no more than two cycles to achieve conception)	
Genetic Testing	$2,500 per person per calendar year $10,000 per lifetime	

Medical Benefit		
Covered Expenses Paid by the Fund up to the UCR Charges	***PPO Charges***	***Non-PPO Charges***
Physician Office Visit	85%	75%
Specialist Office Visit	85%	75%
Telemedicine Services	85%	75%
Telemedicine Services through the Plan's Telemedicine Benefit Provider	85%	Not Covered
Preventive Services	100%	75%
Emergency Room Services	85%	85%
Emergency Medical Transportation	85%	75%
Hospital/Facility	85%	75%
Mental and Nervous Disorders	85%	75%
Chemical Dependency/Substance Abuse	85%	75%
Spinal Manipulation and Naprapathy	85%	75%
Outpatient Physical/Speech Therapy	85%	75%
Outpatient Occupational Therapy	85%	75%
Skilled Nursing Care	85%	75%
Durable Medical Equipment	85%	75%
Infertility Treatment (Participant and Dependent spouse only)	85%	75%
Genetic Testing	85%	75%
TMJ Medical Services	85%	75%
Home Birth Services		
Expenses up to $3,500	100%	100%
Balance over $3,500	85%	75%
All Other Covered Medical Services	85%	75%

Prescription Drug Benefit		
Out-of-Pocket Maximum per Calendar Year (excluding prescription narcotics (narcotic agonists) and charges for specialty drugs under the Copayment Assistance Program)	\$5,000 per person \$5,000 per family	
Maximum Benefits Paid under the Prescription Drug Benefit		
Infertility Treatment (Participant and Dependent spouse only)	\$10,000 per lifetime	
Your Co-Payment Amount	***Retail (34-day supply)***	***Mail (90-day supply)***
Generic	\$10	\$20
Preferred Brand	20% (\$25 minimum)	20% (\$50 minimum)
Non-Preferred Brand	30% (\$45 minimum)	30% (\$90 minimum)
Specialty (co-insurance)	Retail or Mail Order Co-Payments Apply	
Your Co-Payment for prescription narcotics (narcotic agonists) is always 20% if greater than the minimum Co-Payment amount and is not subject to any out-of-pocket maximum.		

Dental Benefit			
Covered Expenses Paid by the Fund	***Delta Dental PPO Charges***	***Delta Premier Charges***	***Non-Participating Charges***
Maximum Benefit	\$1,500 per person per calendar year except for Diagnostic and Preventative Services provided to Dependents under the age of 19		
Diagnostic and Preventive Services	100% of PPO amount	100% of maximum approved fee	100% of UCR Charges
All Other Covered Services	80% of PPO amount	80% of maximum approved fee	80% of UCR Charges

Vision Benefit		
Your Co-Payment Amount (Once Every Calendar Year)	***PPO Charges***	***Non-PPO Charges***
Exam with Dilation as Necessary	$0 Co-Payment	$0 Co-Payment for eligible Dependents under age 19 Balance over $40 for Participants and eligible Dependents over age 19
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	Balance over $110
Disposable	$0 Co-Payment; $150 allowance	Balance over $110
Frames	80% of balance over $150	Balance over $110 for frame, lenses and options
Standard Plastic Lenses		
Single Vision Bifocal Trifocal	$0 Co-Payment $0 Co-Payment $0 Co-Payment	Not Covered
Lens Options		
UV Coating Tint (Solid and Gradient) Standard Scratch Resistance Standard Polycarbonate Standard Anti-Reflective Coating Standard Progressive (Add-on to Bifocal) Other Add-Ones and Services	$15 Co-Payment $15 Co-Payment $15 Co-Payment $40 Co-Payment $45 Co-Payment $65 Co-Payment 20% off Retail Price	Not Covered

Employee Assistance Program (EAP)		
Counseling with EAP Staff Members	No charge for up to five sessions of counseling per problem, situation or issue	
Wellness Benefits		
Covered Expenses paid by the Fund up to UCR Charges	***PPO Charges***	***Non-PPO Charges***
Physical Exam (and specified lab tests)	100%	Not Covered
Weight Watchers (Participant and Dependent spouse only)	$8 monthly Co-Payment per person for digital only membership $19 monthly Co-Payment per person for digital and workshops membership	
Hearing Aid Benefit		
Covered Expenses paid by the Fund up to UCR Charges	***PPO Charges***	***Non-PPO Charges***
Benefit Amount (hearing aid and exam)	100% up to $900 per Ear	
Frequency Limit	One per Ear for any 36 Consecutive Month Period	
Hospice Benefit		
Covered Expenses paid by the Fund up to UCR Charges	***PPO Charges***	***Non-PPO Charges***
Benefit Amount	85%	75%

1.03. Schedule of Benefits for Medicare Retirees.

Death Benefit			
Medicare Retirees	$10,000		
Supplemental Medical Benefit			
Amounts Payable During any Hospital Confinement	***Amount Paid by Medicare in 2021***	***Amount Paid by Participant in 2021***	***Amount Paid by Fund***
First 60 Days	Amounts over $1,484	$832	$652
61st Day Through 90th Day	Amounts over $371 per day	$133 per day	$238 per day
91st Day Until End of Lifetime Reserve	Amounts over $742 per day	$266 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%
Skilled Nursing Facility			
First 20 Days	100%	0%	0%
21st Day Through 100th Day	Amounts over $185.50 per day	$66.50 per day	$119 per day
Prescription Drug Benefit			
Out-of-Pocket Maximum per Calendar Year (excluding charges for specialty drugs under the Copayment Assistance Program)	$2,500 per person per calendar year		
Your Co-Payment Amount	***Retail (31-day supply)***	***Retail (90 day supply)***	***Mail (90-day supply)***
Generic	Greater of $5 or 20%	Greater of $15 or 20%	Greater of $10 or 20%
Preferred Brand	Greater of $15 or 20%	Greater of $45 or 20%	Greater of $30 or 20%
Non-Preferred Brand	Greater of $30 or 20%	Greater of $90 or 20%	Greater of $60 or 20%
Specialty (co-insurance)	20%		

Dental Benefit			
Covered Expenses Paid by the Fund	***Delta Dental PPO Charges***	***Delta Premier Charges***	***Non-Participating Charges***
Maximum Benefit	$1,500 per person per calendar year except for Diagnostic and Preventive Services provided to Dependents under the age of 19		
Diagnostic and Preventive Services	100% of PPO amount	100% of maximum approved fee	100% of UCR Charges
All Other Covered Services	80% of PPO amount	80% of maximum approved fee	80% of UCR Charges

Vision Benefit		
Your Co-Payment Amount (Once Every Calendar Year)	***PPO Charges***	***Non-PPO Charges***
Exam with Dilation as Necessary	$0 Co-Payment	$0 Co-Payment for eligible Dependents under age 19 Balance over $40 for Participants and eligible Dependents over age 19
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	Balance over $110
Disposable	$0 Co-Payment; $150 allowance	Balance over $110
Frames	80% of balance over $150	Balance over $110 for frame, lenses and options
Standard Plastic Lenses		
Single Vision Bifocal Trifocal	$0 Co-Payment $0 Co-Payment $0 Co-Payment	Not Covered

Vision Benefit		
Your Co-Payment Amount (Once Every Calendar Year)	***PPO Charges***	***Non-PPO Charges***
Lens Options UV Coating Tint (Solid and Gradient) Standard Scratch Resistance Standard Polycarbonate Standard Anti-Reflective Coating Standard Progressive (Add-on to Bifocal) Other Add-Ones and Services	 $15 Co-Payment $15 Co-Payment $15 Co-Payment $40 Co-Payment $45 Co-Payment $65 Co-Payment 20% off Retail Price	Not Covered
Employee Assistance Program (EAP)		
Counseling with EAP Staff Members	No charge for up to five sessions of counseling per problem, situation or issue	
Wellness Benefits		
Covered Expenses paid by the Fund up to UCR Charges	***PPO Charges***	***Non-PPO Charges***
Weight Watchers (Participant and eligible spouse)	$8 monthly Co-Payment per person for digital only membership $19 monthly Co-Payment per person for digital and workshops membership	

SECTION 2: ELIGIBILITY

2.01 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 for contributions received from a Related Plan. A 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, Continuing 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 the Initial Eligibility Requirements.

Example of Pro-Rated Hours from a Related Plan:

Bruce works 1,000 hours for an Employer who contributes $8.00 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 $11.60 per eligible hour for Welfare Plan benefits. After the Fund Office receives the $8,000.00 ($8.00 x 1,000 hours) in contributions from the Related Plan, Bruce's Accumulation Account would then be credited with 689.66 Eligibility Hours ($8,000/$11.60 = 689.66).

B. Benefit Quarters

Eligibility for Active Employee Benefits is offered in three-calendar-month intervals, called Benefit Quarters. Benefit Quarters end on each 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 subsequent Benefit Quarter if you have the necessary Eligibility Hours in your Accumulation Account.

C. Initial Eligibility Requirements

1. General Eligibility Requirements

Except as otherwise provided in this Section 2.01(C), you are 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.

2. Pre-Apprentice Orientation Program

If you are an apprentice who completes the Pre-Apprentice Orientation Program through the Pipe Fitters' Training Fund, Local 597 and are hired by an Employer immediately following completion of the Pre-Apprentice Orientation Program, you are eligible for Active Employee Benefits on the first day of the second month following your completion of the Pre-Apprentice Orientation Program and will be deemed to meet the Initial Eligibility Requirements. Once you have been deemed to meet the Initial Eligibility Requirements under this Section, Active Employee Benefits will continue for the remainder of the current Benefit Quarter and for the entire next Benefit Quarter. Thereafter, you must meet the Continuing Eligibility Requirements to maintain eligibility.

3. United Association (U.A.) Organizing Program

If you are an Employee newly organized through the U.A. Organizing Program who previously performed work within the trade and territorial jurisdiction of the Union for an employer who is not signatory to a collective bargaining agreement with the Union, you will become immediately eligible for Active Employee Benefits on the first day you work for an Employer. You may only gain initial eligibility under this Section once per lifetime.

In order to gain initial eligibility under this Section, you must be able to provide sufficient documentation showing that you were previously working for a non-signatory employer doing work in the trade and territorial jurisdiction of the Union. The determination of whether an Employee is eligible for immediate eligibility under this provision is delegated to the Business Manager of the Union who will report such determination at the following Board of Trustees meeting.

Once you have been deemed to meet the Initial Eligibility Requirements under this Section, Active Employee Benefits will continue for the remainder of the current Benefit Quarter and for the entire next Benefit Quarter. Thereafter, you must meet the Continuing Eligibility Requirements to maintain eligibility.

4. Industry Expansion Program

The Welfare 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 Welfare Fund.

The Industry Expansion Program applies to Employees of an 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:

a. Whether granting qualified status will advance the economic security of the industry and thus, the Welfare Fund.

b. 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.

c. Whether the Employer maintained health care coverage for Employees prior to becoming a signatory contractor.

d. 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 must meet the Continuing Eligibility Requirements to maintain eligibility in subsequent Benefit Quarters.

D. Continuing Eligibility Requirements

Once you meet the Initial Eligibility Requirements, 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 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

Generally, coverage for you and your Dependents will end on the March 31st, June 30th, September 30th or December 31st (end of the Benefit Quarter) where you do not have 375 hours in your Accumulation Account on the applicable determination date. When your Plan coverage ends, your Dependents' coverage under the Plan (if any) also ends.

However, if you cease work in Covered Employment and continue to work in Industry Employment, your coverage under the Plan will end on the last day of the month in which you work for such Employer even if you have Continuing Eligibility based on your Accumulation Account, and any remaining hours in your Accumulation Account will be forfeited as of the last day of the month in which you work for such Employer.

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 Continuing Eligibility Requirements. 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 Requirements 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 a maximum of 754 credited 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. 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 coverage 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 the 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 Continuing 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 the 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 the 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 the 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.

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

Under the Family and Medical Leave Act of 1993 (FMLA), you must submit an application for leave to your Employer. You or your Employer must submit a copy of the approved application to the Trustees so that your rights to health care coverage are protected during your leave.

During your absence, you will continue to receive coverage under the Plan. If you return to work for an Employer within the FMLA guidelines, 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 elect COBRA Continuation Coverage. Contact the Fund Office for additional information about your coverage during FMLA leave or continuing your coverage under COBRA.

You have the right to take unpaid leave for certain situations if you meet the following criteria:

1. You worked for the same Employer for at least 12 months;

2. You 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.

The duration of leave available to you will depend upon the reasons for which you are taking the leave, and you should confirm details with your Employer.

1. You may qualify for up to 12 weeks (during any 12-month period) of unpaid leave for your own serious illness, the birth or adoption of a child, to care for a seriously ill spouse, parent or child or qualifying exigency to deal with the affairs of your spouse, child, or parent because he or she is called to covered active military duty. A qualifying exigency includes short-notice deployment, military events and related activities, childcare and school activities, financial and legal arrangements, counseling, rest and recuperation, post-deployment activities and additional activities as defined under the FMLA in 29 CFR Part 825.

2. You may qualify for up to 26 weeks (during any 12-month period) of unpaid leave to care for a covered service-member with a serious injury or illness incurred while on covered active military duty if the Employee is the spouse, child, parent or next of kin of the service-member as defined under the FMLA in 29 CFR Part 825. However, please be aware that this 26-week leave is the maximum time period allowed and is not in addition to the 12-week leave provided above.

2.02 Retiree Benefits

A. General Eligibility Requirements

When you retire, you and your Dependents will be eligible for Retiree Benefits if you meet the following requirements:

1. You are receiving a pension from:

   a. The Pipe Fitters' Retirement Fund, Local 597; or

   b. A defined benefit pension plan sponsored by the Union; or

   c. A defined benefit pension plan sponsored by the Gary Community School Corporation or the School City of Hammond and you have a total of at least 25 years of coverage under the Plan; and

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 self-payment for Retiree Benefits after the run-out of your Accumulation Account; and

4. You authorize any applicable Retiree self-payment(s) to be deducted from your monthly pension benefit 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 self-

payment, you must pay the difference in order to be eligible for Retiree Benefits. Note that in order to cover your Dependents, you must be enrolled in Retiree Benefits.

B. Accumulation Account Eligibility

An Employee who retires, is eligible for Retiree Benefits and has sufficient hours in his Accumulation Account to meet the Continuing Eligibility Requirements, will be considered a Retiree for purposes of Coordination of Benefits. The benefits for a Retiree who has sufficient hours in his Accumulation Account to meet the Continuing Eligibility Requirements will be based on the Active Employee Schedule of Benefits for as long as the hours in his Accumulation Account provide eligibility. Thereafter, the benefits for a Retiree will be based on the applicable Retiree Schedule of Benefits.

C. Retiree Self-Payments

A Retiree self-payment is a payment that you are required to make to maintain your eligibility for Retiree Benefits.

1. Standard Retiree Premium

If an eligible Retiree self-pays for himself and two Dependents, no additional self-payment is required for the Welfare Fund to cover additional Dependents. 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 Retiree Benefits.

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 to an Active Employee on COBRA.

However, depending on your employment status, the Standard Retiree 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.

The Standard Retiree Premium does not include the separate monthly premium for Dental and Vision Benefits.

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

a. General Provisions

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 Union's 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 Retiree Premium for Retiree Benefits while you are engaged in Non-Covered Employment. After your Accumulation Account balance runs out, you will receive Retiree Benefits 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 Premium 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 Retiree 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.

b. 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.

c. 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:

i. During the remainder of your Non-Covered Employment, you will be charged the applicable premium as follows: (1) the Standard Retiree Premium, if the Accumulation Account applies or (2) the Related Employment Premium, if the Accumulation Account does not apply.

ii. 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 Retiree 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 being charged the lower Standard Retiree 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.

3. 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 Retiree Premium for Retiree Benefits 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 Retiree 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 Retiree Premium will be determined each September 1 thereafter. The higher premium rate 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 Retiree Premium will be charged beginning the following September 1. Thereafter, the lower Standard Retiree 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 Retiree Premium for Retiree Benefits regardless of the amount of his or her Social Security earnings.

4. Premium for Retiree Dental and Vision Coverage

If you want to receive Dental and Vision Benefits after your retirement, you must pay a separate monthly premium for such coverage, as described herein. The Dental and Vision Benefit Premium is separate and distinct from the other Retiree Premiums under the Plan (including the Standard Retiree Premium, Related Employment Premium, and the Premium for Substantially Employed Disability Pensioners). The Dental and Vision Benefits are optional, but you cannot elect the Dental and Vision Benefits separately from the Medical Benefit. You also cannot elect only the Dental Benefit or only the Vision Benefit.

To receive Dental and Vision Benefits at the time of your retirement, you must authorize the Fund in writing to deduct the Dental and Vision Benefit Premium from your monthly pension benefit check from the Pipe Fitters' Retirement Fund, Local 597. If the amount you receive from your monthly pension benefit check is not sufficient to cover the Dental and Vision Benefit Premium, you must pay the difference to be eligible for Dental and Vision Benefits under the Plan. The amount of the Dental and Vision Benefit Premium is determined by the Trustees and is subject to prospective change at any time.

5. Failure to Make Timely Self-Payment

If you do not pay the applicable Retiree premiums, you and your Dependents' eligibility for Retiree Benefits will terminate, and you will not be allowed to re-enroll at a later date, unless you regain coverage as an Active Employee.

D. Medical and Prescription Drug Benefits Available after Retirement

Retiree Benefits under the Plan consist of Pre-Medicare Retiree Benefits and Medicare Retiree Benefits.

1. Pre-Medicare Retiree Benefits

If you are eligible for Retiree Benefits and you are not entitled to Medicare, you may receive Pre-Medicare Retiree Benefits. Pre-Medicare Retiree Benefits generally consist of the same benefits provided to Active Employees and their Dependents, except for the Weekly Accident and Sickness Disability Benefit and the Accidental Dismemberment benefit which are excluded.

2. Medicare Retiree Benefits

If you are eligible for Retiree Benefits and you are entitled to Medicare, you may receive Medicare Retiree Benefits. Medicare Retiree Benefits consist of the Supplemental Medical Benefit and the Prescription Drug Benefit.

The Supplemental Medical Benefit supplements benefits payable by 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. Ancillary Benefits after Retirement

You may also receive Dental and Vision Benefits after your retirement, provided you pay the separate monthly premium for such coverage. The Dental and Vision Benefits are optional, but you cannot elect the Dental and Vision Benefits separately from the Medical Benefit. You also cannot elect only the Dental Benefit or only the Vision Benefit.

F. Spousal Opt-Out

Generally, if you do not pay the applicable Retiree self-payment, you and your eligible Dependents' coverage will terminate and you will not be allowed to re-enroll at a later date. However, if your eligible Dependent spouse is receiving medical benefits as a result of his/her current employment, you

may defer covering your spouse under this Plan until his or her employment-based coverage terminates. After your Dependent 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.

G. If You Return to Work After Retirement

If you are eligible for Retiree Benefits and you return to work in Covered Employment, you will continue to be eligible to make self-payments for Retiree Benefits until you become eligible for Active Employee Benefits. You will be eligible for Active Employee Benefits if you satisfy the Initial Eligibility Requirements. 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 Retiree Benefits.

H. When Retiree Benefits End

Retiree Benefits under the Plan are not vested and will not vest at any time. Accordingly, your coverage will terminate on the earliest of the date:

1. You stop meeting the Retiree eligibility requirements under the Plan;
2. You fail to submit a timely Retiree self-payment;
3. You die;
4. The Trustees discontinue Retiree Benefits; or
5. The Trustees terminate the Plan.

2.03 Dependent Eligibility

A. Dependents' Initial Eligibility

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

1. The date you are eligible for coverage; or
2. The date he or she meets the definition of a Dependent under the Plan.

B. When Dependent Coverage Ends

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

1. The date your eligibility ends for reasons other than your death;
2. The date he or she no longer meets the definition of a Dependent under the Plan;
3. The date your Dependent fails to submit a timely self-payment (if applicable);
4. The date the Trustees terminate Dependent benefits under the Plan; or

5. The date the Trustees terminate the Plan.

C. Surviving Dependent Coverage

If you die while you are eligible under the Plan, your Dependents' eligibility will continue until the date the latest of the following events occurs:

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

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

Once those benefits are exhausted, your surviving Dependents may elect COBRA Continuation Coverage or, if applicable, Surviving Spouse Medical Benefits.

D. Surviving Dependent Medical Benefits

As an alternative to COBRA Continuation Coverage, your surviving spouse and Dependent children may elect Surviving Dependent Medical Benefits under certain circumstances.

1. Eligibility for Surviving Dependent Medical Benefits

Your surviving spouse and Dependent children may be able to purchase Surviving Dependent Medical Benefits if each of the following conditions are met: (1) you die while covered as an Active Employee or Retiree, (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.

A surviving Dependent child is only eligible for Surviving Dependent Medical Benefits if and for so long as the surviving spouse is eligible for Surviving Dependent Medical Benefits. A surviving spouse must elect Surviving Spouse Medical Benefits for a surviving Dependent child to elect such benefits.

If the above listed conditions are met, your surviving spouse and Dependent children will have three months to make a one-time election to purchase this coverage. If any surviving Dependent declines coverage, or fails to make timely payment for such coverage, this option terminates and will not be offered again.

However, if at the time of your death, your surviving Dependent: (1) meets the eligibility requirements for surviving Dependent coverage; (2) has his/her own coverage under an employer sponsored group health plan; and (3) does not elect coverage within the three month period, he or she will be allowed to elect coverage under the Plan upon the termination of his or her employer sponsored group health plan, provided that he or she applies for coverage under the Plan within 90 days of the date the other coverage ends.

For Example:

Paul dies in early 2020. At the time of his death, his wife Ellen is 62 years old, is eligible for a surviving spouse benefit from the Pipe Fitter's Retirement Fund, Local 597 and is covered under

her employer's health plan. She does not elect Surviving Dependent Medical Benefits at the time of Paul's death. In September of 2020, Ellen is laid off and her coverage under her employer sponsored group health plan terminates on October 31, 2020. If she applies for coverage under the Plan on or before January 31, 2021, and makes the requisite self-payments, she may obtain coverage under the Plan's Surviving Dependent Medical Benefit.

2. Premiums for Surviving Dependent Medical Benefits

The premiums for the Surviving Dependent Medical Benefit depend on whether the surviving spouse is eligible for Medicare.

a. Benefits Prior to Medicare Entitlement

The Surviving Dependent Medical Benefit prior to Medicare is the same benefit provided to Dependent spouses and Dependent children of Pre-Medicare Retirees and includes the Prescription Drug Benefit. 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. Effective January 1, 2022, the amount charged will be equal to the Standard Retiree Premium.

b. Benefits After Medicare Entitlement

The Surviving Dependent Medical Benefit after Medicare entitlement is the same benefit provided to Dependent spouses and Dependent children of Medicare Retirees and includes the Prescription Drug Benefit. 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. Effective January 1, 2022, the amount charged will be equal to the Standard Retiree Premium.

3. Termination of Eligibility

Surviving Dependent Medical Benefits will terminate on the earliest of the following dates:

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

b. Remarriage of the surviving spouse;

c. With respect to a surviving Dependent child, the date he or she ceases to meet the Plan's definition of a Dependent;

d. With respect to a surviving Dependent child, the date of the surviving spouse's death; or

e. With respect to a surviving Dependent child, the date the surviving spouse no longer receives the Surviving Dependent Medical Benefit.

E. 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 QMSCO 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 for the purposes of 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.

2.04 COBRA Continuation Coverage

A. General Provisions

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 and prescription drug; or (2) medical, prescription drug and HRA. You can add dental coverage and vision coverage to either option. COBRA coverage does not include the following: Death Benefit, Accidental Dismemberment and Weekly Accident and Sickness Disability Benefit.

If you elect COBRA Continuation 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. Marketplace Coverage

There may be other coverage options for you and your family. For example, you may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. You should review your options under the Marketplace and compare them with the Plan's COBRA Continuation Coverage to determine which option is best for you and your family.

If you have any questions about your rights to COBRA Continuation Coverage, you should contact the Fund Office. For information on the Marketplace, please visit www.healthcare.gov.

C. 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.

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:

a. Your death;

b. Your divorce or legal separation;

c. You reaching eligibility for Medicare; or

d. Your Dependent child no longer qualifies as a Dependent under the terms of the Plan.

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.

4. Second Qualifying Event

If your eligible Dependent experiences a second Qualifying Event (as listed above) while receiving COBRA Continuation Coverage during the first 18 months of coverage, he or she may be entitled to receive an additional 18 months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event is timely and properly provided to the Fund Office. This extension is available only if the second Qualifying Event would have caused your Dependent to lose coverage under the Plan had the first Qualifying Event not occurred.

D. COBRA Premiums

1. Standard COBRA Premium

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

2. COBRA Premium for Employees Who Are 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 an 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.

3. COBRA Premium for Apprentices Actively Available for Employment Based on Training Fund Records

a. COBRA Apprentice Premium Rates

The Plan offers COBRA Continuation Coverage at a reduced rate for apprentices who are actively available for employment based on the Training Fund's records. The COBRA premium for apprentices shall be a percentage of the full COBRA premium based on the apprentice's class as follows:

1st Year Apprentice	40% of full COBRA premium
2nd Year Apprentice	55% of full COBRA premium
3rd Year Apprentice	65% of full COBRA premium
4th Year Apprentice	78% of full COBRA premium

b. Subsidized COBRA Premium for Apprentices

A subsidized COBRA premium is established during the first six months of COBRA for apprentices who are actively available for employment based on the Training Fund's records. The subsidized COBRA premium for apprentices shall be determined as follows: 50% of the reduced rate listed above depending on the class of apprentice.

After the six-month period has elapsed, the apprentice will be charged the reduced premium listed above depending on his apprenticeship class.

For Example:

Third year apprentice, Tom, is actively available for employment based on the Training Fund's records and eligible for COBRA. The October 2021 COBRA premium rate is $1,447.00. Therefore, Tom's subsidized COBRA premium would be calculated as follows: 65% x 1/2($1,447.00) = $470.28.

After six months, Tom would be required to pay the apprentice COBRA premium rate of 65% of the full COBRA premium. 65% x $1,447.00 = $940.55. If Tom continues COBRA Continuation Coverage into his 4th year as an apprentice, the 4th year rates above would apply.

4. COBRA Premium for Employees Unable to Work Due to Non-Work-Related Accident or Sickness

A subsidized COBRA premium is established during the first six months of COBRA Continuation Coverage for Employees who are unable to work as a result of an Accident or Sickness that is not work-related. 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.

E. COBRA Payments and Due Dates

COBRA payments must be made monthly to the Fund Office. The initial COBRA payment is due 45 days after the date the COBRA election is made. Each subsequent payment is due on or before the first day of each month but will be considered timely if the payment is received within 30 days of the due date.

If a COBRA payment is not received by the Fund Office within the time limits specified above, COBRA Continuation Coverage will be terminated retroactive to the last day of the month in which a timely COBRA premium payment was made. Once this coverage is terminated due to a missed payment, no benefits will be reinstated under COBRA Continuation Coverage.

F. 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.

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

G. Electing COBRA 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 other eligible Dependents who were covered by the Plan on the date of the Qualifying Event.

4. The person electing COBRA 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 COBRA 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.

H. 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 otherwise terminated under the Plan.

I. When COBRA Coverage Ends

COBRA Continuation Coverage may end for any of the following reasons:

1. You or your Dependent becomes covered under another group health 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;

2. The required premium is not timely paid;

3. The Trustees terminate the Welfare Plan;

4. 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;

5. Your coverage under the Plan ends and you become entitled to 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

6. Your Dependents become entitled to Medicare after their coverage under the Plan ends.

SECTION 3: HEALTH REIMBURSEMENT ARRANGEMENT FOR ACTIVE EMPLOYEES

3.01 General Provisions and Eligibility

The Plan provides a Health Reimbursement Arrangement (HRA) if you are eligible for Active Employee Benefits, but you can continue to utilize your HRA so long as you are eligible for coverage under the Plan (for example, if you are eligible for Retiree Benefits). An HRA is a notional account established on your behalf when contributions are received under a Collective Bargaining Agreement or participation agreement. An HRA contribution will not be made for any amounts received as COBRA self-payments or Retiree self-payments, and no contributions will be made to your HRA if you are not performing work covered under a Collective Bargaining Agreement or participation agreement.

You may only utilize your HRA if you are otherwise eligible for coverage under the Plan. If you lose your coverage under the Plan, then you may no longer utilize your HRA (e.g., request reimbursement from your HRA balance). Your HRA balance will remain inaccessible until the earlier of the date you reestablish your eligibility for coverage under the Plan, or your HRA is forfeited in accordance with Section 3.09.

3.02 Description of HRA

The Fund Office keeps track of your HRA as a bookkeeping entry. The HRA bookkeeping entry is adjusted at the discretion of the Trustees. The Trustees have determined to make adjustments to the HRAs based on assets in which the HRA balances are invested ("HRA Investment Fund"). The Trustees manage and control all assets of the HRA Investment Fund.

The HRA Investment Fund is valued at fair market value once a year. As of the valuation date, each HRA will be adjusted for the net earnings, losses, appreciation, depreciation and forfeitures that have occurred since immediately preceding the valuation date. The adjustments allocated to your HRA will be in the same ratio as the ratio of the value of your HRA balance to the total value of all assets of the HRA Investment Fund as of the valuation date.

If the Fund issues a reimbursement check to you from your HRA for an Eligible Expense, your HRA balance will be reduced by the amount of such reimbursement. Your HRA balance will be carried over from year to year, except as specified below in Section 3.09.

3.03 No Vesting of HRAs

HRAs are not savings accounts from which you can withdraw at will. You and your Dependents are not vested in your HRA. Amounts accumulated in your HRA can only be used for Eligible Expenses, subject to the rules and provisions set forth in this Section.

Benefits payable under the HRA shall not be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment or encumbrance of any kind, except as required under applicable law.

3.04 Maintaining Coverage and Your HRA

In the event you are going to lose eligibility under the Plan and you have a balance in your HRA, you may contact the Fund Office to deduct the amount of the applicable self-payment (for example, Retiree or COBRA Continuation Coverage self-payments) from your HRA to continue your coverage under the Plan until your HRA is exhausted.

3.05 Eligible Expenses and Reimbursements

A. Entitlement to Reimbursement

Your entitlement to reimbursement from your HRA and the amount of any such reimbursement will be based on your HRA balance at the time the reimbursement is requested. You may receive reimbursement from your HRA only for Eligible Expenses. An expense is an Eligible Expense if it satisfies the following four requirements:

1. The expense is incurred on or after June 1, 2017;

2. The expense is incurred by an eligible individual while covered under the Plan, including any periods during which coverage is extended because of any applicable self-payments;

3. The expense is not payable under any other benefit provisions of the Plan; and

4. The expense is a "qualified medical expense" under Section 213(d) of the Internal Revenue Code (IRC). See subsections B and C below for more details on what constitutes a qualified medical expense.

B. Eligible Expenses

To be an Eligible Expense, the expense must be a "qualified medical expense" under Section 213(d) of the IRC. Examples of a "qualified medical expense" include the following:

1. Self-payments, including Retiree and COBRA Continuation Coverage self-payments;

2. Deductibles and Co-Payments under the Plan;

3. Medical expenses not covered by or in excess of the benefits provided under the Medical Benefit;

4. Expenses for dental treatment, including orthodontia;

5. Guide dogs for blind or deaf persons;

6. Certain travel expenses of the patient when necessary to receive essential medical care, and the travel and lodging expenses of another family member whose presence is necessary for the treatment. The patient's Physician must certify that the family member's presence is necessary for the treatment;

7. Special telephone and television equipment for hearing-impaired persons;

8. Hearing aids and examinations;

9. Smoking cessation programs;

10. Vision expenses, including surgery or laser treatments to correct vision;

11. Schooling for the mentally impaired or physically disabled;

12. Acupuncture;

13. Prescriptions and over-the-counter medications; provided that such items are accompanied by a written prescription and generally accepted as medicine and drugs. Such items shall not include toiletries, sundries or cosmetics; and

14. Weight loss programs, but not food or dietary supplements.

C. Exclusions

No reimbursement will be made from your HRA for expenses that are not listed as "qualified medical expenses" in Section 213(d) of the IRC. Examples of expenses that are not covered include the following:

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

2. School fees for boarding schools or school fees not related to a medical necessity;

3. Cosmetic surgery, procedures and supplies;

4. Child and elder care;

5. Funeral expenses;

6. Hair transplants;

7. Household help other than that qualifying as long-term care;

8. Personal use items;

9. Premiums for coverage through a state or federal Health Insurance Marketplace;

10. Teeth whitening; and

11. Expenses not identified as Eligible Expenses above.

3.06 Submitting Reimbursement Requests

Reimbursements from your HRA are subject to the following requirements:

A. HRA reimbursement requests may be submitted at any time; however, such requests are limited to once per calendar quarter.

B. The minimum amount to request reimbursement is $100. You may accumulate numerous Eligible Expenses in order to reach the $100 minimum and submit them together.

C. You must submit an HRA reimbursement request with a properly completed request form to the Fund Office, and HRA reimbursement request forms are available from the Fund Office. Reimbursement requests must include a copy of the explanation of benefits (EOB), itemized bills or any other documentation as required by the Trustees.

D. HRA reimbursement requests can only be submitted by you or by your spouse pursuant to your written authorization on file at the Fund Office or, in the event you are deceased, by your surviving spouse or Dependent. HRA reimbursement requests may not be submitted by a former spouse, and an HRA balance is not subject to division pursuant to a domestic relations order under the preemption provisions of ERISA Section 514.

E. HRA reimbursement requests must be submitted no more than twelve (12) months after the date the expense was incurred. No reimbursement will be provided for a request that is submitted more than twelve (12) months after the date the expense was incurred. Note that the expense is incurred on the date you received services or items for which you were charged the expense, not the date of payment or invoicing.

3.07 Reimbursements

Upon receipt of an HRA reimbursement request for an Eligible Expense, the Fund Office will issue you a reimbursement check. This check will generally be issued within thirty (30) days of your request for the amount of the Eligible Expense, up to, but not to exceed the amount of your HRA balance. Once the check has been issued, the Fund Office will deduct the amount of such reimbursement from your HRA balance.

If you submit a request for reimbursement and your HRA balance is insufficient to cover the requested reimbursement, the request will not be processed, and you will be notified by mail of this situation. You will have the option of: (1) providing written authorization for partial reimbursement (up to your HRA balance); or (2) resubmitting the reimbursement request at a later date when your HRA balance has increased (but no later than twelve (12) months after the date the expense was incurred). If you authorize a partial reimbursement, you cannot submit an HRA reimbursement request for the balance of the expense that was partially reimbursed at a later date.

3.08 Your Right to Opt-Out

You may choose to permanently opt-out of your HRA and forfeit your right to reimbursement from your HRA at any time by notifying the Fund Office in writing. Any balance in your HRA as of the date the Fund Office receives notice of such opt-out will be permanently forfeited. Any notice of opt-out received by the Fund Office is irrevocable.

3.09 Forfeiture of HRA Balance

Your HRA balance will be forfeited in the following situations:

A. No contributions have been made into your HRA and no reimbursements have been made for a period of two (2) consecutive calendar years.

B. The Fund Office receives at any time written notice that you opt-out of the HRA.

C. You die and you have no surviving spouse or Dependent.

D. Your coverage under the Plan is terminated due to work in Industry Employment.

3.10 Payment of HRA Balance upon Your Death

If you die and there is a balance in your HRA, your surviving spouse or Dependent(s) may use your HRA balance by submitting reimbursement requests to the Fund Office for reimbursement of Eligible Expenses as long as your surviving spouse or Dependent(s) are otherwise eligible for coverage under the Plan. Any remaining HRA balance not reimbursed to your surviving spouse or Dependent(s) will be forfeited if the account has no reimbursement activity for a period of two (2) consecutive calendar years.

If you die and you have no surviving spouse or Dependent(s), your HRA balance, if any, will be forfeited.

SECTION 4: HEALTH REIMBURSEMENT ARRANGEMENT FOR RETIREES

4.01 General Provisions and Eligibility

You are eligible for the Health Reimbursement Arrangement (HRA) for Retirees only if you meet the following requirements:

1. You are receiving a monthly pension benefit from the Pipe Fitters' Retirement Fund, Local 597;

2. You are eligible for Retiree Benefits under the Plan; and

3. Your birth date is before June 1, 1962 **OR** you retired with a disability pension from the Pipe Fitters' Retirement, Fund, Local 597 before November 2, 2017.

This HRA is separate and distinct from the Health Reimbursement Arrangement for Active Employees as described in Section 3 of the Plan.

4.02 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. Reimbursable Expense Periods begin on November 1 and end the following October 31.

4.03 Account Funding, Reimbursement for Expenses and Opt-Out

A. Account Credits

Each November 1, your HRA will be credited if you are eligible to receive your November pension check from the Pipe Fitters' Retirement Fund, Local 597. This means that you must be alive on November 1 for your HRA to be credited.

For Example:

On August 1, Bob's HRA balance was $0. Bob receives a notice telling him that his HRA will be credited on November 1 and he will be sent a reimbursement for his Eligible Expenses. Bob passes away on October 25 before his HRA is credited on November 1. Because Bob is not alive on November 1, his HRA will not be credited and no reimbursement is available.

The amount credited will be determined by multiplying $60 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 receive from the Pipe Fitters' Retirement Fund, Local 597.

B. Reimbursement for Expenses

Some time prior to your HRA being credited, your Automatically Reimbursable Eligible Expenses identified in Section 4.04 and incurred during the Reimbursable Expense Period will be totaled and you will receive a letter stating the amount of your annual reimbursement and the anticipated date of receipt.

If, however, your Automatically Reimbursable Eligible 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 4.05.

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.

C. Your Right to Opt-Out

You may choose to permanently opt-out of your HRA and forfeit your right to reimbursement at any time by notifying the Fund Office in writing. Any balance in your HRA as of the date the Fund Office receives notice of such opt-out will be permanently forfeited. Any notice of opt-out received by the Fund Office is irrevocable.

4.04 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 Drug 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.

4.05 Eligible Expenses

Eligible Expenses are "qualified medical expenses" under Section 213 of the Internal Revenue Code (IRC) that you and/or your eligible spouse incur which are not Automatically Reimbursable Eligible Expenses as defined in Section 4.04. Examples of a "qualified medical expense" include 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 <u>not</u> 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 to 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.

4.06 Payment of Benefits Upon the Retiree's Death

If there is a balance in your HRA on the date of your death, 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. Such claims may be submitted at any time but no more than once per calendar quarter. The remaining HRA 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 Dependent(s), your HRA balance, if any, will be forfeited.

Additionally, your HRA balance will be forfeited if your surviving spouse (or if there is no surviving spouse, your Dependents) loses coverage under the Plan (including COBRA Continuation Coverage), unless he or she is able to establish that he or she is covered under another employer sponsored group health plan that meets the Patient Protection and Affordable Care Act of 2010 (ACA) requirements of integrated coverage.

SECTION 5: DEATH BENEFIT

5.01 Eligibility for Death Benefit

If you are eligible for Active Employee Benefits or you are covered under the medical benefit Plan as a retired Employee, your coverage includes the Death Benefit. The amounts of the Death Benefit are provided in the Schedule of Benefits. The Death Benefit will be paid to your beneficiary in the event of your death regardless of the cause of death. Your beneficiary must submit a claim form for benefits and proof of your death.

The Trustees contracted with an insurance carrier to provide this Death Benefit and the benefit will be paid in accordance with the terms of the policy, which is incorporated by reference into this booklet. In the event of a conflict between the terms of this booklet and the policy for Death Benefits, the terms of the policy govern. If you wish to receive a copy of the terms and limitations, please contact the Fund Office.

5.02 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 or if you have not designated a beneficiary, your Death Benefit will be 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 6: ACCIDENTAL DISMEMBERMENT BENEFITS

6.01 Eligibility for Accidental Dismemberment Benefits

If you are eligible for Active Employee Benefits, your coverage includes the Accidental Dismemberment 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.

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.

6.02 Limitations on Accidental Dismemberment Benefits

The Accidental Dismemberment Benefit does 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 18.

SECTION 7: WEEKLY ACCIDENT AND SICKNESS DISABILITY BENEFITS

7.01 Eligibility for Weekly Accident and Sickness Disability Benefits

If you are eligible for Active Employee Benefits, your coverage includes the Weekly Accident and Sickness Disability Benefit. Retirees and those covered under COBRA Continuation Coverage are not eligible for this benefit.

To be eligible to receive the Weekly Accident and Sickness Disability Benefit, you must be disabled due to an Accident or Sickness that prevents you from performing your job and you must be under the care of a Physician.

7.02 Payment of Weekly Accident and Sickness Disability Benefits

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.

Benefits are paid for a maximum of 26 weeks for any one period of disability. For each week you are paid benefits under this Section, the Fund will credit you with hours necessary to continue your Active Employee Benefits under the Plan. However, please be aware that if you are on FMLA leave and are receiving benefits under this Section, you will either be credited with FMLA hours or Weekly Accident and Sickness hours, but not both.

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.

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.

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.

7.03 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:

David is disabled due to an Accident on December 18, 2020. On Monday, December 21, 2020, the first business day after the Accident, he begins receiving Weekly Accident and Sickness Disability Benefits for 26 weeks through June 21, 2021. John returns to work and suffers a second disability due to a Sickness on July 19, 2021. On Monday, July 26, 2021, the fifth working day after his Sickness begins, he begins receiving benefits. He receives these benefits for a three week period from July 26, 2021, through August 16, 2021. 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 22, 2026.

7.04 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 18, then you are not entitled to Weekly Accident and Sickness Disability Benefits under the Plan.

7.05 Weekly Accident and Sickness Disability Benefits and COVID-19

The Fund will deem a Physician-ordered quarantine related to COVID-19 to qualify as a Sickness, beginning on the date of the Physician's order, that prevents you from performing your job for the purposes of the Weekly Accident and Sickness Disability Benefit. The Physician's order must specify the length of any applicable quarantine.

For COVID-19 related claims, the Weekly Accident and Sickness Benefit will begin on the first business day following the Sickness. Claims for Weekly Accident and Sickness Disability Benefits under this Section do not count as a period of disability for purposes of applying the two periods of disability during any 60-month period limitation.

SECTION 8: MEDICAL BENEFIT FOR ACTIVE EMPLOYEES AND PRE-MEDICARE RETIREES

8.01 Eligibility for Medical Benefit

If you are eligible for Active Employee Benefits or Pre-Medicare Retiree Benefits, your coverage includes the Medical Benefit.

8.02 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 amounts of the individual and family deductibles are listed in the Schedule of Benefits.

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.

8.03 Percentage of Benefits Payable

Once you pay the calendar year deductible, the Fund will pay the percentage of your Covered Medical Expenses listed in the Schedule of Benefits up to the Usual and Customary Fees, and up to any Plan maximums.

8.04 Out-of-Pocket Maximum

The maximum amount you pay for Covered Medical Expenses each calendar year is the out-of-pocket maximum listed in the Schedule of Benefits. Once you reach the applicable out-of-pocket maximum, the Fund pays 100% of any additional Covered Medical Expenses, up to any specific Plan maximums, for the rest of the calendar year.

The family out-of-pocket maximum may be satisfied through any combination of individual out-of-pocket maximums. Once you meet the family out-of-pocket maximum, no further individual out-of-pocket maximum will be applied to any eligible member of your family during the remainder of the calendar year.

8.05 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 network. 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, you 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.

8.06 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.

To ensure you receive the maximum benefits available under the Plan, you should ask your Physician to contact the Fund Office when referring you for services as part of an ongoing treatment plan to determine if such services are subject to case management.

8.07 Covered Medical Expenses and Exclusions

A. Covered Medical 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 as applicable).

2. Medical care and treatment, including surgery, that is listed as a Covered Medical Expense under the Plan and is provided by a legally qualified Physician or other qualified health care professional acting within the scope of his or her licensure as defined by state law.

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, radioactive therapy, magnetic resonance imaging (MRI), positron emission tomography (PET) and computed tomography (CT/CAT) scans.

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. 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.

10. Care provided in a Skilled Nursing Care Facility subject to the limitations provided in the Schedule of Benefits 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 Mental and Nervous Disorders.

12. Treatment for Chemical Dependency/Substance Abuse.

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 treatment plan is submitted or the expense is incurred within 90 days of the Accident.

15. Spinal manipulation and naprapathic services ordered by a provider acting within the scope of his or her license as follows:

    a. Detection, treatment or correction of structural imbalance, subluxation or misalignment of the vertebral column, up to the maximum shown in the applicable Schedule of Benefits when performed by a person licensed by the State to perform such procedures. No benefits are provided for covered individuals under age 16.

    b. Naprapathic services performed by a person licensed by the State to perform such services. Naprapathic services include, but are 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. No benefits are provided for covered individuals under age 16.

16. Organ and bone marrow transplants subject to the following:

    a. If both the donor and recipient are covered under the Plan, each will have their benefits determined separately under the Plan.

    b. If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits will be provided for both you and the donor.

    c. Benefits will be provided for:

i. Inpatient and outpatient services covered under the Plan related to the transplant surgery.

ii. The evaluation, preparation and delivery of the donor organ.

iii. The removal of the organ from the donor.

iv. The transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

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 surgical assistant or surgical technician who assists a Surgeon in performing surgical procedures.

19. Licensed ambulatory surgery center services.

20. Routine well newborn and child care.

21. Routine immunizations.

22. Operating and recovery room charges.

23. Allergy serums.

24. Genetic testing services up to the maximums shown in the applicable Schedule of Benefits, provided there is a Medically Necessary reason for conducting the test. Genetic testing services include, but are not limited to the following:

    a. State-mandated newborn screening tests for genetic disorders;

    b. Testing for a genetic mutation in the BRCA1 and BRCA2 genes;

    c. Covered pregnant woman if the test or procedure is recommended by the American College of Obstetricians and Gynecologists and/or the American Academy of Pediatrics;

    d. Pre-implantation genetic diagnosis (where one or more cells are removed from an embryo and genetically analyzed to determine whether genetic abnormalities are present) in situations where the associated in vitro fertilization procedure is also covered by the Plan;

e. Tests to determine a covered individual's sensitivity to FDA-approved drugs and tests to determine the effectiveness of an FDA-approved drug;

f. Carrier testing for certain genetic disorders (such as Cystic Fibrosis) for covered individuals in any of the following groups:

   i. Couples seeking prenatal care;

   ii. Couples who are planning a pregnancy;

   iii. Persons with a family history of the genetic disorder in question;

   iv. Persons with a first degree relative identified as a carrier; or

   v. Reproductive partners of persons with the genetic disorder in question.

g. The detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics in covered individuals who meet all of the following conditions:

   i. The testing method is considered scientifically valid for identification of a genetically linked inheritable disease;

   ii. The covered individual displays clinical features/symptoms of a genetically linked inheritable diseases, or the covered individual is at direct risk (e.g., family history, first or second degree relative) for the development of a genetically linked inheritable disease (pre-symptomatic); and

   iii. The results of the test will directly impact clinical decision-making, the clinical outcome or the treatment being delivered to the covered individual.

25. Physical therapy which is the treatment of a disease, injury or condition by physical means 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.

26. Occupational therapy which is constructive therapeutic activity 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.

27. Speech therapy which is the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies or previous therapeutic processes 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. 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.

29. 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.

    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.

    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.

    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.

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; and (3) you submit a letter of medical necessity from your doctor.

30. Elective medical and surgical sterilization procedures.

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

32. Applied behavior analysis (ABA) services for the treatment of autism by a provider that is certified and licensed in the state to perform such services in which the services are provided.

33. Laser eye surgery (LASIK) for Active Employees.

34. Medical services for treatment of temporomandibular joint syndrome (TMJ).

35. Bone anchored hearing aids (osseointegrated auditory implants or cochlear implants).

36. Acupuncture.

37. Infertility treatment for participants and their Dependent spouses up to the maximum shown in the applicable Schedule of Benefits. Covered infertility services include, but are not limited to the following:

    a. Artificial insemination;

    b. In-vitro fertilization, intracytoplasmic sperm injection and preimplantation genetic diagnosis provided the following conditions are met:

        i. For a participant whose spouse is of the opposite sex, the participant's oocytes or donor eggs are fertilized with the participant spouse's sperm or donor sperm, unless the spouse is unable to produce and deliver functional sperm or egg, and the inability to produce and deliver functional sperm or egg does not result from a vasectomy or another method of voluntary sterilization;

        ii. The participant and his/her spouse have a history of involuntary infertility, which may be demonstrated by a history of (1) at least two years' duration failing to result in pregnancy when the participant and the spouse are of opposite sexes; or (2) if the participant and his/her spouse are of the same sex, six attempts of artificial insemination over the course of two years failing to result in pregnancy; or

        iii. The infertility is associated with any of the following: (1) endometriosis; (2) exposure in utero to diethylstilbestrol, commonly known as DES; (3) blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or (4) abnormal male factors, including oligospermia, contributing to the infertility.

    c. Fertility preservation treatment, including cryopreservation of reproductive materials (i.e., sperm, oocytes, embryos and ovarian tissue), provided the following conditions are met:

i. The participant and/or spouse has been diagnosed with a disease or condition which causes imminent infertility, such as cancer or Turner's Syndrome; or

ii. The participant and/or spouse's treating physician anticipates iatrogenic (treatment-induced) infertility occurring as the result of Medically Necessary treatment of a separate, non-fertility related diagnosis, such as chemotherapy, pelvic radiotherapy or other surgical procedure expected to render one permanently infertile (i.e., hysterectomy or oophorectomy).

Fertility preservation treatment is only covered for participants and/or spouses who can demonstrate imminent infertility. For the purposes of this Section, imminent infertility means infertility is likely to be diagnosed within one (1) year after the remission of the disease or completion of treatment which caused the infertility. Age-related conditions such as menopause are not considered conditions which cause imminent infertility.

Covered expenses for fertility preservation treatment do not include the costs associated with the storage of reproductive materials.

38. Preventive Services as required by federal law. The list of Preventive Services changes from time to time, so please visit www.healthcare.gov/preventive-care-benefits for a comprehensive list.

39. Charges for "routine patient costs" incurred by a "qualified individual" who is participating in an "approved clinical trial." For purposes of this benefit, the following applies:

    a. A "qualified individual" is someone who is eligible to participate in an "approved clinical trial" and either the individual's doctor has concluded that participation is appropriate, or the Participant provides medical and scientific information establishing that their participation is appropriate.

    b. "Routine patient costs" generally include all items and services that typically would be covered under the Plan for an individual not enrolled in a clinical trial. Routine patient costs do not include the actual device, item or service that is being studied. Also excluded are items and services that are given only to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient; or a service that is clearly consistent with widely accepted and established standards or care for a particular diagnosis.

    c. An "approved clinical trial" means a Phase I, II, III, or IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

40. Telemedicine services as provided for in the Schedule of Benefits.

41. Any procedures or services covered under the Plan as listed above that is rendered by a qualified Physician or other qualified health care professional acting within the scope of his or her licensure as defined by state law.

B. Medical Expenses Not Covered by the Plan

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

1. Services or supplies that are not Medically Necessary, as determined by the Fund.

2. Services or supplies in excess of any maximum benefit or limitation specified in the Plan.

3. Services or supplies that are not specifically listed as a Covered Medical Expense under the Medical Benefit.

4. Services or supplies received by a person, facility or organization acting outside the scope of the applicable license.

5. 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 Medical Expenses for a Skilled Nursing Care Facility.

6. Custodial or long-term care provided in the home.

7. 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 Medical Expenses in Section 8.07(A). Coverage for inpatient and/or out-patient hospitalization in connection with a covered dental procedure is covered as a Covered 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.

8. Eye refractions or the fitting or cost of eyeglasses or contact lenses, other than those required following cataract surgery.

9. Dental services and supplies (including orthodontia) for treatment of temporomandibular joint syndrome (TMJ), except as specifically provided in Section 8.07(A).

10. Prescription Drugs, except those provided when the claimant is an Inpatient in a Hospital, Skilled Nursing Care Facility, or residential treatment facility.

11. Any losses, expenses or charges for cosmetic surgical procedures and related expenses, except:

    a. For the repair of congenital defects of your Dependent child;

    b. For the repair of defects resulting from a surgery, Accident or Sickness; or

    c. For conditions resulting from accidental injuries due to Accidents or Sicknesses, including scars, tumors or diseases that occur.

12. 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).

13. Any expenses or charges for treatment related to sexual dysfunction, unless the Trustees determine that the dysfunction is the result of an Accident or malignancy (including treatment for malignancy).

14. 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.

15. Any expenses or charges for chelation therapy except for acute arsenic, gold, mercury or lead poisoning.

16. Marriage counseling.

17. Travel expenses for health care.

18. Ambulatory surgical center services or doctor's surgery suites that are not licensed by the State in which they operate.

19. Wigs or toupees (except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an Accident or Alopecia), hair transplants or hair weavings.

20. Personal comfort or convenience items. 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.

21. 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 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.

22. Treatment for smoking cessation programs or devices, except as required by federal law or a Preventive Service.

23. 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.

24. Long-term maintenance therapy, work hardening programs, group or individual exercise programs, swimming and/or physical fitness programs.

25. Nutritional counseling, except as required by federal law or a Preventive Service.

26. Special home construction or vehicle modification.

27. Surgical and/or laser correction of refractive errors and refractive keratoplasty procedures including radial keratotomy surgery.

28. 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.

29. Inpatient or outpatient expenses resulting from behavioral problems, conduct disorders, learning disabilities and developmental delays that are not the result of a Mental Illness, except as provided under Section 8.07(A).

30. Any expenses or charges for orthopedic shoes.

31. Hearing aids except as provided under the Hearing Aid Benefit and under Section 8.07(A).

32. Services and supplies for or related to genetic counseling.

33. 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.

34. Charges incurred for special education provided to any individual. This exclusion does not apply to diabetes education as provided in Section 8.07(A).

35. 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.

36. 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.

37. 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 or Preventive Services as provided in Section 8.07(A).

38. Massage therapy, except as required by federal law.

39. Recreational therapy.

40. Hot and cold therapy of any nature.

41. Charges for any of the circumstances listed under the General Plan Exclusions in Section 18.

8.08 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, 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 Medical Benefit ends.

SECTION 9: SUPPLEMENTAL MEDICAL BENEFIT FOR MEDICARE RETIREES

9.01 Eligibility for Supplemental Medical Benefit

You are covered by the Supplemental Medical Benefit if you are eligible for Retiree Benefits, pay the applicable premium, and are eligible for Medicare.

Under the Supplemental Medical Benefit, the Plan supplements the benefits payable under Medicare. The Fund pays benefits only if you are enrolled in Medicare Parts A and B. 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 the Schedule of Benefits. Although Medicare revises the amount of benefits they pay each year, this Plan does not automatically change its benefit level.

9.02 Covered Expenses

The 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 as listed in the Schedule of Benefits.

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%.

9.03 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 18.

SECTION 10: FAMILY WELLNESS CENTERS

10.01 Eligibility for Family Wellness Centers

If you are eligible for Active Employee Benefits or Retiree Benefits, you may access services provided by the Family Wellness Centers.

10.02 Benefits under the Family Wellness Centers

The Family Wellness Centers provide a broad scope of primary care services, routine annual exams and screenings, select laboratory services, chronic condition coaching, health screenings and health coaching at no additional cost to you or your Dependents. The Family Wellness Centers also provide on-site access to select generic drugs.

The Family Wellness Centers are staffed by experienced physicians, registered nurses, medical assistants and physical therapists. The Family Wellness Centers are open Monday through Friday and located at the following addresses:

Mokena Family Wellness Center
10844 W. 187th Street
Mokena, IL 60448
(708) 326-6270

Indiana Family Wellness Center
10090 Georgia Street, Suite 3
Crown Point, IN 46307
(219) 472-4077

Please contact the Family Wellness Centers to schedule an appointment or visit www.marathonhealth.com for more information.

SECTION 11: PRESCRIPTION DRUG BENEFIT

11.01 Eligibility for Prescription Drug Benefit

If you are eligible for Active Employee Benefits or Retiree Benefits, your coverage includes the Prescription Drug Benefit. The benefit amounts are shown in the Schedule of Benefits. 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 the Plan's coordination of benefit rules.

11.02 General Provisions

The Prescription Drug Benefit is administered by a prescription benefit manager (PBM). As a result, the Prescription Drug Benefit is subject to the contractual agreements between the Fund and 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.

11.03 The Retail Pharmacy Program

A. Using a Participating Pharmacy

The Retail Pharmacy Program offers benefits for short-term prescriptions (up to a 31-day or 34-day supply, as applicable). When you become eligible for benefits, you will receive the appropriate identification cards for use 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 maximums described above, in the Schedule of Benefits and in accordance with clinical quantity limits based on usage considered reasonable, safe and effective. 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 Medical Benefit or Supplemental Medical Benefit and does not count toward your Medical Benefit out-of-pocket maximum. Your Co-Payments do, however, count towards your Prescription Drug Benefit out-of-pocket maximum.

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 must pay the full cost of the prescription and then you request a claim form for reimbursement from the PBM or the Fund Office. You will only be reimbursed the amount the Fund normally pays for that prescription minus your Co-Payment.

11.04 Mail Order Program

You may use the Mail Order Program 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 Pharmacy Program, and a 90-day prescription to be submitted to the Mail Order Program.

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 Order Program:

1. Request a new patient home delivery form by calling the PBM or the Fund Office;

2. Complete all required information on the form;

3. Enclose the Physician's prescription for a 90-day supply of medication (and up to three refills);

4. Enclose the Co-Payment, include credit card information on the form, or call the PBM with your credit card information for each prescription, if applicable.

The Mail Order Program will deliver your order to the address you provide. 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 a reasonable amount of time, please call the Mail Order Program's customer service department at the number on your Welfare Fund ID card. This number is also on the mail order form and is available from the Fund Office.

11.05 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. Contraceptives as required by federal law;

E. Insulin on prescription (including test strips, lancets and all diabetic supplies, for all participants and Dependents who are not eligible for Medicare);

F. Needles and syringes on prescriptions;

G. Specialty injectable prescriptions as described herein;

H. Smoking cessation prescriptions as required by federal law;

I. Aerochambers and similar devices used to maximize the delivery of metered-dose inhaler medications into the lungs;

J. Up to six pills of Viagra, Cialis or Levitra per month for the treatment of erectile dysfunction. However, the Plan may temporarily allow a higher quantity with prior authorization from the Plan's PBM; and

K. Federal legend vitamins and minerals.

11.06 Drugs Not Covered

This Prescription Drug Benefit does not cover the following:

A. Over-the-counter medications, except as required under federal law;

B. Investigational or Experimental drugs;

C. Prescription drugs covered under federal, state or local programs, including workers' compensation, for which there is no charge;

D. Medications for sexual dysfunction, inadequacies or enhancements, except as provided in Section 11.05;

E. Amphetamines and/or anorexiants for weight loss;

F. Nutritional supplements, food supplements or substitutes (prescribed or over-the-counter), except as required by federal law;

G. Retin-A, except for the treatment of acne vulgaris;

H. Any item classified as a device or supply through the prescription card program, unless specifically included in Section 11.05;

I. 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;

J. Rogaine or similar drugs and preparations to promote hair growth;

K. Allergy serums;

L. Products indicated for cosmetic use;

M. Drugs covered under Medicare Part B for Medicare Part D Retirees and Dependents;

N. Drugs for any of the circumstances listed under the General Plan Exclusions in Section 18.

11.07 Mandatory Generic Drug Program

If you have a prescription filled with a brand drug when a generic equivalent is available, you will pay the applicable brand drug Co-Payment (Preferred or Non-Preferred) as well as the difference between the cost of the generic and brand drug. The additional amount you pay for having a prescription filled with a brand drug that has a generic equivalent (the cost difference) will **NOT count** toward your Prescription Drug Benefit out-of-pocket maximum.

The generic name of a drug is its chemical name and the brand name is the trade name under which the drug is advertised and sold. Both generic and brand name drugs must meet the same federal requirements for safety, purity and strength.

If you are unsure if there is a generic equivalent for a brand name drug, please contact your Physician, pharmacist or the PBM.

11.08 Specialty Drug Benefits

A. General Provisions

After an initial fill at a retail pharmacy, all specialty injectable Prescription Drugs and ancillary supplies are covered exclusively through the PBM. Specialty oncology drugs, like all other specialty prescriptions, are covered exclusively under the specialty pharmacy except for specialty oncology drugs that are submitted and paid under the Medical Benefit.

Your Co-Payment amounts for Specialty drugs are shown in the Schedule of Benefits. A list of the drugs covered under this 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 non-injectable drugs having one or 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.

B. Copayment Assistance Program

You may be eligible for the Copayment Assistance Program through SaveonSP, an organization that works with Express Scripts. The Copayment Assistance Program helps you and the Plan reduce costs for certain specialty drugs.

Under the Copayment Assistance Program, SaveonSP identifies high-cost specialty drugs that are eligible for copayment assistance through the drug manufacturer. If copayment assistance is available, SaveonSP helps you apply for financial assistance directly from the drug manufacturer. The copayment assistance you receive from the drug manufacturer is expected to completely cover your payment for the specialty drug.

Participation in the Copayment Assistance Program is voluntary. However, if you choose not to participate in the program, you will be responsible for paying a higher copayment, which may vary depending on the specialty medication. Because the specialty drugs under the Copayment Assistance Program are considered non-essential health benefits, your copayment amount will **NOT** count towards any deductible or out-of-pocket maximum under the Plan.

The specialty drugs covered under the Copayment Assistance Program change from time to time. Accordingly, please contact SaveonSP at (800) 683-1074 to request an updated list.

11.09 Prescription Drug Cost Savings Incentive Programs

From time to time the Fund may adopt programs offered by the PBM 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 the Schedule of Benefits.

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

11.10 Prescription Drug Out-of-Pocket Maximum

The maximum amount you pay for expenses under the Prescription Drug Benefit each year is the out-of-pocket maximum listed in the Schedule of Benefits. If you reach this 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. Families can meet the out-of-pocket maximum listed in the Schedule of Benefits without each family member meeting his or her individual out-of-pocket maximum.

SECTION 12: DENTAL BENEFIT

12.01 Eligibility for Dental Benefit

If you are eligible for Active Employee Benefits, your coverage includes the Dental Benefit. If you wish to receive the Dental Benefit after retirement, you must pay a separate monthly premium for such coverage. However, you will only be permitted to receive the Dental Benefit after retirement if you also pay the applicable Retiree self-payment to maintain your medical benefits under the Plan.

12.02 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.

Delta Dental will review the information, estimate the benefits payable under the Plan and return the form to your Dentist.

12.03 Alternate Course of Dental Treatment

In determining the amount of benefits payable, Delta Dental 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 more expensive level of care, you will be responsible for paying any excess cost you incur.

12.04 Percentage of Dental Benefits Payable

The Dental Benefit pays the percentage 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.

12.05 Dental Network

To provide you with the greatest access to the Dentist of your choice, you may seek care from a (1) Delta Dental PPO Dentist, (2) Delta Dental Premier Dentist, or (3) Nonparticipating Dentist.

A. PPO Network

You and your eligible Dependents will receive the greatest discounts if you choose a Dentist in the PPO network. Dentists in the PPO network agree to provide services at fees that are generally lower than those of nonparticipating Dentists.

To minimize your out-of-pocket costs, contact Delta Dental or the Fund Office for information about Dentists in the PPO network. Although you are not required to use a PPO Dentist, you will reduce costs for both you and the Fund when you use a Dentist in the PPO network.

B. Premier Network

While the largest cost savings occurs when you select a Dentist within the PPO network, a second favorable option is to choose a Dentist in the Premier network. The Premier network is larger than the PPO network, giving you more Dentists to choose from, but the Dentists in the Premier network offer lower discounts as compared to the PPO network. Although a Premier Dentist is considered a Non-PPO provider, the Premier Dentist accepts the total of the reimbursement from the Plan and your Co-Payment, if any, as full reimbursement for covered services.

C. Nonparticipating Providers

If you and your Dependents choose a Dentist who is not in the PPO network or Premier network, the nonparticipating Dentist may balance bill you for covered services. Both PPO and Premier Dentists are prohibited from balance billing you for services. You will incur more out-of-pocket costs if you choose a nonparticipating Dentist.

12.06 Covered Dental Expenses

The following list provides examples of covered dental expenses, including services and supplies provided by a Dentist or provided under a Dentist's supervision. ***Please contact Delta Dental for a complete list of covered dental expenses.***

A. Diagnostic and Preventive Services:

1. Two routine oral examinations per calendar year.

2. Two routine prophylaxis treatments by a Dentist or dental hygienist per calendar year.

3. Dental x-ray, when professionally indicated and Medically Necessary. Full-mouth dental x-rays are limited to two times per calendar year.

4. Dental sealants for each Dependent child under the age of 19.

5. One topical application of sodium or stannous fluoride by a Dentist or dental hygienist per calendar year.

6. 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.

B. All Other Covered Services

1. Extractions of teeth (including wisdom teeth) and cutting procedures to the teeth and/or gums, including pre-operative and post-operative care.

2. Anesthetics administered in connection with oral surgery covered under the Dental Benefit.

3. Injections of antibiotic drugs by the attending Dentist.

4. Periodontic treatment and surgery, including periodontal cleaning, scaling and other treatment for diseases of the gums and tissues of the mouth.

5. Endodontic treatment, including root canal therapy and pupal therapy.

6. Emergency treatment for the relief of dental pain when no other treatment is given during the same visit.

7. Fillings, inlays, and crowns. Gold restorations will only be covered if amalgam, silicate or plastic materials will not adequately restore the tooth.

8. 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.

9. Initial installation of a full or partially removable denture, temporary denture or fixed bridgework.

10. Dental (tooth) implants. 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.

11. Dental treatment for temporomandibular joint syndrome (TMJ).

12.07 Orthodontia Care Coverage for Active Employees

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, pursuant to the Schedule of Benefits. Coverage for orthodontia care is not available for you or your Dependents after your retirement.

12.08 Exclusions and Limitations

Benefits shall not be paid by this Plan for any of the following services and supplies. ***Please contact Delta Dental for a complete list of exclusions and limitations.***

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. For services rendered prior to the date you became eligible for benefits;

E. Veneers; or

F. Any of the items listed in the General Plan Exclusions in Section 18.

12.09 Extension of Dental Benefits

Coverage for dental expenses ends when your eligibility under the Plan 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.

SECTION 13: VISION BENEFIT

13.01 Eligibility for Vision Benefit

If you are eligible for Active Employee Benefits, your coverage includes the Vision Benefit. If you wish to receive the Vision Benefit after retirement, you must pay a separate monthly premium for such coverage. However, you will only be permitted to receive the Vision Benefit if you also pay the applicable Retiree self-payment to maintain your medical benefits under the Plan.

13.02 Covered Vision Expenses

The Vision Benefit is provided exclusively through a contract with a vision care network, and the Vision Benefit covers expenses for exams, lenses or contacts and frames provided or ordered by an optometrist or ophthalmologist, up to the maximums shown in the Schedule of Benefits.

13.03 Exclusions and Limitations

No payment will be made under the Vision Benefit for the following expenses:

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 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 18.

SECTION 14: THE EMPLOYEE ASSISTANCE PROGRAM

14.01 Eligibility for Employee Assistance Program

If you are eligible for Active Employee Benefits or Retiree Benefits, your coverage includes the Employee Assistance Program.

14.02 The Employee Assistance Program

The Employee Assistance Program (EAP) provides you and your Dependents with short-term counseling and referrals for a variety of life issues, including without limitation: alcohol and drug abuse; stress, anxiety, and depression; marital, family and relationship discord; child and adolescent behavioral problems; domestic violence; childcare; elder care; financial and legal concerns; and educational and career-related problems. The EAP does not address difficulties related to salaries, job assignments or other work-related issues.

These confidential EAP services were developed to help you and your family cope with personal difficulties that can affect your lives both at home and at work. Persons eligible to use the EAP have access, at no additional charge, to up to five counseling sessions per problem, situation or issue.

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 EAP. Confidentiality is compromised only when a threat to life exists (i.e., suicidal or homicidal risk, stalking or child abuse).

SECTION 15: WELLNESS EXPENSE BENEFIT

15.01 Wellness Expense Benefit

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

15.02 Routine Physical Exam Benefit

A. Eligibility for Routine Physical Exam Benefit

If you are eligible for Active Employee Benefits or Pre-Medicare Retiree Benefits, your coverage includes the Routine Physical Exam Benefit. This benefit applies to you and your Dependent spouse. Medicare Retirees are not eligible for this benefit because they already receive coverage for many of these services through Medicare and the Supplemental Medical Benefit under the Plan.

Please contact the Fund Office or download the wellness postcard from the Fund website and give it to your provider when you visit them for your routine physical exam.

B. Routine Physical Exam Benefit

Under the Routine Physical Exam Benefit, the Fund will pay **100% of Usual and Customary Fees** for the covered services instead of the 85% or 75% generally payable for outpatient services. No deductible or Co-Payments will need to be paid for the services listed below. Any other Medically Necessary tests and services ordered by the Physician are covered under the Medical Benefit and subject to the deductible and coinsurance.

The Trustees strongly encourage you to use a PPO provider for your Routine Physical Exam Benefit. If you do, the covered services will be paid by the Fund at 100%. However, if you go to an out-of-network provider, this amount may be substantially less than the amount charged by your provider. As a result, you may be required to pay charges above the Usual and Customary Fees payable under the Plan.

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.

15.03 Weight Loss Program Benefit

A. Eligibility for Weight Loss Program Benefit

If you are eligible for Active Employee Benefits or Retiree Benefits, your coverage includes the Weight Loss Program Benefit. This benefit applies to you and your Dependent spouse.

B. Weight Loss Program Benefit

The Weight Loss Program Benefit is provided exclusively through Weight Watchers®. The Fund will pay the full cost of the Weight Watchers® program you choose, subject to the Co-Payment and eligibility conditions provided in the Schedule of Benefits. You may enroll in Weight Watchers® online through the link provided on the Fund's website. You will need to provide your first and last name, your billing address and your Union identification number.

SECTION 16: HEARING AID BENEFIT

16.01 Eligibility for Hearing Aid Benefit

If you are eligible for Active Employee Benefits or Pre-Medicare Retiree Benefits, your coverage includes the Hearing Aid Benefit. Medicare Retirees are not eligible for this benefit.

16.02 Hearing Aid Benefit

The Fund provides 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 17: HOSPICE BENEFIT

17.01 Eligibility for Hospice Benefit

If you are eligible for Active Employee Benefits or Pre-Medicare Retiree Benefits, your coverage includes the Hospice Benefit. Medicare Retirees are not eligible for this benefit.

17.02 Hospice Benefit

The Hospice Benefit provides payment for hospice care expenses 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 and are payable pursuant to the Schedule of Benefits.

A. Home Care

Allows patient to receive care in his or her own home. Services and equipment covered 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 8.07(A); and
6. Oxygen and its administration.

B. Outpatient Care

Care that you receive in a licensed medical facility.

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

C. Inpatient Care

Care that you receive while you are an admitted patient in a Hospital or hospice facility.

1. Room and board which may include overnight visits by family;

2. Nursing services;

3. All other related Hospital expenses;

4. Physician services; and

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 covered services 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; and

3. Special incidental services for the patient, such as special dietary requirement, transportation between home and other sites of care.

SECTION 18: GENERAL PLAN EXCLUSIONS

18.01 Exclusions from Coverage

The following non-exhaustive list of services and expenses are not covered under the Plan:

A. Care, treatment, procedures, services or supplies provided to a person who is not covered and/or eligible under the Plan.

B. Accidents, Sicknesses or dental treatments for which you are entitled to benefits under a workers' compensation or occupational disease law. This exclusion, however, does not apply to the Death Benefit or Accidental Dismemberment Benefit.

C. 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.

D. Any expenses or charges caused by your voluntary participation in a riot.

E. Any expenses or charges caused by war or any act of war, whether declared or undeclared.

F. Any expenses or charges incurred during the commission of a felony or involvement in a criminal act, except for injuries resulting from acts of domestic violence or suicide.

G. 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.

H. Any expenses or charges for which you do not have to pay.

I. 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.

J. 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.

K. Any expenses or charges for Experimental or Investigative Treatments and Procedures.

L. Any expenses or charges for services and supplies that exceed the Usual and Customary Fees.

M. Any expenses, charges or treatments received in any penal facility or jail or equivalent institution.

N. 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).

O. Any expenses or charges for third party ordered care, such as a pre-employment physical.

P. 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.

Q. Charges that would not have been made if this Plan did not exist.

SECTION 19: COORDINATION OF BENEFITS

19.01 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.

19.02 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. This Plan when you are covered as:

   1. An Employee and as a Dependent; or

   2. A Dependent child of more than one Employee.

19.03 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 its 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.

This Plan defines Allowable Expenses as any necessary, reasonable and customary item of expense for medical care or treatment that is covered under at least one of the plans by which you are covered. 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 Expense and a benefit paid, as long as the service is covered under this Plan. Allowable Expenses do not include any portion of a charge that is not considered a Covered Medical Expense under this Plan.

If you or a Dependent is covered by another group plan or source in addition this Plan, the order of benefit payment will be determined according to the Plan's Coordination of Benefits Rules.

19.04 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. The plan who covers the parent who had custody at the time the child reached the age of majority will be primary.

    3. If there is no court decree and the parent with custody has remarried, the order of benefits for the child are 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. For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the spouse's plan will be primary and the parent's plan will be secondary.

F. 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.

G. 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.

H. If a person who has COBRA Continuation Coverage is also covered under another plan as an employee, Retiree or dependent, the COBRA Continuation Coverage is secondary.

I. 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.

19.05 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.

19.06 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 Retiree

If you retire and are eligible for Retiree Benefits, 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 Based on Active Employee 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 Retiree Benefits, 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 Based on Retiree 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 20: SUBROGATION OR REIMBURSEMENT

20.01 Reimbursement to the Plan

The Fund's right of subrogation and reimbursement arises when benefits are paid on behalf of you or your Dependent as a result of an Accident or Sickness for which another party may be responsible. By accepting benefits under the Plan, you agree to reimburse the Fund for all such expenses paid on your behalf or your Dependent's behalf related to the Accident or Sickness.

Under these circumstances, the Fund is entitled to full and total reimbursement (100%) of its past, present or future expenditures related to the Accident or Sickness from all Third Party recoveries and as such, you shall be deemed to hold the right to recovery against such party in trust for the Plan.

20.02 Third Parties Defined

A Third Party is defined as a person or a business entity and shall include, but is not limited to:

A. Any person or entity legally responsible for your injury;

B. Other benefit plans;

C. An insurance company, including but not limited to the party at fault's insurance;

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.

20.03 Your Responsibilities

By accepting benefits under this Plan, your responsibilities include, but are not limited to the following:

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 the following:

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. Any accident reports; and

4. Any other information the Fund Office requests.

C. If you fail to meet your responsibilities, the Fund 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 the right to prosecute your claim and maintain an action against the Third Party on your behalf.

20.04 If You Are Reimbursed by a Third Party

The Fund is entitled to 100% reimbursement of all medical and short term disability claims paid on your and/or your Dependent's behalf, related to the Accident or Sickness, from all Third Party recoveries.

The Fund's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of you and/or your Dependent, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Therefore, if you and/or your Dependent receive payment from or on behalf of a Third Party for claims paid by the Fund, you must reimburse the Fund for 100% of benefits paid under the Plan. The proceeds from the settlement or judgment must be divided as follows:

A. The Plan has priority over all monies recovered. Accordingly, you or your representative must pay a sum sufficient to fully reimburse the Fund for all (100%) benefits paid related to the Accident or Sickness. You must pay your own legal fees and other costs of litigation in connection with the recovery from a Third Party. No reductions or deductions are allowed for litigation costs, court costs, or attorneys' fees (i.e., the Common Fund Doctrine, Make Whole Doctrine, and/or any other state law affecting these rights are preempted by this Plan provision under ERISA).

B. Any remaining monies 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/or your Dependents shall be responsible for compliance with these provisions and the provisions of any Subrogation and Reimbursement Agreement. You will also be responsible for compliance by your or your Dependents' agents, representatives 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 and 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. The Fund reserves the right to be reimbursed for its court costs and attorney's fees necessary to recovery payment.

Upon full reimbursement to the Fund, future claims related to the Accident or Sickness not already paid by the Fund will be your and/or your Dependent's responsibility, unless and until you and/or your Dependents incur related expenses which exceed the proceeds from your and/or your Dependents' ultimate recovery.

20.05 Attorney Common Fund Doctrine Claims against the Fund

If you and/or your Dependent(s) retain your own attorney, you are wholly responsible for all attorney's fees or other expenses incurred to obtain the Third Party recovery. If the attorney(s) that you and/or your Dependent(s) retain in relation to an Accident or Sickness brings a separate claim or lawsuit against the Fund to recover his/her attorney's fees under the Common Fund Doctrine, *quantum meruit*, unjust enrichment or other similar state laws, you and/or your Dependent(s) are required to reimburse the Fund from the money you and/or your Dependent(s) recover from any Third Party for (i) any money judgment entered against the Fund in the lawsuit brought by the attorney and (ii) the Fund's attorney's fees and costs defending the lawsuit, regardless of whether the Fund prevails or loses. You and/or your Dependent(s) shall fully indemnify, hold harmless and defend the Fund and its Trustees, employees and agents from and against any such claims or lawsuits. The Fund shall have the right to appoint counsel.

To the extent the Fund is required to initiate a formal proceeding against you and/or your Dependent(s) to enforce its reimbursement rights, you and/or your Dependent(s) shall also be responsible for the Fund's attorney's fees and costs incurred. In addition, to the extent the expenses, including but not limited to attorney's fees and costs, incurred by the Fund exceed the amount you and/or your Dependent(s) recover from any third party or you and/or your Dependent(s) refuse or fail to reimburse the Fund from any third party recovery, the Fund shall have the right to withhold benefits to you and/or your Dependent(s) until such time that the Fund is reimbursed in full for all expenses, including but not limited to attorney's fees and costs.

20.06 Lien on Third Party Recoveries

You and/or your Dependent(s) grant the Fund a lien on the monies recovered from any Third Party in the amount of (i) all medical and short term disability claims paid on your and/or your Dependent's behalf, (ii) any money judgment entered against the Fund in the lawsuit brought by the attorney, and (iii) the Fund's attorney's fees and costs in defending the lawsuit, regardless of whether the Fund prevails or loses.

SECTION 21: CLAIMS AND APPEALS PROCEDURES

21.01 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 you institute legal action after the denial of your internal appeal or after the denial of your external review, your lawsuit must be filed within 90 days of the date of such denial.

B. Discretionary Decision Making Authority of the Trustees

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. 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 nor affect the rights and liabilities of any of the parties under 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; to interpret any facts relevant to the determination; and to determine eligibility and entitlement to benefits under 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.

21.02 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 a 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 Plan, 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

To file a claim for benefits under this Plan, you must generally submit a completed claim form within 365 days from the date the service for the charge is rendered. You may obtain the claim form by calling the Fund Office. A claim may be filed by a participant, covered Dependent, an authorized representative or by a network provider. If you use the services of a PPO or other network provider, the provider will generally file your claims for you. If a claim is filed by a provider, the provider will not automatically be considered a claimant's authorized representative.

1. Hospital, Physician and Medical Claims for Active Employees and Pre-Medicare Retirees

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. Unique ID number found on your medical ID card;

e. Date of service;

f. CPT Plus 2021 Edition (the code for Physician services and other health care services found in the *Current Procedural Terminology, Fourth Edition*, as maintained, updated and distributed by the American Medical Association);

g. ICD-10 (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. Hospital, Physician and Medical Claims for Medicare Retirees

The Fund contracts directly with Medicare to receive Medical 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 Medicare Retirees will not have to file a claim for their supplemental benefits with the Fund Office.

3. Prescription Drug Claims

You can avoid the need for filing direct claims by presenting your identification card to the pharmacy when you have your prescription filled. If you need to file a claim form, you may send or fax it and any accompanying receipts to the PBM Claims Department as identified on your identification card.

4. Dental Claims

All dental and orthodontia claims should be filed with Delta Dental. The Fund will consider your claim to have been filed as soon as it is received by Delta Dental.

5. All Other Benefits

You should contact the Fund Office about how to file a claim for all other benefits provided under the Plan.

D. Where to File a Claim

1. Hospital, Physician, and Medical Claims for Active Employees and Non-Medicare Retirees

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 the following address:

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

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

2. Prescription Drug Claims

For more information on where to file a Prescription Drug claim, please contact the PBM by using the number located on the back of your identification card.

3. Dental Claims

All dental and orthodontia claims should be sent to the following address:

Delta Dental
P.O. Box 5402
Lisle, IL 60532

4. All Other Benefits

Your vision claims should be filed with the Vision Network Provider as stated in Section 13. You should file your death, hearing and weekly disability claims at the following address:

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

21.03 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. A claim is considered to have been filed on the day it is received by the appropriate recipient as indicated in Section 21.02(D) even if it is incomplete.

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.

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. Death Benefit and Accidental Dismemberment Claims

Ordinarily, the Fund will notify you of the decision on your claim within 90 days from the Plan's receipt of the claim. The Fund may extend this period one time for up to 90 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 90-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

3. 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.

21.04 Notice of Initial Decision

The Fund will provide you with a written decision, in a culturally and linguistically appropriate manner, of the initial determination about your claim within certain timeframes after your claim is received. The notice must provide the following information:

A. Sufficient information to identify the claim involved, including the date of service, the healthcare provider, the claim amount (if applicable), and a statement that, upon request, the Fund will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

B. The specific reason(s) for the denial of benefits or other Adverse Benefit Determination, including the denial code and its corresponding meaning;

C. A specific reference to the pertinent provision(s) of the Plan upon which the decision is based;

D. A description of any additional material or information that is needed to process your claim and an explanation of why the information is needed;

E. A copy of the internal and external review procedures and time periods to appeal your claim, and a statement of your right to bring a civil action under ERISA following an Adverse Benefit Determination on review;

F. The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman to assist individuals with the internal claims and appeals and external review processes;

G. 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;

H. If your health or Weekly Accident and Sickness Disability claim was denied on the basis of not being Medically Necessary, of being Experimental Treatment or of 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; and

I. For Weekly Accident and Sickness Disability claims, the following additional information must be provided:

1. An explanation of the decision, including the basis for disagreeing with or not following:

    a. The views presented by you of the health care and vocational professionals who treated or evaluated you;

    b. The views of medical or vocational experts obtained by the Fund in connection with your claim, without regard to whether the advice was relied upon in making the Adverse Benefit Determination; and

    c. A disability determination by the Social Security Administration.

2. 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 alternatively, a statement that such internal rules, guidelines, protocols, standards or other similar criteria do not exist.

3. 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.

21.05 Internal Appeal Procedures

A. Internal 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 Dismemberment Benefit claim.

You must file a request for an appeal of the denial of a Death Benefit or Accidental Dismemberment Benefit 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. Internal Appeal Procedures

The internal 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. Before the Fund can issue a final internal Adverse Benefit Determination based on new or additional evidence and/or a new or additional rationale, you must be provided, free of charge, with the new or additional evidence and/or the new or additional rationale; this information must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is required to be provided to give you a reasonable opportunity to respond prior to that date.

4. 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.

5. 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 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 Internal 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 business days after the decision has been reached.

2. Weekly Accident and Sickness Disability Benefit Claims

The decision will be made in the same manner as for health claims, except that if the additional information required to be sent under Section 21.05(B)(3) is provided to you within 30 days of the next regularly scheduled meeting of the Board of Trustees, then the appeal determination will be postponed until the second regularly scheduled meeting following the date the additional information is provided.

3. Death Benefit and Accidental Dismemberment Benefit 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.

21.06 Notice of Decision on Internal Appeal

The Fund will provide you with a written decision, in a culturally and linguistically appropriate manner, on any appeal of your claim. The notice of a denial of a claim on appeal will state the following:

A. Sufficient information to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable). Upon request, the Fund will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

B. The specific reason(s) for the determination including the denial code and its corresponding meaning;

C. Reference to the specific Plan provision(s) on which the determination is based;

D. 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;

E. A statement of your external appeal rights, an explanation regarding how to initiate those rights, and your right to bring a civil action under ERISA following an Adverse Benefit Determination on internal appeal; and

F. The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman to assist individuals with the internal claims and appeals and external review processes;

G. 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;

H. If the determination was based on Medical Necessity review or because the treatment was Experimental or Investigational or some 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 Plan to your claim, or a statement that it is available upon request at no charge; and

I. For Weekly Accident and Sickness Disability claims, the following additional information must be provided:

1. An explanation of the decision, including the basis for disagreeing with or not following, as applicable:

a. The views of the health care and vocational professionals who treated or evaluated you;

b. The views of medical or vocational experts obtained by the Plan, without regard to whether the advice was relied upon in making the Adverse Benefit Determination; and

c. A disability determination by the Social Security Administration.

2. 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 alternatively, a statement that such internal rules, guidelines, protocols, standards or other similar criteria do not exist.

3. A description of any contractual limitations period applying to your right to bring a civil action under ERISA following an Adverse Benefit Determination on internal appeal, as well as the calendar date on which the Plan's 90-day limit for filing suit expires.

21.07 External Review Procedures

A. External Review Filing Deadline

If your health care claim involving medical judgment or a rescission of coverage was denied under the internal appeals procedures, resulting in an Adverse Benefit Determination, you have the right to file a request for an external review by an independent review organization with the Fund Office within four months of the date of the internal appeal decision.

However, you do not have a right to request external review if your health care claim did not involve medical judgment or a rescission of coverage. For example, a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that you or your Dependent fails to meet the requirements for eligibility under the terms of the Plan is not eligible for the external review process.

B. External Review Process

The external review process works as follows:

1. Request for External Review

Within five days of the Plan's receipt of the request for external review, the Plan must determine whether:

a. You are or were covered under the Plan at the time of service or requested service;

b. The Adverse Benefit Determination does not relate to your failure to meet the Plan's eligibility requirements;

c. You exhausted or are deemed to have exhausted the Plan's internal appeal process; and

d. You have provided all information and forms required to process an external review.

2. Determination of Eligibility for External Review

Within one business day after the completion of this review, the Fund must notify you (or your authorized representative) whether the request is complete and is eligible for review. If the request is not complete, the Fund must provide notice of what information or materials are needed and allow you to perfect the request within the four-month filing period or 48 hours following receipt of the notification, whichever is later. If the request is not eligible for external review, the notice must include the reason(s) for ineligibility and contact information for the Employee Benefits Security Administration.

3. Referral to an Independent Review Organization (IRO)

If your request is eligible for review, the Fund will utilize an unbiased method to assign the external review to one of its three IROs. The timeline for completion of the external review is as follows:

a. The IRO will timely notify you of receipt of assignment of the external review and such notice will inform you that you may provide additional information within ten business days following receipt of the notice. The IRO is not required, but may, accept and consider additional information submitted after ten business days.

b. The Fund must provide the claim file and any information considered in making the Adverse Benefit Determination within five business days after the date of assignment to the IRO. Failure by the Fund to submit the information to the IRO may result in an immediate reversal of the Adverse Benefit Determination. The IRO must send notice of such to you and the Fund within one business day.

c. The IRO must forward any additional information received from you to the Fund within one day of receipt and the Fund may reconsider and reverse its

decision, terminating the external review. The Fund must provide notice within one business day of such a decision to you and the IRO.

d. The IRO will review all information received de novo and may not be bound by any decisions or conclusions reached during the Fund's internal claims and appeals process. In addition to all information provided, the IRO may consider the following information, if the IRO deems it appropriate:

i. The claimant's medical records;

ii. The attending health care professional's recommendation;

iii. Reports from appropriate health care professionals and other documents submitted by the Plan, claimant or treating provider;

iv. The terms of the Plan;

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

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

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

4. Request for an Expedited External Review

You may make a request for an expedited external review if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal or standard external review as described above would seriously jeopardize the life or health of the claimant or would jeopardize the ability to regain maximum function or if the final Adverse Benefit Determination concerns an admission, availability of care, continued stay or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

An expedited external review will occur in accordance with the procedures stated above for a standard external review, except that each step must be performed in the most expeditious method and the IRO must provide the claimant of its decision as expeditiously as the circumstances require, but no more than 72 hours after the IRO receives the request for an expedited external review. If the decision is not communicated in writing, the notice must provide written confirmation to you and the Plan within 48 hours after notice is provided.

C. Timing of Notice of Decision on External Review

The assigned IRO must provide written notice of the final external review to the claimant and the Plan within 45 days after the IRO first receives the request for review.

D. Content of Notice of Decision on External Review

The IRO will provide you and the Fund with a written decision. The notice of the decision will contain all of the following:

1. A general description of the reason for the request for external review including sufficient information to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning and the reason for the previous denial.

2. The date the IRO received the assignment and the date of the IRO decision.

3. Reference to the evidence or documentation, including the specific coverage provisions and evidence-based standards that were relied on in making its decision.

4. A discussion of the principal reason(s) for the IRO's decision, including the rationale for the decision and any evidence-based standards that were relied on in making its decision.

5. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or the claimant.

6. A statement that judicial review may be available to the claimant.

7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsmen established under Section 2793 of the Public Health Service Act.

21.08 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.

21.09 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 a valid claim before payment is made. The affidavit will release the Fund from further liability.

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

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

21.11 Benefit Payment to an Incompetent Person

Benefit payments under the Plan 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.

21.12 Misrepresentation or Falsification by Participant

If you make an intentional misrepresentation or falsification of any information or a matter in connection with any application or claim for benefits, the Trustees or their representative(s) may deny all or part of the benefits that might otherwise be due.

21.13 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.

21.14 Prohibition on Rescission

The Plan cannot rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. A rescission is a cancellation or discontinuance of coverage initiated by the Plan that has retroactive effect, unless it is attributable to a failure to pay timely required premiums or contributions towards the cost of coverage. The Plan must provide 30 calendar days advance notice to a covered person before coverage may be rescinded.

SECTION 22: DEFINITIONS

22.01 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. **Active Employee** means an Employee who is not retired.

C. **Adverse Benefit Determination** means a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on:

1. A determination of a person's eligibility to participate in the Plan (including a rescission of coverage);

2. A determination that a benefit is not a covered benefit;

3. The imposition of a source-of-injury exclusion, network exclusion or other limitation on otherwise covered benefits; or

4. A determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

D. **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.

E. **Chemical Dependency/Substance Abuse** means any abuse of, addition to, or dependency on the use of drugs, narcotics, alcohol, or any other chemical (except nicotine).

F. **Collective Bargaining Agreement** is any applicable Collective Bargaining Agreement now existing or executed in the future between the Union and an Employer which provides for Contributions to the Trust Fund, as well as any extensions, amendments, or renewals thereof.

G. **Co-Payment** means the fixed dollar amount you are required to pay for services at the time you receive services.

H. **Covered Employment** means employment of an Employee by an Employer for which contributions to this Fund are required.

I. **Covered Medical Expenses** means the UCR Charges for expenses ordered by a Physician and incurred by a covered person for Medically Necessary services and supplies required for the treatment of a non-occupational Accident or Sickness.

J. **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.

K. **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.

L. **Dependent** means any one of the following individuals:

1. An Employee's spouse (marriage license and birth certificate required).

2. Each child of an Employee from the date he or she first becomes a child of the Employee to the end of the month in which such child attains age 26 (birth certificate required).

3. An unmarried child who is incapable of self-sustaining employment by reason of mental or physical disability, provided:

   a. Such incapacity began before the end of the calendar year such child attains age 26; 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.

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.

M. **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, (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.

N. **Employer** means any person, firm, association, partnership or corporation which is a signatory to a Collective Bargaining Agreement which requires contributions to this Fund. 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.

O. **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.

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.

P. **Fund and/or Welfare Fund** means the Pipe Fitters' Welfare Fund, Local 597.

Q. **Fund Office** means the office of the Pipe Fitters' Welfare Fund, Local 597.

R. **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.

S. **Industry Employment** means work performed in the trade and territorial jurisdiction of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada (UA) for any employer that is not a signatory to a collective bargaining agreement with the UA or any local union affiliated with the UA.

T. **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.

U. **MCA** means the Mechanical Contractors Association of Chicago.

V. **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.

W. **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.

X. **Mental Illness** means those illnesses classified as a disorder in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

Y. **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.

Z. **Plan and/or Welfare Plan** means the Pipe Fitters' Welfare Fund, Local 597, as set forth in this document as adopted by the Trustees and as thereafter amended by the Trustees.

AA. **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.

BB. **PPO** means the preferred provider organization, which is a network of providers that the Fund contracts with to provide a particular benefit (e.g., medical, dental, vision) and to help control costs.

CC. **Prescription Drugs** means legal drugs and medicine approved by the United States Food and Drug Administration (FDA) and dispensed by a pharmacist pursuant to the written prescription of a Physician.

DD. **Preventive Services** means:

1. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved, except as provided below;

2. Immunizations for routine use in children, adolescents and adults that have a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

3. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

4. With respect to women, to the extent not described above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

EE. **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.

FF. **Retiree** means a person who meets the applicable eligibility requirements for Retiree Benefits.

GG. **Sickness** includes pregnancy, childbirth, abortion and related medical conditions among other illnesses.

HH. **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).

II. **Union** means the Pipe Fitters' Association, Local Union 597.

JJ. **Usual and Customary Fee or Charges** means the following:

Medical Expenses

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 fee shall be based on 125% of the amount that would be allowed by Medicare.

   For Emergency Room services from a Non-PPO provider, the fee will be the greater of the following amounts: (a) the median of the amount negotiated with PPO providers for the Emergency Room service; (b) the amount the Plan generally uses to determinate payments for Non-PPO services but applying only PPO provider cost-sharing; or (c) the Medicare rate, excluding any PPO provider cost-sharing.

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

Dental Expenses

1. For service or supply covered under a Plan PPO or similar organization contract, the fee shall be the amount the service provider (Delta Dental PPO and/or Delta Dental Premier) 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 fee will be equal to the 90^{th} percentile of the fee most often charged in the same area by providers with similar training and experience for a comparable service or supply as determined by the Board of Trustees. "Area" means metropolitan area or a county, or a greater area if needed to find a cross section of providers of a comparable service or supply.

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

KK. **Welfare Fund and/or Fund** means the Pipe Fitters' Welfare Fund, Local 597.

LL. **Other Terms**

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

Terms	**Section**
1. Accumulation Account	2.01

SECTION 23: ADDITIONAL PLAN INFORMATION

23.01 Plan Name

Pipe Fitters' Welfare Fund, Local 597.

23.02 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 the date of this Restatement, the Trustees of the Fund are as follows:

Union Trustees	Employer Trustees
Mr. Dennis M. Hahney Pipe Fitters' Welfare Fund, Local 597 45 North Ogden Avenue Chicago, Illinois 60607	Mr. Brian Helm Helm Group 2279 E. Yellow Creek Road PO Box 690 Freeport, Illinois 60132
Mr. Chris Hernandez Pipe Fitters' Welfare Fund, Local 597 45 North Ogden Avenue Chicago, Illinois 60607	Ms. Kathleen McCauley McCauley Mechanical Construction 8787 South 87th Avenue Bridgeview, IL 60455
Mr. Michael P. Maloney Pipe Fitters' Welfare Fund, Local 597 45 North Ogden Avenue Chicago, Illinois 60607	Mr. Marc A. Pittas Hill Mechanical Services 11045 Gage Avenue Franklin Park, Illinois
Mr. Kevin M. Morrissey Pipe Fitters' Welfare Fund, Local 597 45 North Ogden Avenue Chicago, Illinois 60607	Mr. John Rayburn MCA of Chicago 7065 Veterans Blvd Burr Ridge, Illinois 60527

23.03 Plan Sponsor and Administrator

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

23.04 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.

23.05 Agent for Service of Legal Process

Nichole Linhardt
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.

23.06 Fund's Website

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

23.07 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.

23.08 Collective Bargaining Agreement

The Fund is maintained in accordance with a Collective Bargaining Agreement between the 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.

23.09 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, except for the Death Benefit and Accidental Dismemberment Benefit which are insured.

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

23.10 Discretionary Authority of Plan 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.

23.11 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.

23.12 Type of Plan

This Plan is maintained for the purpose of providing death, accidental 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.

23.13 Gender

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

23.14 Assignment

No participant, Dependent or beneficiary entitled to any benefits under this 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 Fund, or benefits of this Plan. Neither the 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 have the sole discretion to choose to 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 nor does it guarantee that it will choose to honor all or any such authorizations.

23.15 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.

23.16 Severability Clause

If a provision of the Trust Agreement or the Plan or any amendment made to the Trust Agreement or to the Plan is determined or judged to be unlawful or illegal, such illegality will apply only to the provision in questions and will not apply to any other provisions of the Trust Agreement or the Plan.

23.17 Recovery of Benefits Paid in Error

If for any reason, any benefit paid to a covered person under this Plan is determined to have been in error, or wholly or partially in excess of the amount to which such payee was entitled to receive under the Plan, the Trustees may collect such erroneous benefit payment or overpayment by any remedy as the law may provide.

23.18 HIPAA 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.

23.19 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.

23.20 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.

23.21 Statement of ERISA Rights

As a participant in the 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 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.

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 Trustees 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. Further, 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 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 two months of employment. However, in no event shall coverage begin later than the 91st day following the first day of employment.

For example, Maria was first employed by an affiliated organization on January 11, 2021, and will complete two months of employment on March 11, 2021; so she is eligible for benefits on April 1, 2021.

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, 2021. He will continue eligibility through the end of that month and have three additional months of eligibility through April 30, 2021.

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 the Schedule of Benefits.

When you retire, you and your eligible Dependents will be eligible for Retiree Benefits, 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 Accident 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: NON-BARGAINING UNIT EMPLOYEE ELIGIBILITY EFFECTIVE JANUARY 1, 2022

For purposes of this Appendix B, the term "Non-Bargaining Unit Employee" means any employee of a contributing Employer who is actively employed at least 30 hours per week, including but not limited to corporate owners, corporate officers, and other salaried employees, and is not a bargaining unit alumni, participant of the Welfare Fund or another collectively bargained health and welfare fund, or an employee covered by a Collective Bargaining Agreement.

A. INITIAL ELIGIBILITY

As a Non-Bargaining Unit Employee, you are eligible for benefits on the first day of the month following the month in which your contributing Employer submits the required contributions on your behalf and the following conditions are met:

1. Your contributing Employer has a valid, executed participation agreement with the Welfare Fund;

2. Your contributing Employer makes timely contributions on your behalf;

3. You satisfy any probationary period for newly hired employees required by your contributing Employer (up to two calendar months); and

4. You did not previously opt-out of the Plan. However, if you opted-out of the Plan because you were enrolled in another employer sponsored group health plan, then you may be eligible for coverage under the Plan, provided you apply for coverage within 60 days of the loss of your other coverage.

Coverage under the Plan for Non-Bargaining Unit Employees includes medical, prescription drug, dental, vision, death, accidental dismemberment and weekly accident and sickness disability benefits. For the avoidance of doubt, Non-Bargaining Unit Employees will not be entitled to a Health Reimbursement Arrangement ("HRA"), the Fund's Family Wellness Centers, Retiree Benefits or Surviving Dependent coverage.

B. CONTINUED ELIGIBILITY

You will continue to be eligible for benefits under the Plan for each calendar month in which your contributing Employer timely submits the required contributions. The Board of Trustees of the Welfare Fund determines the amount of contributions required for eligibility.

C. TERMINATION OF ELIGIBILITY

Your coverage under the Plan will end upon the earliest to occur of: (1) the date the participation agreement between your contributing Employer and the Welfare Fund terminates; or (2) the last day of the calendar month during which contributions were contributed on your behalf to the Welfare Fund.

If your coverage terminates, you will then be eligible to elect COBRA Continuation Coverage as set forth under the terms of the Plan.

APPENDIX C: BLUECROSS BLUESHIELD OF ILLINOIS DISCLOSURE NOTICE

BlueCross BlueShield of Illinois

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.